One moment you're covered in blood and next it's what's for tea? An interpretative phenomenological analysis of residential care staff's experiences of managing self-harm with looked after children.

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Abstract

Young people in care have been found to have a higher incidence of self-harming behaviours. However, despite research findings that managing self-harm can be stressful for carers, there has been a dearth of literature which has specifically examined residential carers' experiences of this. Therefore, the current study used an interpretative phenomenological approach to explore the experiences of residential carers in relation to self-harm. Three superordinate themes emerged from the study, each with a number of subordinate themes. 'Surviving' illustrated how managing self-harm can be a difficult experience for residential carers and therefore they need a number of coping strategies to draw upon to manage. 'We're out here alone' represented participants' feelings around being held individually responsible for managing acts of self-harm and also feeling as though outside agencies were inadequate or slow to respond to the young people's needs. 'Losing control' reflected when coping strategies failed, and participants were left feeling uncontained. It also demonstrated the potential negative consequences on their life outside of work. Recommendations are discussed for future practice, including regular staff supervision, team consultation, training and shared risk planning.

Keywords

Residential care, care staff, experiences, self-harm

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Article history

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Introduction

The challenges of working in residential childcare

Residential carers are those who support young people living in children's homes. The young people who live in such homes often have extensive abuse histories, with complex attachment, social and educational needs. Residential carers who work directly with these young people are regularly exposed to daily stressors within the home, including but not limited to physical and verbal aggression, efforts to run away, self-harm and suicide attempts (McLean, 2015). Intervening in such situations can be highly stressful for the residential carers and can often leave them as the target of aggression (Seti, 2007). They are arguably supporting some of the most complex children in society, however, official reviews have highlighted that often their level of training does not adequately prepare them to manage such complex children (Department for England, 2012). Although there has been some headway in improving the training standards with the introduction of the Level 3 Diploma in Residential Childcare there is still no minimum training standard agreed across the UK (Narey, 2016).

Looked after children and self-harm

Self-harm is believed to be due to a combination of genetic, biological, personality, psychological, social and cultural factors (Evans, Hawton & Rodham, 2004). Hawton, Saunders and O'Connor (2012) set out a list of factors based on previous research, which can increase the risk of self-harm. Looked after children are often exposed to an increased number of these risk factors, including: poverty, low income, parental relationship breakdown, substance misuse, mental health problems and / or chaotic or unstable patterns of parenting (Sweeny, 2008). Hurry and Storey (1998) reported that although looked after children only make up 1% of the population they account for 10% of the young people who present in accident and emergency following self-harm.

Specifically those in residential care are at the highest risk of self-harm. This is perhaps not surprising as they often have the most serious forms of mental health problems (Hawton et al., 2012). Meltzer and Lader (2004) found that in Scotland 39% of young people in residential care self-harmed compared to 18% living with birth parents. More recent studies have found proportionally similar prevalence rates. Harkess-Murphy, Macdonald and Ramsey (2013) reported that 32% of young people in care had self-harmed or thought about self-harming, compared to 12% who were not in care (Doyle, Treacy and Sheridan, 2015). Caution should be taken with the more recent studies though as these were taken from much smaller surveys. Given the high rates of self-harm in residential homes it is likely that the residential carers who support these young people encounter intense experiences, which may produce powerful emotional responses (Furnivall, Wilson, Barbour, Connelly, Bryce & Phin, 2007).

In caring professions it is well acknowledged that self-harm can be a particular stressor for staff (Saunders, Hawton, Fortune & Farrell, 2012; Tofthagen, Talseth & Fagerstrom 2014). The majority of studies in this area are quantitative in nature and examine hospital staff's attitudes towards those who self-harm (Friedman, Newton & Coggan, 2006; Mackay & Barrowclough, 2005). A smaller number of qualitative studies have also explored nursing staff's experiences of inpatient mental health settings and found themes relating to feelings of uncertainty and concerns over potential fatality (Thompson, Powis & Carradice, 2008; Wilstrand, Lidgren, Giljie & Olofsson, 2007). In addition to the literature on nursing professions, studies have been conducted with parents of children who self-harm. This is particularly significant because those who care for looked after children take on a therapeutic parent role, which hybrids their formal job role of carer, with the more emotional investment that a parent would usually provide. Ferrey, Hughes, Simkin, Locock, Stewart, Kapur, Gunnell and Hawton (2016) undertook a qualitative study in the UK with 35 young people who had self-harmed and their parents. Thematic analysis highlighted the on-going emotional impact on parents. One parent stated that 'she was surprised she never got carted away in a white jacket' (p. 3), while others stated they had problems with sleeping and eating due to anxiety. Parents also reported the

negative impact on their marriages, other children and jobs, as well as the isolation brought about by feelings of guilt from what others may think. Similar findings have also been elicited by earlier studies (McDonald, O'Brien & Jackson, 2007; Oldershaw, Richards, Simic & Schmidt, 2008).

The experiences and impact of self-harm on residential carers

Despite the evidence that the role of residential carers in children's homes is challenging, there is a scarcity of literature about the impact of working with self-harm.

Furnivall et al. (2007) conducted a survey-based study of residential childcare staff in Scotland. The aim was to compare the results with other professionals' opinions, which had previously been collected in the Scottish Needs Assessment Programme (SNAP, 2003). Questionnaires were sent out to 10% of the workforce (289 residential carers) and replies were received from 104 (36%). Residential carers described the nature of the problems, including violence, aggression, self-harm and substance abuse. One item on the questionnaire invited comments on the most recent and most worrying experiences of working with looked after children. One respondent reported 'self-harm with cutting to all areas of the body especially the genital area' (p. 6). When asked about the impact of their experiences, one residential carer stated: 'I am only a carer — this was way over my head' (p. 9). Overall the results from the survey offer insights into the views of residential carers. The response rate although only 36% compares favourably with other studies of this kind.

The only qualitative study identified, which has concentrated on residential carers' experiences of self-harm in looked after children was that by Williams and Gilligan (2011). One theme elicited from their interviews was *the impact of young people's self-injurious behaviour on staff*. Participants spoke about how the impact of the incidents encroached on their family life 'you'd be thinking about it at home, telling your partner or family. I was very shook up' (p. 18). One participant reported the incidents to be harrowing, stating that she had

'nightmares after the incident' (p. 18). Another participant described the incidents as being quite traumatic reporting that that she was a vegetarian with a fear of blood but had started to buy red meat so she could desensitise herself as she felt her reaction to blood was escalating incidents. Unfortunately this study does not specify any recognised qualitative research method. It appears that no systematic analysis was used but rather patterns were identified intuitively and reported.

Rationale for the research

In summary, looked after children, and specifically those in residential care, are at increased risk of self-harm due to being exposed to a greater number of associated risk factors. There have been numerous studies investigating the impact self-harm has on parents and caring professionals with them all reporting that these experiences evoke strong emotional reactions. Conversely, the experiences of, and the impact self-harm has on residential carers specifically, has been relatively neglected. A thorough search of the literature only discovered one paper, Williams and Gilligan (2011), which did not use a systematic analysis to derive the themes.

The rationale for the present study was that a robust phenomenological analysis of residential carers' lived experiences of self-harm was needed.

Method

Residential carers' experiences of managing self-harm is suited to a qualitative approach as this allows the participant, without restraint, to reflect on their experiences in their own words. Interpretative Phenomenological Analysis (IPA) is a method described by Smith, Flowers and Larkin (2009) and emphasises how people, although experiencing the 'same' environment, may perceive it in different ways (Willig, 2008, p. 53). Therefore the stance of IPA assumes that data collected allow access to people's interactions with the world and the sense they make of it.

IPA is underpinned by a number of theories including phenomenology and hermeneutics. Phenomenology relates to putting aside our 'taken for granted' experiences and instead concentrates on our perception of them. While hermeneutics is the study of interpretation — the whole is understood in terms of the parts, and each part is understood in terms of the whole. IPA involves a 'double hermeneutic', in that the individual participant is making sense of their experiences, while the researcher is making sense of the individual's meaning making (Smith & Osborn, 2008).

Participants

Participants were residential carers and senior residential carers (in the UK this title is used for senior members of the team who have a higher level of qualification or experience) who worked in Local Authority (LA) children's homes in the North East of England. Participants had to have had direct contact with a looked after young person who had self-harmed in the home within the last three years. Nine participants were recruited for the study (four males and five females; four senior residential carers and five residential carers — pseudonyms are used throughout).

Ethics

Ethical approval was granted by Teesside University School of Health and Social Care Research Governance and Ethics Committee. Further to this the LA's Research Advisory Group granted approval.

Interview format

Data was collected via semi-structured interviews guided through an interview schedule. An hour was set aside for each interview to take place. Participants were asked open-ended questions about their general and specific experiences of self-harm, the impact self-harm had on their relationships and the support

received in relation to managing incidents. All interviews were taped with a digital recorder and transcribed verbatim.

Data analysis

The transcripts were analysed using IPA. Firstly the transcripts were read repeatedly to help the researcher become immersed within them. The next stage was initial noting, whereby the researcher noted down anything of interest under 3 types of comments: 1) *descriptive comments* (describing the content); 2) *linguistic comments* (exploring the specific use of language); and 3) *conceptual comments* (conceptualising what had been said). Emergent themes were then identified from the initial notes. Each transcript was then attended to separately by reorganising emergent themes into related clusters. At the end of this, an initial map of how emerging themes fit together for each transcript was produced. The final step entailed looking for connections across the whole sample. The list of themes was drawn up for the whole and then reconfigured into superordinate themes, which represented shared higher order qualities.

There are a plethora of guidelines, which assess the quality of qualitative research and Smith, Flowers and Larkin (2009) recommends Yardley's (2000) guidelines. These are made up of four principles: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. A number of these methods were employed in this study to enhance the credibility of the findings. These included participant validation, where members were contacted after the analysis to check that themes were reflective of their narratives. Six out of nine participants responded with comments stating that the themes reflected their experiences. The remaining three participants did not respond. Triangulation was undertaken with supervisors to improve the validity of the research. A reflective diary was also used to make the researcher's assumptions and existing beliefs transparent as it is inevitable that the researcher's own preconceptions will have an impact on the interpretation of the research. The researcher used to work in residential care; therefore it is likely that this will have had an impact on the interpretation of the data. The
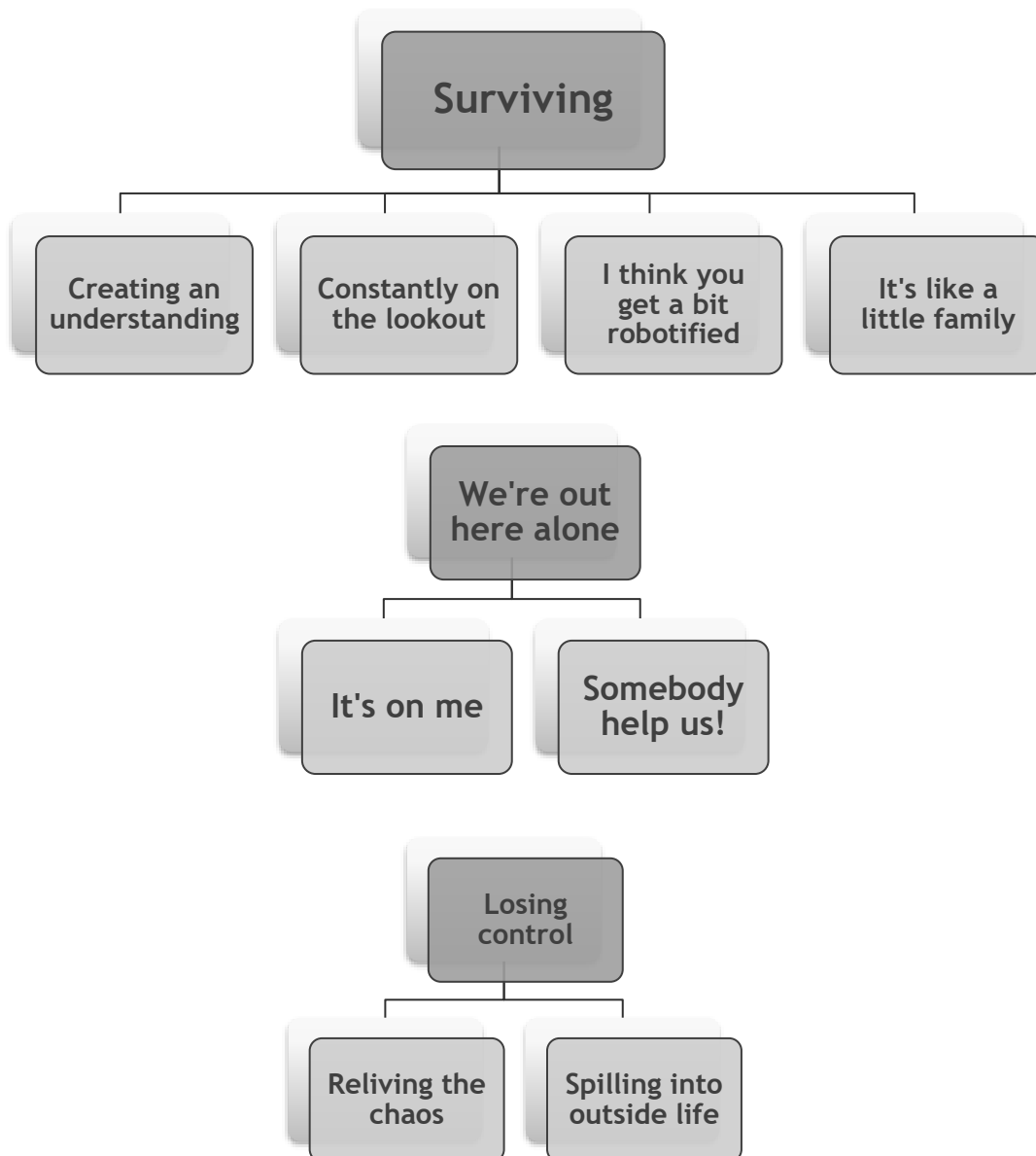
reflective diary helped to circumvent this, as well as keeping as close to participants' accounts as possible.

Results

The analyses of the nine interviews led to the emergence of three superordinate themes, which contained varying numbers of subordinate themes. Figure 1 illustrates this.
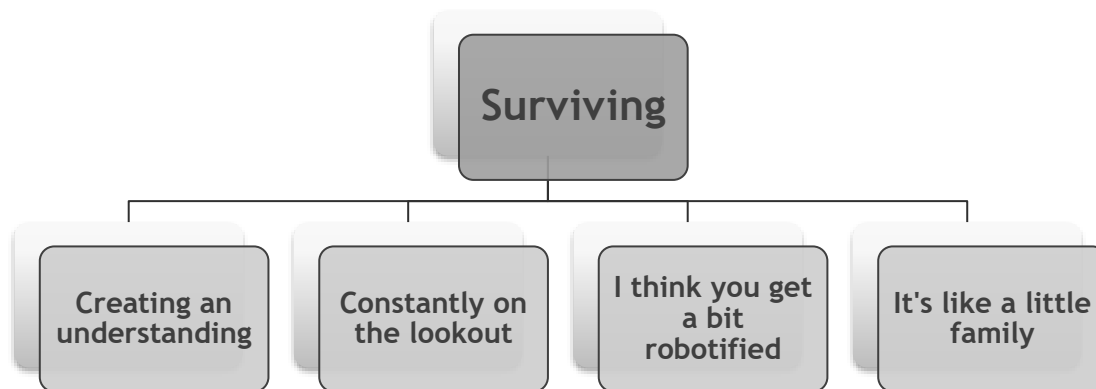

Figure 1: Superordinate themes (dark grey) and subordinate themes (paler grey)

Surviving

Figure 2: Superordinate 'Surviving' theme (dark grey) and its subordinate themes (paler grey)

The first superordinate theme illustrates how participants need a variety of coping strategies to manage self-harm both in relation to the behaviour itself, and to their own responses to it.

Creating an understanding

Participants tried in a variety of ways to comprehend the behaviour and seven out of nine participants imposed a self-defined framework of categories:

> Rachael: I think some self-harmers, even myself rightfully or wrongfully probably have them in three categories; your kind of minor superficial self-harmers, a little bit of a cry for attention, your middle ones that are hurting themselves and they're a little bit more serious and then I think you have your high end self-harmers (…) ones that really do damage when they cut themselves and it's kind of a life or death situation.

> Nick: If someone cuts on the inside of the arm very deep, I'm severely concerned about that person but scratches on the outside, I'm not as concerned that it's life threatening.

> Victoria: It seems to be for me 2 levels, people who self-harm (…) to follow trends and then you'll get the other end of the scale where people (…) use it for a coping mechanism.

The participants seem to use the categories to help guide how risky the behaviour is, which may assist them in feeling as though they have some control in managing it.

Rachael also made sense of the behaviour in an intellectualised way rather than in a way that connects with the young person's story at an individual level:

> Rachael: But on the emotional side, that's a little bit more different because you want to get to the root of what is driving it, it's quite hard to listen (…) it's just not nice to hear their stories and how sad they feel inside to make them want to hurt themselves. So the physical bit I don't find that difficult to deal with (…) I'm not scared of blood.

In this excerpt Rachael names that it is difficult for her to deeply connect with the young person's history. It appears that the correction aspect of the act, that is the problem solving, is much easier for her to put into action than the connection side, where she has to relate with the affect being communicated.

Constantly on the lookout

This subordinate theme reflects how participants are often on high alert either to pre-empt self-harm or to respond quickly if necessary.

> Adam: [Y]ou've got to try and be aware at all times, especially with this young person, you have to be on alert from the moment you come in to the moment you leave your shift.

Tracey: It's worse for me if someone doesn't know how to safely self-harm (…). So you've always got to have your eyes peeled and be ready to respond.

Stephanie goes on to explain how this can be mentally tiring:

Stephanie: You're constantly on the look and on the go. It's mentally draining. It's not so much a physically draining job but the self-harm and stuff as well, it's mentally draining and I think it's because you're constantly on the look and on the go.

I think you get a bit robotified

A number of the participants talked about how they have learnt to manage situations of self-harm in a robotic fashion, which incorporates both an autopilot type response to a situation and also a way to detach from their own feelings. Participants use a variety of words to describe these responses. Rachael and Eric discuss what they call the robotics:

Rachael: We explain to some of our kids that, 'we are humans too you know, yes we might deal with some incidents like robots because we're that used to, but, do you think we'd be doing this job if, if we didn't care?'

Eric: I think you get a bit robotified and just deal with it.

Nick discusses how he goes into autopilot:

Nick: I think you kind of go into sort of autopilot (…) you go into this alright ok, I'll dress the wounds, I'll talk to them, I'll see if I can get the root problem(…). So it just kind of like clicks in.

It's like a little family

Team support was described in nearly all of the participants' accounts; however there was some variation in how participants described this. Janet speaks of it like a family:

> Janet: We're all quite close in here as well, so, it is like a little family, so, you can be quite open about how you feel;

Tracey talks about the team in an intimate way too:

> Tracey: It's a strange place residential because you spend that much time with people I can go to the kettle and put 13 cups out and I can make everyone's cup of tea and coffee, exactly how they like them (…). You spend so much time with people, you do become very important to each other and I think that's when it's difficult, when there's a lot of self-harm that them relationships are really important.

The way she talks about the specific preferences of tea and coffee exemplifies the importance of each individual relationship to her. Calling residential 'a strange place' also links in with how intertwined this job role is in comparison to other jobs.
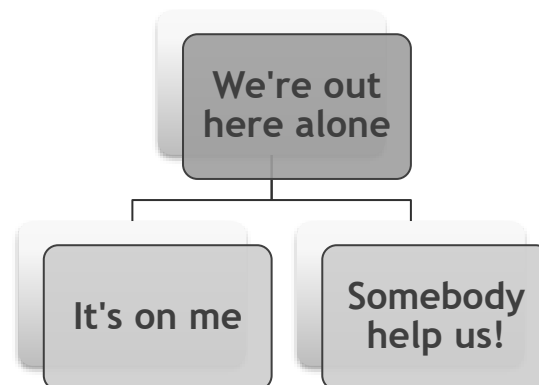
We're out here alone

Figure 3: Superordinate 'We're out her alone' theme and its subordinate themes (paler grey)

The second superordinate theme focuses on how participants can feel a host of responsibilities for managing self-harming behaviour, whilst also feeling unsupported from outside services.

It's on me

This subordinate theme focuses on the responsibility participants feel for managing the act of self-harm correctly.

> Rachael: [B] ut I definitely worry about the blame thing. So, some people might try to avoid dealing with a self-harmer because they're that fearful that if something goes badly wrong and there's a fatality (…) are you going to be blamed and hung out to dry (…) so, it's very worrying, if there was a very serious incident, how you would be treated as a member of staff and how that would be looked into (…). It's bad enough trying to live with that anyway, especially if you were caring for that young person, without all the other pressure of the organisation or the police (…) or whatever investigations have to unfold, looking into

> the ins and outs and trying to point a finger somewhere as if
> there's a negligence.

There is a strong sense that any efforts to do the right thing would be criticised and her concerns seem to relate to the fact that someone has to be blamed regardless of whether this is warranted as she states 'and trying to point a finger "as if" there's a negligence'.

Nick refers to the many questions which run through his mind:

> Nick: I think in work you're more concerned about doing the
> right thing. 'Have I ticked these boxes? Have I notified the right
> people?' Your mind is ticking over about legalities. You know
> 'have I done the right thing?'

Again Nick has to ensure everything has been done correctly so that if there were any repercussions he would be covered. It may be that staying close to policy helps him feel more secure and that the risk is shared.

Adam also speaks about the amount of pressure he feels in making decisions:

> Adam: If something happens to them we're going to have to live
> with it and then answer the questions of why didn't we do this or
> why didn't we do that?

Somebody help us!

This subordinate theme was heavily present in certain participants' accounts and referred to participants feeling unsupported from those outside of the home.

> Tracey: [I]t's just that, there's a need for support amongst
> ourselves but it can …almost feel like a deafening silence from
> the other side of that bubble that we're in and as a team we can
> send off long emails and concerns and two days later you're back
> and you're like, nobody has heard me (laughs);

Tracey's use of metaphor to describe the home like a bubble illustrates something which is penetrable and visible to others but yet untouched. She explains how she makes attempts to break the bubble, which often go ignored. Roger also talks about his frustration with not having help from outside agencies:

> Roger: [W]e make the referral and we get told there's a six month waiting list and there's a four month waiting list and we sit and watch our young people get destroyed;

Tracey goes on to express her concerns that the looked after world is intentionally kept concealed, and this is perhaps a societal defence because the truth about what children in care have been through is too difficult for people to absorb.

> Tracey: I think people want to not acknowledge the truth about children in care.

Losing control
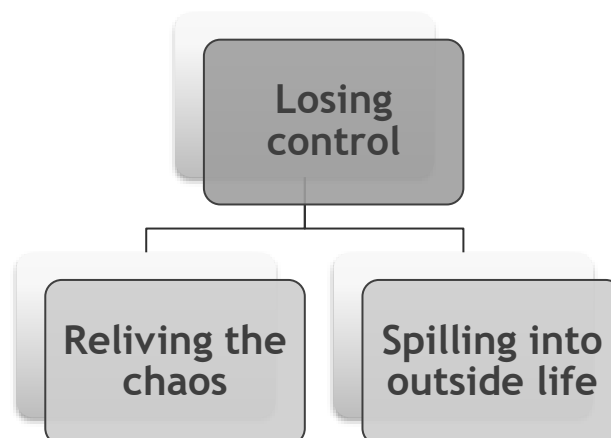
Figure 4: Superordinate 'Losing control' theme and its subordinate themes (paler grey)

The third superordinate theme describes how participants' coping strategies can at times fail them, leading to problems both in the moment and after the event, which can manifest as a loss of control.

Reliving the chaos

This subordinate theme illustrates how participants can experience a breakdown in coping strategies, which can leave them feeling stressed. Stephanie's extract shows an example of this:

> Stephanie: Time slows right down, so, a minute can seem, like (…) 15 minutes but it must have only been 5 or 3 or 2 (…) and you're just thinking, safety, safety, safety, all the time, keep them safe, you know. And your brain gets busy and you can't think properly. You're thinking you haven't got gloves, shit you haven't got gloves, you'd get shot if you didn't put gloves on but you know you have to put the bandage around but I've got no gloves on but you know, you have to stop that bleeding.

Stephanie's account describes how her stress impacts on her ability to both estimate time correctly and think coherently. Her language in the extract also appears to mirror her stressed state as she repeats herself on numerous occasions and discusses how her mind gets more active at these times.

Other participants' recollections also encapsulated the traumatic element of these events. Roger summaries this succinctly:

> Roger: I think they stay with you all the time. They do stay in your brain like, (pause) they can be quite traumatic sometimes.

Spilling into outside life

The majority of participants spoke about how their work spilled over into their home lives in a variety of forms. Tracey talks about how difficult it can be:

> Researcher: How has the experience affected you outside of work, do you think?
>
> Tracey: I think, it's just (…) learning to find ways to switch off and jump back into normal life, like you can be walking around a supermarket thinking, last night I was covered in blood and somebody cut their wrist all down here and were bleeding all over and I wrapped it up and I went to the hospital and got them sorted and now I'm trying to decide whether I want chicken or pork and it's like, it can seem so hard sometimes to switch that back to normal.

This seems to show the contrast between her two worlds and how she struggles to manage the disparity between them. Stephanie also discusses how she takes things home with her:

> Stephanie: I take it home with me but often when you're home, you've got no one to talk to, so you have to wait until you go back to work.

Eric goes on to speak about how the work has impacted his home life:

> Eric: Yeah, you miss out on a lot of social life, relationships and things. I've had (*xxx*) marriages since I've come here and that's not normal. I started sleeping when I sort of go home, do what I need to do and then have an hour and half's sleep, drink a lot more (pause);

Eric talks about how the job has caused ruptures in his relationships and appears to attribute this directly to the work. He also states that he uses alcohol as a

coping strategy outside of work and pauses after he says this as if he knows that it is not an effective way to manage.

Discussion and clinical implications

This study is the first to use a robust qualitative method to analyse residential carers' experiences of managing self-harm with looked after children. Participants spoke about the challenging nature of managing self-harm in residential homes. For this reason they had learnt to develop an assortment of coping strategies which provided them with some assistance for managing these difficult situations and feelings.

Participants discussed the emotional detachment they experienced as a way to manage difficult aspects of the job. Whilst this may serve a purpose in the short term it is likely that this could impact on compassionate care in the long term as participants stated that over time they became cut off, which has implications for both the carer and the young person. Hughes (2004) discussed the concept of 'blocked care' whereby stress impacts on a parent's ability to provide love and empathy to a child which leads to a narrower focus on the child's behaviour. Empathy is a central tenet in the work relating to traumatised young people and if the staff struggle to feel empathy for the young person they are unlikely to make an emotional connection with them, which is vital for the young person's recovery (Hughes, 2004). To assist with this, reflective practice could be used to facilitate residential carers' understanding of the reasons for and impact of emotional detachment. Previous studies have found similar responses whereby nurses had learnt to 'shut off' in order to manage their feelings (Thompson, Powis & Carradice, 2008).

Another finding of the study relates to the stress of managing incidents of self-harm due to the fear of blame. Participants found that at times the weight of responsibility for managing self-harm was a foreboding concern. Yalom (1998) states that people actively try to remove themselves from responsibility due to the fear of being held responsible. In relation to this, Maurizio (2008) discusses

the blame function logic, whereby people are either 'right' or 'wrong' for their actions. He notes that this logic is often applied to frontline staff as opposed to seeing the linear causes which may have led to the events. Reason (1997) states that due to the high levels of autonomy in Western culture individuals are taught to be individually responsible, thereby when an incident occurs people search for a culprit. In this respect a blame culture develops, as Rachael says. 'trying to point a finger somewhere "as if" there's a negligence' as opposed to looking at the system. It is possible therefore that staff members' reliance on ticking boxes and following procedure is a way to externalise some of the responsibility back to the system. Previous research has found similar results whereby nurses found the responsibility for potentially fatal actions difficult to tolerate (Thompson et al., 2008; Wilstrand et al., 2007). Williams and Gilligan (2011) also found that residential carers worried about deviating from procedure because the responsibility was left with them. To help overcome this, risk management plans could be put in place by the care team with the support from appropriately trained mental health professionals such as Child and Adolescent Mental Health Services (CAMHS) clinicians and specialist Looked After Children Services. This could further be supported by wider systems such as education and in-house parties. Such forward planning provides a more collaborative approach which means the whole system works together with carers feeling they are working in partnership as well as being validated in terms of the importance of their role.

There was also a strong consensus amongst participants that external support was not readily available or adequate for the young people and participants relayed their concerns about long waiting times. There also seemed to be a feeling amongst participants that the looked after system was being concealed from society. This appears to demonstrate the concept of societal defence, which is a way of protecting against the truth around the trauma which children in care have suffered (Jacques, 1955). Foulkes (1948) first discussed the concept of the social unconscious and Weinberg (2008, p. 15) defined it as 'the co-constructed shared unconscious of members of a particular social system such as community, society, nation or culture'. Hopper (2003; 2012) states that social

trauma is particularly prevalent in relation to the social unconscious as collectively society defends against the difficult feelings associated with trauma through secrecy and taciturnity. This fits with the account that the looked after world is hidden, perhaps so that society do not have to tolerate the uncomfortable feelings it engenders.

Another finding of this study was the feeling of participants 'losing control' which related to when participants' coping strategies started to fail them which led to problems with their own containment. For some participants this loss of control manifested as a stressed response to the child's self-harming behaviour. This is perhaps not surprising given that they are expected to be responsible for managing the act 'correctly', yet as discussed in other themes they feel inadequately supported and scrutinised. It also goes against their presumed inherent want to care and protect. It is also possible that the participants' stressed response may be a reflection of the powerful projections and re-enactments that the young person uses to communicate their internal world.

Johnson (2016) states that residential staff are at risk of primary traumatisation, due to the witnessing of violent behaviour including self-harm; and also secondary traumatisation due to being exposed to another's traumatic experiences and symptoms. Trauma was not the focus of this study, and this therefore remains a tentative link; however there did appear to be indications of trauma present in participants' accounts. Senior managers should be aware that the situations care staff deal with may cause lasting psychological effects. Perry (2003) states as there is a lack of investment in frontline services for secondary trauma, supervisors are left with the task of managing this within the homes (p. 8). In this respect, services need to be better informed about how trauma impacts on care staff and how supervision, consultation and training can be used proactively to address these issues sensitively.

Participants also spoke about how the work impacted on their life outside of the home. This relates to previous research by Ferrey et al. (2016) who found parents of children who self-harm to have on-going problems with their

emotional state which had ripple effects into family life. Williams and Gilligan (2011) also found managing self-harm to have a negative impact on home life for residential carers. Tyler (2011) reports that in order to manage these feelings, care staff may leave the organization, go on sick leave or build up more rigid defences, which further perpetuates the problem.

Although it sits outside of the realms of this research it is possible that the three superordinate themes reflect the children's internal world: surviving, feeling alone and struggling to cope. Previous work by Hindle and Shuman (2008) reported similar findings with their play therapy case study 'Sam': a 9 year old boy who had been in care. Through his plasticine modelling of a war zone they interpreted his internal world as one of 'standing alone, taking on the whole world and surviving' (p. 83).

Recommendations

- Reflective practice groups facilitated by professionals with appropriate training and experience to help staff better understand their emotional reactions to self-harm and the implications of these.

- Professionals who are appropriately trained in risk management to consider supporting the creation of risk plans when the young person is stable which incorporate the views of the carer. This will help the residential worker to feel more empowered and supported in their role.

- Training for managers and staff in supervisory positions relating to the psychological impacts of managing self-harm and how this could be incorporated usefully into their supervision.

- Consultation and training for residential care staff on trauma informed care and its associations with self-harm.

The current study only focused on residential carers and senior residential carers. Future research could explore home managers' experiences of self-harm to see how the results compare to the current study.

Limitations

Every effort was made to ensure the results of the study were robust, but it is important to acknowledge its limitations. Only six of the nine participants responded to the participant validation and therefore it is possible that the three who did not respond did not agree with the themes. Also the researcher's previous experience of working in a children's home may have influenced the themes elicited.

Conclusion

Managing self-harm was reported to be an emotionally demanding experience for care staff and they had learnt to manage using a variety of coping mechanisms. In the short term these were effective but had potential to incur longer-term damage to both themselves and the young people. Clinical implications included the need for more focused supervision around the potentially traumatic elements of managing these events, consultation for staff teams and a move towards shared risk planning. As this study is relatively novel, future research is recommended to expand on the specific findings of the research in more depth.

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