Survival, signalling and security: Foster carers' and residential carers' accounts of self-harming practices amongst children and young people in care

Abstract

Research on clinician's interpretations of self-harming practices has shown that they can often be negative. To date there has been limited consideration of other professionals' narratives, notably those working in social care. This article presents focus group and interview data generated with foster carers (n=15) and residential carers (n=15) to explore the symbolic meanings ascribed to self-harm amongst the children and young people they care for. Three repertoires of interpretation are presented: survival, which conceives self-harm as a mechanism for redefining the identity of 'looked-after'; signalling, which understands self-harm as a communicative tool for the expression of emotion; and security, which sees self-harming practices as testing the authenticity and safety of the caring relationship. Through their focus on socio-cultural narratives, carers position themselves as experts on self-harm due to their intimacy with young people's social worlds. This construction potentially creates distance from health professionals, which is problematic given the current privileging of inter-professional working.

Background

Self-harm has been defined as an act with a non-fatal outcome, whereby an individual initiates a behaviour or ingests a substance with the intention of causing harm to themselves (Owens, Hansford, Sharkey & Ford, 2016). It remains a highly contested construct however, with notable debates abounding about the underpinning causes of self-harm (Chandler, Myers & Platt, 2011; Millard, 2013; Chandler, 2014), the practices that constitute it, and the differentiation of acts with and without an associated suicidal intent (Muehlenkamp & Kerr, 2010; Kapur, Cooper, O'Connor & Hawton, 2013). Such contestations largely arise from the diversity of repertoires deployed to construct meaning and the complex processes often involved in understanding such practices (Chandler, 2014). Attending to contrasts in narratives is imperative. It is only through the elicitation of (dis)continuities within and across registers of meaning that we can start to address any incongruence between the needs of those who experience self-harm and the tenor of support offered by professionals delivering formal and informal care (Sinclair & Green, 2005; Chandler, 2014).

The present article offers an exploration of the symbolic meanings ascribed to self-harming practices by social care professionals, notably foster and residential carers. To date there has been no empirical consideration of this professional group's narratives despite necessitating examination. Children and young people in care are at an elevated risk of suicide-related outcomes (Pilowsky & Wu, 2006, Sawyer, Carbone, Searle & Robinson, 2007; Katz, Au, Singal, Brownell, Roos, Martens…Sareen. 2011), with a recent systematic review indicating that they are more than three times as likely to attempt suicide as the general population (Evans, White, Turley, Slater, Morgan, Strange & Scourfield, 2017). Within this high risk context, social care professionals play a significant and immediate role in intervention and management, being centrally involved in securing specialist mental health provision (Stanley,

2007). As such, their accounts are likely to be highly influential in informing the extent and nature of support offered.

This process might be complicated by the complex and intricate relational dynamics that exist within the care system. Although roles are often clearly and statutorily delineated and bounded, in practice we may witness the blurring of the personal and the professional (Thompson & McArthur 2009). In essence, corporate parenting is conducted in a formal, statutory capacity, but simultaneously requires carers to carry out the intimate, everyday task of nurturing a child (Schofield, Beek, Ward & Biggart, 2013). It is somewhat inadequate then to rely upon the extant research exploring other professional groups' accounts: carer's responses and reactions may be even more complex, potentially touching upon the ruminative, emotive sense making processes documented by parents (Hughes, Locock, Simkin, Stewart, Ferrey, Gunnell …Hawton, 2017).

Whilst not directly applicable, the corpus of research on clinicians' accounts of self-harm does provide a useful departure point for the exploration of social care practitioners' narratives. Since Jeffery's (1979) consideration of the moral accounts provided by A&E staff, numerous studies have described how those who self-harm have been negatively typified within clinical settings (McAllister 2003; Hadfield, Brown, Pembroke & Hayward, 2009; Gibb, Beautrais & Surgenor, 2010; Saunders, Hawton, Farrell & Fortune, 2012). Indeed, they are often prevented from assuming what the 'sick role', where individuals are deemed to have a legitimate claim to a sanctioned form of social deviance (Jeffery, 1979). Rather individuals who self-harm are often constructed as attention seekers, unentitled to assistance due to the infliction of their own injuries (Chandler, 2016). Such accounts are intricate however, with many also being inscribed with sympathy and compassion, particularly towards children and young people (Crawford, Geraghty, Street & Simonoff, 2003; Friedman, Newton, Coggan, Hooley, Patel, Pickard & Mitchell, 2006; Sun, Long & Bore, 2007).

Rather unsurprisingly, studies have found that the negative symbolic meanings held by clinicians has led to negative experiences amongst those utilising services (Taylor, Hawton, Fortune & Kaypur, 2009; Chandler, 2016). Punitive or inadequate treatment has been reported to increase hopelessness, discourage future help-seeking and even contributes to future repetition (Hunter, Chantler, Kapur, & Cooper, 2013; Owens et al., 2016). Moreover, dominant understandings of self-harm are largely located with the bio-medical model, which had led to the elision of more complex socio-cultural explanations (Redley, 2004; Chandler et al., 2011). These broader understandings have ranged from the utilisation of self-harming practices to cope, often through the displacement of emotional pain, to the construction of self-harm as an act of learned social deviancy (Sinclair & Green 2005; Adler & Adler 2007; Adler & Adler 2011; Chandler 2012a; Chandler 2012b; Chandler 2016). Omission of these multifaceted meanings has historically led to the perpetuation of restricted taxonomies of the self-harming individual (Adler & Adler 2011), which has arguably inhibited the provision of sensitive and appropriate support.

Beyond constructing self-harming practices and the self-harming individual, professionals' narratives also serve as an important vehicle for the configuration and performance of their own identity (Atkinson, 2014). Previous descriptions of the 'atrocity stories' that clinical practitioners tell about the patients they care for provides insight into their professional identity work, and how this construction informs their approach to support. Within these stories, patients are often positioned as violators of established norms (e.g. being authentically 'sick'), which permits professionals' to assert the illegitimacy of any rights to their expertise (Stimson & Webb, 1975; Dingwall, 1977; Morriss, 2015; Morriss, 2016). In defining these 'illegitimate claims', clinicians can avoid their expert status from being challenged or threatened. Within the context of self-harm, we might suggest that the pathologisation of individuals engaged in such practices allows professionals to retain their

expert status. This may be a vital piece of identity work given professionals' reporting of low levels of confidence and a paucity of knowledge about self-harming practice (Wilstrand, Lindgren, Gijle, & Olofsson, 2007; Gibb et al., 2010). When attending to social care practitioners' narratives then, it is important to not only consider what accounting devices they deploy, but also what purpose these serve in terms of the construction of their (and others) identity, and how this translates into the provision of care.

Drawing upon interview data generated with foster and residential carers, this paper explores the symbolic meanings ascribed to self-harming practices amongst the children and young people they care for. These different care settings provide an interesting contrast as individuals who reside in care are reported to be at a higher risk of suicide-related outcomes than those in foster care (Cousins, Taggart & Milner, 2010; Taussig, Harpin & Maguire, 2014). Treating narratives as contingent constructions, the papers focuses on participants' accounts, which are understood as versions of experiences intended to move or persuade the listener (Atkinson, 2014; Atkinson, 2017). The results examine the various ways in which carers' interpret self-harm (hereafter termed repertoires of interpretation), and how these interpretations serve as key rhetorical devices that support the desired portrayal and positioning of the narrator (Atkinson, 2014; Atkinson, 2017).

Presented interpretations are grounded in the socio-cultural understanding that self-harm is an act of symbolic communication intended to both challenge and reify roles and relationships within the caring system. This interpretation informs the nature of support provided, with carers' approach to prevention, intervention and longer-term management focusing on the development of supportive caring relationships that promote safety and emotional intimacy. Through these repertoires, carers are able to construct themselves as experts due to their intimacy with young people's social worlds. This identity configuration has the potential to

create distance and even tension between the various professionals involved in addressing self-harming practices amongst those in care.

Method

Presented data were generated with carers who have a statutory responsibility for children and young people aged 18 years or younger in Wales. Of those residing in local authority care in Wales during 2016 (n=5660), the vast majority were in out-of-home placements (n=4,715) (StatsWales, 2016). These placements were made up of foster care (n=4,365) and local authority or private sector residential care (n=250), while a smaller number of young people lived independently (n=100) (StatsWales, 2016). Historically, family-based placements such as foster care have been the preference in Wales, with residential care being the "last resort" for individuals with acute needs, particularly around attachments (Elliott, Staples & Scourfield, 2017). However, recent data from Wales indicates that individuals commonly leave residential care to return home, and thus entrenched assumptions about the "type" of young person in different placements is more complex and variable (Elliott et al., 2017).

The study draws upon tenets from the grounded theory approach, aimed at generating and refining new theoretical insights from empirical data (Glaser & Strauss, 1967). Focus groups and interviews were undertaken with participants. The utilisation of interview data to explore narratives and meanings has been debated (Hammersley, 2003), amidst critiques that they offer a distinct means of revealing private realities (Atkinson & Silverman, 1997; Gubirum & Holstein, 2002). Rather interview data is argued to be a methodically constructed social product emerging from an interaction (Gubirum & Holstein, 2002). In light of this critique, the interview data presented in this paper does not necessarily claim to elicit carers' authentic

'reality'. Both narratives and the narrator are conceived as interesting social phenomena, constructed and negotiated through the process of presenting accounts.

Data were generated between November 2015 and May 2016. Participants comprised foster carers (n=15) and residential carers (n=15). Twenty-three participants were female and seven were male. Ten of the professionals had up to five years of experience of caring for children and young people, twelve had 6-10 years of experience, and eight had more than 16 years of experience. Nineteen individuals provided generic foster care or residential care placements, whilst a further 11 described themselves as offering specialist placements for young people exposed to particular forms of maltreatment or with additional physical, behavioural, or emotional needs. Twenty-nine participants had direct experience of self-harm in children and young people, with one individual focusing on their general interpretations and preparedness to intervene.

Recruitment was conducted through a private foster care association, a national foster carer network, and a private residential care association representing a large number of group homes. Each association disseminated study information to composite members via an email or organisational meeting. Members were invited to attend a focus group on a pre-specified date or provide contact details to arrange participation in an interview. The recruited sample represented a diverse range of care experiences and geographical locations, although purposive sampling was conducted to increase the number of males within the foster care group. Nine participants took part in interviews, with six being conducted via telephone and three being conducted in person. Four focus groups were undertaken with 21 participants. Interviews lasted 25 to 75 mins, with focus groups lasting 60 to 105 mins. The topic guide addressed: carers' lived experiences of self-harm and suicide amongst the children and young people they care for, including their perceptions and interpretations of causes; existing management strategies, including inter-professional working; and prevention and intervention

needs. Data generation and analysis were conducted iteratively, with additional questions being integrated into the interview schedule as themes emerged. Data were recorded with a digital audio recording device. Audio-recorded data were transcribed verbatim by a professional transcription service and reviewed for accuracy.

Ethical approval for the study was provided by Cardiff University's School of Social Sciences Ethics Committee. Study participants were provided with an information sheet in advance of the study and had the opportunity to ask questions prior to the commencement of data collection. Participants undertaking in person interviews provided written consent, while those taking part in telephone interviews provided verbal consent, which was audio-recorded. Pseudonyms are used within the data excerpts to ensure anonymity.

A thematic analytical approach was applied, derived from grounded theory (Strauss & Corbin, 1998). An 'open' reading of the data was undertaken to code the text. A coding framework was developed, being revised and refined as additional data were analysed. Analysis progressed to axial coding in order to assemble the repertoires of interpretation that carers' deploy. In accordance with the stipulation of axial coding, each category comprised of four key elements that are intended to offer it explanatory power. Firstly, codes were categorised according to the phenomenon under study (e.g. self-harm) to characterise the ways in which carers' conceive practices (e.g. authentic and inauthentic; superficial and serious). Such binaries were inductively identified from participant narratives, although they clearly map onto the extent research literature. Secondly, categories were explored in terms of the conditions that are perceived to give rise to the phenomenon. This is where the repertoires of interpretation came into sharp focus. The definition of this category was expanded to consider carers' construction of their own identity and how this informed the repertoires deployed. Thirdly, the categories explored the actions and interactional strategies utilised to manage the phenomenon. Fourthly, the consequences of these strategies were

considered. Analysis entailed the continued revisiting of the data in order to re-contextualize and further develop categories. Some categories were collapsed or expanded through comparison. Three super-ordinate themes emerged that most accurately encapsulated the carers' repertoires of interpretation, with a number of sub-themes being subsumed by these overarching constructs.

It is important to note that whilst the present results offer three central repertoires, narratives were not essentially coherent. Indeed, as Chandler (2014) illustrates, accounts are equally likely to be characterised by chaos narratives, where we witness a lack of any narrative at all. To minimize bias emergent and final themes were interrogated and confirmed with two colleagues who have methodological and substantive expertise in this area. Memos documenting researcher reflexivity were recorded throughout data collection and analysis. The proprietary qualitative analysis software package NVivo 10 on Windows was utilized for data storage and analysis.

Results

Participants delineated two types of self-harm amongst the children and young people that they care for. They predominantly drew upon the tropes of visibility and authenticity to characterise differences, resonating with motifs routinely deployed throughout the literature on self-harm (Scourfield, Roen & McDermott, 2011). Authentic self-harm was seen as a largely hidden behaviour, which was considered a rare event experienced by a small number of individuals. Young people engaged in these practices were thought to likely have a diagnosable mental health illness and to be in need of specialist clinical intervention. In some cases this type of self-harm was understood to have an emerging suicidal intent, with practices occasionally escalating to a suicide attempt. In contrast, the vast majority of self-harm was viewed as superficial, often conducted with the intention of being seen by another.

In this instance, self-harm was largely constructed as a relational phenomenon, locatable within a socio-cultural rather than a bio-medical discourse. The following results present the three key repertoires participants' use to account for largely "superficial" self-harm and considers how professionals utilise them to explain management strategies.

Survival

The first repertoire of interpretation is reflected by the construct of survival, whereby self-harm is considered to be utilised by young people as they seek to redefine and reclaim their identity within the care system. Participants spoke extensively of young people's need to constantly negotiate the ascribed label of 'looked-after', which often leads to their differentiation and stigmatisation as vulnerable and lacking (Davies & Wright, 2007; Mannay, Evans, Hallett, Staples, Roberts, Rees & Andrews, 2017). Self-harm was seen as offering a mechanism for individuals to distance themselves from this structurally disadvantaged and disenfranchised position, providing an important sense of control and agency. One residential carer presented an account of how the self-harming practices of a young person they cared for shifted the nexus of power, leaving the carer to feel weak and vulnerable:

> *He's doing it and he knows we are quite helpless. And he really, really enjoys control. … He knows, but with a lot of them, they know that as soon as they start to display some of these behaviours, they don't just get one member of staff who's ignoring the behaviours. It's all of a sudden it could be three members of staff that they're getting to deal with the situation or two members of staff.*

Such narratives were often interwoven with the trope of resistance, with some young people being considered to actively confront care system structures through their self-harming practices. One particular foster carer told of how a child in their care drew upon

self-harm in response to the lack of choice afforded to them, from access to social media to the geographical location of their placement:

> *But she cannot cope with routine, boundaries, consequences. She has no control over anything other than her behaviour. F U* [fuck you] *I'm going. And her mobile phone and the self-harming and that is her control.*

In juxtaposition to resistance however, were reported efforts to actively engage with care professionals in order to successfully navigate the system and achieve the most advantageous position available. Participants suggested that for a number of young people in care, self-harm was believed to be the single most effective mechanism for obtaining manoevrability within and between care placements. One residential carer discussed how a young girl had attempted suicide in order to be removed from her birth home, following a period of selective mutism that went unnoticed. Others spoke about self-harm being used to secure movement into residential care when young people felt uncomfortable with the normative family structure provided by foster placements.

The theme of survival further extended to consider young people's management of role conflict. This was particularly evident throughout discussions around central events within care proceedings. Review meetings and contacts with birth families were described as key sites of internal conflict for those in care, as tensions between their various roles, responsibilities and loyalties were brought into sharp relief. One foster carer observed that self-harm can serve as a method for managing the anxiety of care proceedings, whilst allowing temporary respite from painful conflict:

> *The ones we have had in our care* [who self-harm], *a lot of it was the birth family not allowing the child to enjoy their time in care and the child experiencing split loyalties: "I'm enjoying my time in care but at LAC reviews I've got to say that I don't like it or*

at contact I've got to say how horrible it is and then that information gets fed back to my carer and then she' s going to hate me for saying that".

Participants' narratives continued to discuss how some individuals sought to move beyond the seeming impasse between their birth and care families through the creation of chaos. Indeed, some young people were thought to ensure their survival of the care experience through the recreation of the disruption and insecurity experienced within their birth home:

I think, we can't know the absolute of the backgrounds they've come form and I think it must be very disturbing to young people when they have come from, to put it bluntly, a shit background. Where nothing functions properly…. And then they come into a place where they are respected, they are clothed properly and well. They are fed properly and well. They are housed properly and well. They have got their own room, they have got so much and this must actually be a strange feeling to them. And some carers that I was recently with were contemplating, we were talking about the way in which the kids actually bring the chaos that they lived with, into your home.

Within the context of such chaos narratives, self-harm practices were seen as a vehicle for jeopardising a potentially secure and comfortable placement, so that individuals could retain the safety and familiarity of disruption. Two participants discussed how the chaotic nature of some young people's lives left them feeling vulnerable and disorientated within stable placements, occasionally leading to cutting practices to express their distress:

Joe, we haven't had, we've had 18 months now real self harm, seemed to have found a different way of being. Cutting himself, letting us know he's not happy. What we became aware of and he's been to lots and lots of placements in children's homes. Um, he would scupper a placement with poor behaviour and the ultimate in the end for him

was last year. But it felt as if as soon as he got to care with people who really cared for him, he'd go away. I'm getting out of here. This is too hard.

Signalling

The second repertoire deployed by carers was that of signalling, which centres on the belief that self-harm serves as a major communicative tool for young people within the caring relationship. This was due to an assumption that individuals residing in care do not always possess the skill to articulate their emotional needs. In tracing the care histories of those that they look after, participants often touched upon the challenging context of the birth family and the inadequate or problematic attachments they had provided for the young person.

Accounts were often expressed in terms of the trope of 'attention-seeking'. A number of carers spoke at length of how many young people had a history of engagement in 'negative', high-risk behaviours so that '*anyone will take notice of them. They are so desperate to feel cared for and to be needed and wanted by somebody, presumably parent or carer'*. Self-harm was thus seen as a specific behaviour that could indicate the need for attention by carers, and was interpreted as a short-hand method for signalling that the individual was experiencing a problem and required support. One foster carer recounted the apparent struggle to articulate emotions:

I think that's one of things I've learnt over the years is with the young people is that it's they want your attention, they want you to know what is wrong with them, but they don't know how to express what is wrong with them.

Another foster carer told of a young girl in their care who routinely engaged in the practice of making ligatures in order to convey a need to discuss her feelings:

> *She tore a little ligature this morning, and what that initiated was quite a lengthy conversation about something that's been upsetting her for the last few days… She doesn't need to express her upset by doing this first. Tearing a ligature first. Showing everyone as if to say "oh, I'm upset obviously I've got something on my mind". And then spilling the beans about whatever it is that's bothering her.*

Beyond this, participants spoke about self-harm being employed to repair relationships with carers, whereby it is used to resolve momentary conflict and signal to carers that the young person wants to restore their roles and relational dynamic. One residential carer spoke of how a young boy would start to harm himself with a ligature when he had transgressed some rule within the residential placement. He was not seen as attempting suicide however, but rather was aiming to restore the previous status of the care relationship:

> *Shaun as well, there would have been an incident beforehand. There would have been something of an escalation of an incident and behaviour. And he uses it as his way of building that bridge back with staff, because he needs you to. So the self harm serves a purpose for him. It's for you to nurture him. Rescue him.*

A small number of participants also spoke about other needs they felt that young people were signalling through self-harm, with the need for 'touch' being mentioned. In this instance, the application of no-touch policies within care settings was considered to leave young people without any physical contact. One carer suggested that '*these kids were seeking the ultimate touch'*, and on occasion could engage in physically destructive behaviour necessitating restraint in order to meet this need. With a more specific focus on self-harm, another residential carer felt that a young boy would engage in practices during their work shift so as to receive physical comfort:

And he was only doing it when I was on shifts. Then, he wanted me touch him. So we had to look at different ways so I could give him a hug rather than going to all that length to get. He started to calm down when I give him more touch.

Inscribed in the accounts of signalling was indication of how it structured the support afforded to young people. Whilst the immediate response was always to clean wounds or severe ligatures, longer-term strategies involved trying to encourage open communication within the caring relationship. One foster carer discussed how they were working with one young girl to verbally articulate their fears and worries so that they did not become reliant on self-harm as the primary mechanism for expressing themselves:

Well obviously I, I made sure that she was physically OK, but then I learned to pre-empt the strikes so then I learned that that was a trigger. And I used to articulate her anxieties for her, so if I knew there was a test coming up in school for example, I would say to her, "Oh, there's a test coming up in school, we're likely to feel a little bit wobbly, but it'll go away afterwards".

Security

The third repertoire of interpretation drawn upon by carers' was that of security, whereby children and young people are considered to self-harm as part of a need to test the authenticity and safety of the caring relationship. This sentiment was expressed within a context where many children and young people in care were considered to struggle to trust adults, particularly the multitude of professionals that routinely rotate through their life:

And trust as well, like. Very rare that these lads trust people because they can't. Seen so many places. You can't speak to people when you don't trust them.

One of the primary reasons why carers deemed that young people could not trust was because they had been perpetually let down or adults had failed to authentically engage with them.

For example, one foster carer told of how a young person in their care had disengaged from a number of services because they had not felt properly listened to, and thus professionals did not know them beyond their homogenised identity of 'looked after':

> *Because we were saying to her* [Educational Psychologist] *"Look at, look at her school work". And you know, we almost had to force her look at the reality, look at the evidence. Everything you spoken to the child, the child has played dumb. But she's not...when the young person fools you or they think they fooled you, they lose trust because they know they are not being authentic and if you actually cared about them you'd know.*

Participants mainly described young people as being able to develop trust when they experienced security within a relationship. Self-harm was a deemed a symbolic site where young people could resolve some of their uncertainty over whether carers can provide a safe placement. One residential carer discussed how a young girl had repeatedly self-harmed throughout various care placements when she felt vulnerable and insecure. These practices had continued as she moved into her current placement, with the carer suggesting she was testing the placement's ability to competently intervene and take care of her:

> *Before Jessica came to us, Jessica was in secure* [mental health unit] *and she'd ligatured on quite a few occasions in secure. So she came to us already knowing that there was a possibility that she'd ligature, so we put everything in place. The risk assessment. Got the cutter* [specialist tool for severing ligature], *everything was in place. And I think she did it once. And for me it was just to make sure we, we're there and it was safe and she was safe. And she did it not to the point that it was tight but it was choking here. And she never did it again.*

Equally however, carers' felt self-harm could escalate where trusting relationships had been fostered, as young people felt comfortable in the knowledge that there would be adequate intervention and support. A number of residential carers touched on young people waiting for certain staff to be on a shift before they engaged in self-harming practices, as they knew they could secure help from that person:

> *It was mainly with me and Jill, um, that's when he would go back into the past and get really upset and cut himself…And then he said that he felt safe with me and Michelle and he didn't feel safe with anyone else. That's when he did the behaviours.*

> *If he doesn't have the boundaries or the safety. He would only do it on the fact he's got boundaries, he's got the safety and he commits to himself. I don't actually want to hurt myself but here I've got these staff who will bring me down so I can do it on this.*

As an extension of the perceived need to test for physical safety, carers' further considered that young people could engage in self-harm in order to secure emotional safety, notably acceptance of their identity. Grounding explanations in the assumption that individuals in care had experienced extensive rejection throughout their lives, self-harm and other high risk behaviours were interpreted as an attempt to ascertain if carers would accept them regardless of the '*provocative nature of their actions'*. Speaking of one young girl who had entered their residential home, a carer recounted the display of behaviour they felt was intended to shock:

> *She had her blouse rolled up so you could see all the scratches. Obviously we knew that she was a superficial self-harmer. And she was rolling them up as she came in through the door. And it was me and Julie and I said to Julie "don't look shocked". And I mean it was nothing that we hadn't seen but we didn't show the shock factor if you like...*
> *Uhm the same evening prior to going to bed she came down stairs and said "I have a baby's bottle for bed. Can I fill it with milk?" I said "Sure love of course you can, if*

that's what you do and it helps you sleep". Anyway she went to bed that night with this baby's bottle that she brought with her.

Through this particular act of story telling, the process through which repertoires of interpretation inform responses becomes evident. In this instance, the management strategy of the residential care home centred on the provision of unwavering acceptance of the individual, alongside a concerted effort not to be shocked or overtly react:

I said to the staff in the morning about having a bottle 'cause I was here in the night time. I said "She has a bottle don't mention it". And that was in March, we haven't seen her with dummy and bottle since. We just did not talk about it. ... she was testing us to see if we were going to let her have it or whether if we had said, "No you're not having it"... And we just sort of say you know we can help you but what you're doing is nothing that we haven't seen. So she no longer, if she superficially cuts, she'd squeeze it and then come in and then ask for a wipe. Um, and because it hasn't shocked us, it doesn't happen as often.

A number of other carers drew upon the tropes of 'not making a fuss' or 'not giving them attention'. Rather the focus was on clearly demonstrating that they could be trusted to take care of the young person and could offer a safe space:

[We manage the incident in a] *safe way, erm, and that could even be in making sure that there's, erm, clean things around and that they. You know that they know where they can go to. You know keep themselves clean and, erm, you know ensure that they're doing it as safely as possible. But try, not ever saying to them this isn't, you know it's not okay to do this… about accepting people for who they are I suppose.*

Discussion

The present study has explored foster and residential carers accounts of self-harm amongst the children and young people that they care for. Elicitation of their repertoires of interpretation serves to further illustrate the multiplicity and complexity of narratives that pertain to self-harming practices. Three central repertoires emerged through the data to explain intentionality amongst individuals' engaged in 'superficial', 'visible' self-harm. 'Authentic' self-harmers were constructed as a separate concern, with a unique set of motivations and needs, often due to a complex underlying mental health condition. Central to this differentiation was whether practices were seen to be within the purview of social care professionals. Individuals engaged in mores serious self-harm practices were often considered unsuitable for foster or residential care, and medical intervention was not contested. While these self-harming identities inductively emerged through participant narratives, they clearly resonate with enduring binaries of authentic and inauthentic practices within the wider literature (Scourfield et al., 2011). As the presented participants' narratives largely extend to describe 'superficial' practices, the present data should not be seen as characterising social care professionals' interpretations of self-harm amongst individuals who present an imminent risk to life or display a clear suicidal intent.

Whilst there were evidently some discontinuities between repertoires, they were underpinned by a shared assumption: self-harm is predominantly a socio-cultural phenomenon that is largely a response to the experience of entering into and residing within the care system. Indeed, it was considered to form part of a complex process of identity work as children and young people navigate and negotiate the inscribed label of 'looked-after'. Studies have demonstrated how those in care are frequently the subject of 'othering', where they are differentiated from the general population due to their exposure to multiple vulnerabilities (McMurray, Connolly et al. 2011; Mannay et al., 2017). Self-harm was thought to open up a vital space for young people to distance themselves from the nexus of power relations that

renders them marginalised and disadvantaged by providing a sense of agency and control. This trope of control resonates with the narratives of self-harm that have been presented by those engaged in such practices, which have focused on coping with challenging circumstances or attempting to displace emotional pain with physical discomfort (Sinclair & Green 2005; Adler & Adler 2007; Adler & Adler 2011; Chandler 2012a; Chandler 2012b). Control can equally manifest in the construction of chaos (Sinclair & Green 2005), with young people being seen to seek familiarity and even stability through continued disruption.

Whilst repertoires touched upon the structural causes of self-harm, carers felt that young people's problematic relationship with the care experience often play out at the interpersonal level. Self-harm was seen as an attempt to test the authenticity and security of the caring relationship. This may be partly explained by carers' expectation to simultaneously be parent and professional within their role of 'corporate parent' (Thompson & McArthur, 2009; Schofield et al.,. 2013). Such blurring of boundaries could be considered to introduce confusion and ambiguity for young people, with self-harm potentially serving as a mechanism for them to cut through this uncertainty and ascertain if carers can be trusted to keep them safe.

Carers' further conceived that self-harm may act as communicative tool for young people to signal the need for emotional intimacy. Utilisation of this tool was often expressed with the trope of 'attention-seeking'. This construct has been routinely employed within clinical professionals' narratives of self-harm (Jeffery, 1979; Sun et al., 2007), suggesting some similarity across professions. However, whilst often delivered as a negative critique, couched in moral censure (Chandler, 2016), foster and residential carers revealed a rather more nuanced and compassionate framing of this concept. It was seen as a somewhat inevitable consequence of a complex series of life events. This complexity of meaning encourages us to revisit the "atrocity stories" that clinicians tell about "attention-seekers". Extant research

frequently present such stories as one-dimensional and the more rounded interpretation drawn out by this study should be considered more fully amongst other professional groups.

Dominant socio-culturally orientated repertoires of self-harm provides clear insight into carers' rationale for their approach to support, whilst illustrating the importance of understanding professionals' accounts if we are to change practices. Construction of self-harm as a largely relational phenomenon means that carers invest in strengthening their relationship with young people. Strategies include trying to unpack the reasons why the young person has engaged in such practices, supporting them to consider the underpinning emotions and encouraging them to identity other opportunities for self-expression. Equally, carers prioritise demonstrating acceptance of young people, and shying away from any negative emotional reaction to self-harm. In many respects, such approaches respond to the complex socio-cultural narratives reported by of young peoples, with the focus on the individual's needs suggesting some movement beyond restricted taxonomies of self-harm (Adler & Adler, 2007). However, there has been extremely limited consideration of the self-harming narratives of children and young people in care. Further research is required to consider if there are particular constructions of practices amongst this population, and their perceptions of support models delivered by different professionals.

Explication of social care professionals' registers of meaning also provides insight into how they configure and perform their identity in relation to self-harm (Atkinson, 2014). It is evident that such repertoires provide an important heuristic device for carers to construct themselves as experts. The legitimacy of this expert status is grounded in a particular type of warrant: intimacy. Inscribed throughout participants' stories was a clear sense of them 'knowing' the individuals they care for due to their proximity on a daily basis. As such, carers' not only observe the immediate and longer-term effects of self-harm, they are partial to the events and emotions that build to it. Drawing on Goffman's (1959; 1961)

dramaturgical approach, we might suggest that foster and residential carers consider themselves to be privy to young people's 'backstage', which involves the assimilation of self-harm as part of a complex piece of identity work. Though this understanding of expertise, carers potentially serve to distance themselves from mental health professionals, who are perceived to only witness young people's performative practices, or 'front stage'. Indeed, carers spoke about other professionals not seeing the 'reality' of young people's lives due to their rare exposure to them.

Delineation of potential tensions in constructions of expertise has important implications for the prevention, intervention and management of self-harm within care settings, especially given the current policy climate around mental health and wellbeing. Existing NICE (National Institute for Health and Care Excellence, 2010) guidance on the promotion of mental health for those residing in care recommends the provision of a dedicated and sensitive multi-agency support that is inclusive of mental health professionals. To date such structures are not considered to working effectively (House of Commons Education Committee, 2016; York & Jones, 2017). Explanations of these challenges have often been attributed to inadequate time and access (Stanley, 2007), but discrepancies and debates around expertise need to attended to. Policy and practice must progress beyond stipulation of inter-professional working, and take active measures to support this process. For example, recent recommendations to emerge from the foster care sector include enhancing the professional standing of carers through the introduction of accredited and standardised pre- and post-approval training (Lawson & Cann, 2016). There is further focus on incorporating learning about their role into social work (and other professionals) training to improve understanding and collaboration, and ensuring that carers' views are always invited and taken into consideration by those involved with the team around the child. To support this, further research is required to explore the "atrocity" stories that various professionals tell about each

other in regard to self-harm treatment and care pathways. Research might further consider how professions interpret and respond to the atrocity stories that others tell about the individuals engaged in self-harming practices.

Conclusion

To date there has been limited research attending to social care professionals' construction of self-harm, which is imperative given the wealth of research tracing how medical professionals often negatively typify those engaged in such practices. The present study has considered how foster and residential carers interpret self-harm as a largely relational phenomenon, motivated by children and young people's need to find identity and meaning within the care system. Deployment of this socio-cultural understanding has the potential to create distance from those professionals drawing upon medical discourses. Future research should address children and young people's own explanations of self-harm, particularly in relation to their experience of care. It should extend to consider the interface of relevant professional groups in order to understand how convergence and discontinuities in repertoires of interpretation impact upon inter-professional working.

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