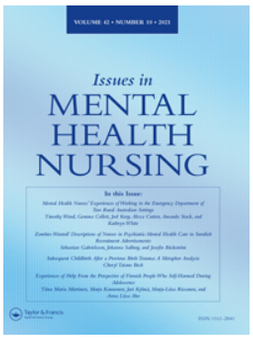

Issues in Mental Health Nursing

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/imhn20

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To cite this article: Tiina Maria Miettinen, Marja Kaunonen, Jari Kylmä, Marja-Liisa Rissanen & Anna Liisa Aho (2021) Experiences of Help From the Perspective of Finnish People Who Self-Harmed During Adolescence, Issues in Mental Health Nursing, 42:10, 917-928, DOI: 10.1080/01612840.2021.1904468

To link to this article: https://doi.org/10.1080/01612840.2021.1904468

Published online: 06 Apr 2021.

ISSUES IN MENTAL HEALTH NURSING
2021, VOL. 42, NO. 10, 917–928
https://doi.org/10.1080/01612840.2021.1904468

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Experiences of Help From the Perspective of Finnish People Who Self-Harmed During Adolescence

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ABSTRACT

Adolescent self-harm is a widespread phenomenon, and a significant problem worldwide. This study describes the experiences of help from the perspective of Finnish people who have suffered self-harm during adolescence. Data were collected from 27 participants as essays and interviews. Participants included both females and males with different backgrounds and treatment experiences. The data were analysed using inductive content analysis. Participants described having received help from other people in informal and formal ways, and they had both positive and negative experiences of help. The results show that several barriers exist for self-harming adolescents to access help, thus improvement in this area are necessary.

KEYWORDS

Adolescent; help; mental health; qualitative study; self-harm

Introduction

Self-harm is a significant and common universal health problem among adolescents (Hawton et al., 2012; Madge et al., 2008; Skegg, 2005). The term self-harm covers a range of acts and intentions that are usually intended to respond to unbearable tension (Skegg, 2005), and it can be thought of as expressing mental pain (Tofthagen & Fagerstrøm, 2010). The terminology varies, also terms self-injury, self-mutilation, para-suicide, deliberate self-harm, non-suicidal self-injury, self-poisoning and suicide attempt and suicide are used in scientific research (Muehlenkamp et al., 2012; Skegg, 2005; Tofthagen & Fagerstrøm, 2010). The methods of self-harm differ, but self-cutting has been the most common method of adolescent self-harm in several studies (Doyle et al., 2015; Fortune et al., 2008a; Madge et al., 2008; Salmi et al., 2014). The term self-harm is used in this study to mean any intentional self-injury irrespective of intent (Michelmore & Hindley, 2012), and encompasses self-harming thoughts and suicidal acts (Salmi et al., 2014).

Self-harm is more common among females (Madge et al., 2008; Rissanen et al., 2006) and its occurrence is highest in adolescence (Moran et al., 2012). However, the true prevalence of adolescents' self-harm is difficult to define because most of it remains hidden and does not lead to hospitalisation (Doyle et al., 2015; Hawton et al., 2012; Madge et al., 2008), and definitions and methodologies between studies vary (Muehlenkamp et al., 2012). The prevalence level is indicated to vary from 8% to 26% (Doyle et al., 2015; Laukkanen et al., 2009; Moran et al., 2012; Rowe et al., 2014). The nature of self-harm is repetitive, and after self-harm the risk of its recurrence and later suicide is high (Madge et al., 2008; Skegg, 2005). Although self-harm is not always death-seeking, it is important to consider that the risk of suicide is significantly increased after non-fatal self-harm in adolescents and young adults (Keefner & Stenvig, 2020; Olfson et al., 2018). Self-harming adolescents need help to reduce their suffering from self-harm, ease their mental health problems, and to decrease their potential risk of suicide (Michelmore & Hindley, 2012; Moran et al., 2012; Olfson et al., 2018).

Self-harming adolescents have a desire to be helped and they may seek help through the self-harming act (Rissanen et al., 2008; Rissanen et al., 2009; Salmi et al., 2014), but unfortunately, help must be often actively sought (Salmi et al., 2014). Acute care is not always needed, but it is important to understand that the adolescent who contacts health care services wants to be helped in some way (Rissanen et al., 2008). However, most self-harming adolescents do not seek professional help (Doyle et al., 2015; Michelmore & Hindley, 2012; Rowe et al., 2014). According to Doyle et al. (2015), only 9% of adolescents sought professional help before, and 12% after a self-harming act. Sources of support that self-harming adolescents had found as helpful are mostly individuals around them (Holland et al., 2020), and help is sought primarily from family, friends (Doyle et al., 2015; Fortune et al., 2008a; Hasking et al., 2015; Michelmore & Hindley, 2012; Rowe et al., 2014) and school (Fortune et al., 2008b; Hasking et al., 2015). The

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majority of self-harming adolescents do not end up in hospital because of self-harm (Doyle et al., 2015; Hawton et al., 2012; Madge et al., 2008). Without help adolescents remain at increased risk of suicide and psychiatric disorders (Michelmore & Hindley, 2012).

Many adolescents feel guilt and shame after a self-harming act (Wadman et al., 2018) and are reluctant to disclose their behaviour to others (Hasking et al., 2015). Adolescents are afraid of the negative consequences of disclosing their self-harming and fear of negative reactions of others may deter them seeking help (Rowe et al., 2014). Self-harming adolescent may come to a school nurse or doctor for various reasons and might not name self-harm as a problem (Rissanen et al., 2006). If adolescents disclose their self-harm to someone, they disclose it usually to friends and parents (Hasking et al., 2015). Self-harming adolescents may feel that they do not need help, or just do not want it (Doyle et al., 2015). Adolescents may also feel that they need to cope on their own, think that self-harm is just an impulsive thing, fear being labelled as an attention seeker, or not know who to ask for help (Fortune et al., 2008a).

Adolescents have described following problems in getting help: long waiting lists, too few sessions, miscommunications, and being dropped from the services. These problems cause feelings of being personally failed or let down by the system (Wadman et al., 2018). Finnish self-harming adolescents felt that school or health care personnel did not intervene, so they did not care. Uncertainty about the need for help, an inability to seek help, and being left without any help hindered accessing help of those adolescents (Rissanen et al., 2009). Fears of stigmatisation and the potential of confidentiality being breached (Curtis et al., 2018; Fortune et al., 2008a; Hawton et al., 2012; Rowe et al., 2014), beliefs that self-harm is not serious, help would not be helpful, and fears of hospitalisation are barriers for help-seeking (Michelmore & Hindley, 2012). Furthermore, fear that seeking help would create more problems for the adolescent may prevent it. Some adolescents want to protect their parents, and therefore not tell them about their self-harm or seek their support (Wadman et al., 2018).

Facilitators for help-seeking have been described less than barriers. Identified facilitators include issues of confidentiality, being treated respectfully, having a trustworthy person to talk to, and having the option to talk to someone of a similar age (Curtis et al., 2018). In addition, factors contributing help described by adolescents are information about self-harm, and help available for it, and understanding their own need for help (Rissanen et al., 2009). Adolescents expect better information, caring intervention, psychiatric care, open conversation with a trusted helper, and a better availability of help (Salmi et al., 2014). A helper for the self-harming adolescent could be anyone who knows about the adolescent's problem, but adults have a duty to help (Rissanen et al., 2009). A basic requirement is a trusting relationship between the adolescent and the helper (Rissanen et al., 2012). Relatively easily accessible interventions, including distraction techniques, exercise and harm-minimisation techniques are found as helpful sources of support (Holland et al., 2020). Self-harming adolescent needs a reliable contact person and the opportunity to speak openly. Professionals could be told about more difficult problems even if it were easier for the adolescent to talk to friends or family (Idenfors et al., 2015a). Self-harming adolescent must have easy and direct access to professional help and there should be alternative routes to the treatment (Idenfors et al., 2015b).

Many existing guidelines of caring for self-harming adolescents are based on disease-centred thinking, and the information supporting guidelines is collected from hospitalised or otherwise selected people (Rissanen et al., 2011). What is needed, is basic information about the phenomenon, and guidelines of care including the perspective of the self-harming adolescent (Rissanen et al., 2011; Rissanen et al., 2012). Based on previous research, research focussing more on adolescents' experiences of the help is still needed. In a systematic literature review that addressed experiences of professional care and support among adults and adolescents who self-harm presented that there is a need for significant improvement in the treatment of people who self-harm, and also in the attitudes of health care professionals (Lindgren et al., 2018).

In summary, adolescents' self-harm is a common and difficult phenomenon, and it causes a lot of concern during adolescence as well as later in life. Self-harming adolescents need help, but according to existing literature, there are many obstacles to seeking and receiving help. With this study, we wanted to expand the understanding of self-harming adolescents' experiences of help in Finland, so that the service system can be further developed to take better into account of adolescents' needs.

Materials and methods

Purpose and design

The purpose of this study was to describe experiences of help related to self-harm in adolescence. A qualitative descriptive study was conducted as this is a little studied area in Finland, and it was felt as desirable to extensively represent participants' own experiences around this phenomenon (Colorafi Jiggins & Evans, 2016; Holloway & Galvin, 2017).

The research tasks were to describe what kind of help do self-harming adolescents receive, what kind of experiences do self-harming adolescents have about help, and what kind of barriers to help have self-harming adolescents faced?

Sample and participants

Purposive sampling was used when selecting participants, and recruitment was made through channels known to reach adolescents suitable for the study (Colorafi Jiggins & Evans, 2016; Holloway & Galvin, 2017). An information letter including the request to participate was distributed through the support associations websites, and closed

Table 1. An example of the abstraction process.

Original data	First level coding	Second level coding	Third level coding	Connecting category
I wasn't ready to seek help, even though it was offered because of the seriousness of my situation (self-harm)—I didn't think I would be taking seriously	Adolescent's uncertainty about whether she/he will be taking seriously	Adolescents' uncertainty about the severity of their problem	Adolescents' uncertainty	Adolescent related barriers to help
I underestimated my problem and therefore hesitated seeking for help	Adolescent's understatement of her/his problems			
My expectations (for help) were negative, and I didn't think self-harm was serious enough	Adolescent's considering her/his self-harm not serious enough			

discussions in internet support forums, in a youth rehabilitation unit, and in one hospital. The entry criteria for the study were: 1) personal experience of the topic and 2) adolescence, or that the participant described their adolescence experiences. If the respondents wanted to participate in the interview, they could contact the corresponding author by phone or e-mail.

Participants were 27 Finnish citizens who had harmed themselves during adolescence. There were both females and males, although not all participants revealed their gender. Adolescence was defined as being 12–22 years of age in the information letter. The youngest participant was presumably 12 years old, based on the background information provided, and a few adults over 30 years of age described experiences from their youth. All participants did not report their age. The participants were from all over Finland, different social contexts, and with different backgrounds in relation to treatment.

Data collection and analysis

Data were collected as essays (n = 27) and interviews (n = 2). Two of the participants gave two separate answers. Writing was chosen as a method of data collection due to the sensitivity of the topic (Aho & Kylmä, 2012), it was found as an easy way to express the topic as sensitive, and it enabled completely anonymous response. All essays were sent electronically directly to the corresponding author by e-mail or as a file compiled by the support forum administrator. Semi-structured interviews were conducted, one face-to-face and another by telephone. The interviews were structured according to the themes derived from the research tasks. Themes were "what kind of help", "experiences of help", and "barriers to help", and some guiding questions were derived from these themes. However, participants could share their stories freely, and the guiding questions acted as encouragement. Through interviews, more in-depth information was gathered from the participants (Holloway & Galvin, 2017; Taylor & Francis, 2013).

Data were analysed using inductive content analysis (Colorafi Jiggins & Evans, 2016; Elo & Kyngäs, 2008). All the written data was first transferred from e-mail to a word file, and anonymized by deleting the identification data. Data from the support forum was automatically anonymized for names and contacts, and other identification data was deleted by the corresponding author. The interview data was transcribed word for word and anonymized. The text was read through several times to gain an overall picture. Statements corresponding to the research questions were extracted from the text as 189 first level codes.

The first level codes were grouped according to similar content or meaning, and the groups were named as second level codes. The second level codes were compared and combined as third level codes that were organised as connecting categories. This process of abstraction was re-examined whenever new data became available. The results are presented visually in the figures of categories, and in more detail in the text. Direct quotes are presented in order to illustrate the original data, and an example of the abstraction process is given (Table 1) to clarify the analysis (Colorafi Jiggins & Evans, 2016; Elo & Kyngäs, 2008; Holloway & Galvin, 2017).

Ethical considerations

The nature of the study was sensitive due to the topic and the participants involved, and this was considered throughout the whole research process (Aho & Kylmä, 2012). Recruitment of participants was done through channels that provided support. Thus, participants were in treatment or rehabilitation at the time of the study, or they were registered support forum users, or at least aware of the channels for accessing help. The information letter stated that participation was completely voluntary, and there was an opportunity to withdraw from the study at any time. It was also assured participants that their answers would be treated confidentially, and only by the corresponding author. Privacy and anonymity were ensured through carefully handling, anonymization and storage of the material (Holloway & Galvin, 2017; Taylor & Francis, 2013).

The information letter stated that the written response acts as consent to participate in the study, and written informed consent was requested from interviewed adolescents and the parents of interviewed, under 15 years old adolescents (Aho & Kylmä, 2012; Holloway & Galvin, 2017; Taylor & Francis, 2013). The contact details of the corresponding author were made available, and there was an ethical review of the Ethics Committee of the Tampere Region

for the study, and assent of the ethics committee of the Kanta-Häme Hospital District (Dnro E504/19).

Results

In the description of the results, the term "help" had a broad meaning and it was used to describe all kinds of support, care and help. The term "treatment" referred to medical and other official help given by a professional helper, hospital or other official institution. When describing first level codes, the original terms taken from the data are used. In the results, the term adolescent (A) is used to describe all participants.

Diverse help from other people (Figure 1)

Help from loved ones

Adolescents had received all kinds of help from friends, and was described as friends taking care of them, encouragement from friends to seek help, friends being seen as a resource, caring from internet acquaintances, and help from friends in general.

> My friends—have been in it as a resource—If I had been left alone, it may be that my days would have already ended. (A24)

Concrete and general help from family members meant guidance from parents to seek therapy, help from family, parents or siblings in general, and support from the family in general.

> My parents intervened in my cutting and arranged therapy for me. (A15)

Help from various professionals

Adolescents described receiving help from various professionals through talking to them and through visits to them, and other forms of help from professionals were also described. Adolescents had talked to a named nurse confidentially, talked to support persons, to non-judgemental therapists, and had helpful conversations with doctors.

> My therapist is the only person who does not judge my cutting, so I dare talk to her about it. (A6)

Helpful visits were made to psychiatric outpatient clinics, child and adolescent psychiatric outpatient clinics, and the SOS Crisis Centre (a non-profit organisation in Helsinki). Adolescents also described visits to adolescent stations (regional provider of low-threshold services for adolescents) and to school psychologists and school counsellors. Visits to a psychiatrist and psychologist for other reasons were also helpful.

> I was referred to a psychiatrist for mental health problems—I went to a psychiatrist and psychologist regularly for two years. (A15)

Other forms of help received from professionals which were not described through talking and visits, were support from teachers, help from professional people, the possibility of being as yourself with a support person, and the relief form of writing to a researcher.

> A lot of contracts were made with the teachers and they sometimes went to dine with me because I couldn't do it alone. (A10)

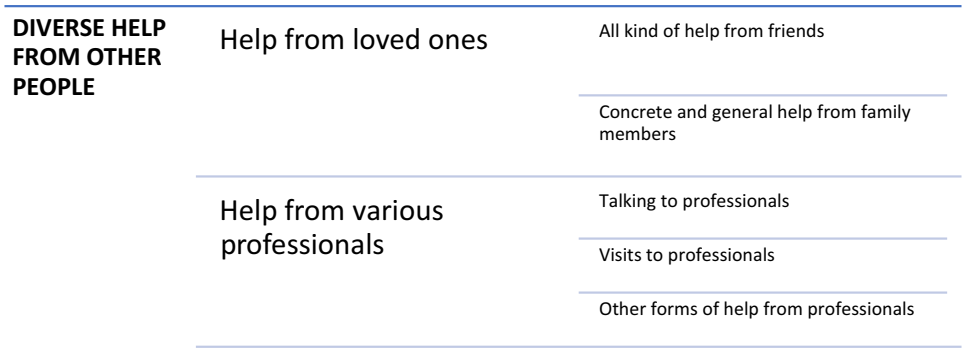

Figure 1. Diverse help from other people.

Adolescents' experiences of well-functioning help (Figure 2)

Adolescents' experience of effective treatments

Adolescents described positive experiences of treatments, positive impacts of treatments, and helpful psychiatric inward treatment. Positive experiences of treatments included the experience of good help received, positive experiences of treatment from a doctor, positive experiences and received help from an adolescents' intensive group, and an experience that therapy was necessary.

> I got into the adolescents' intensive group and it helped me quickly. (A27)

Positive impacts of treatment were described as the returning ability to work through medication, the possibility of gathering oneself through medication, a helpful period in electroconvulsive therapy, and ceasing cutting due to therapy. Conversational help for depression had also been helpful for self-harm.

> If you are depressed, you will receive antidepressants. Possibly also sleeping pills and other necessary. Medicines help to gathering oneself and you don't have to waste your life. (A19)

Figure 2. Adolescents' experiences of well-functioning help.

Psychiatric in-ward treatment had helped so that the adolescent in the ward was constantly monitored, tools that made it possible to self-harm were confiscated, and feelings of being unwell or anxiety decreased in the ward. After an in-ward period, adolescents felt a sense of empowerment and that help had been obtained.

> Just over a year-long in-ward period started. There I felt like I was really getting help. (A20)

Adolescents' self-help

Mental growth of the adolescent and unconventional coping methods were described as adolescents' self-help. Helpful mental growth meant a major increase of the adolescent's resilience being seen as a helpful thing, and adolescent's getting rid of the guilt about illness or getting sick.

> One of the most significant things was increasing my own mental coping. (A17)

Unconventional helpful coping methods included an alter ego developed by the adolescent to keep sane, and recovering from psychosis in an unusual way. The latter was described as the path of recovering has not been quite normal.

> I have built a kind of alter ego, which calculates, measures and analyses everything what is happening or would happen. This keeps me sane. (A13)

Failed seeking or receiving of help (Figure 3)

Problems in help-seeking

Adolescents described difficulties in help-seeking, and that accessing help takes time, and they had experiences of being left alone. Difficult help-seeking was described by adolescents through term tricky. For an adolescent, the threshold to seek help might be too high. To get treatment requires visits to many doctors, seeking referrals from different places, and also looking for help on the internet.

> Had to visit many doctors even long distances before getting treatment. (A15)

Accessing help takes time, which meant that getting an appointment for the psychiatric outpatient clinic is slow and that there might be a long or difficult path to getting good care.

> After contacting a nurse, she made an appointment to me at a psychiatric outpatient clinic. Unfortunately, it took an enormous amount of time before that appointment was. (A18)

Adolescents felt as if they were being left alone: They felt as they were left alone with their self-harm, they thought that help could only come from oneself, and they had experiences of no one caring for you. Also feeling of being treated like air and being all alone in the world were described, and that even the love of one's own parents' being unrecognisable towards the adolescent.

> A couple of years ago I was certainly eager to seek help. Today I have found that the help cannot come from outside of oneself. (A7)

Ineffectiveness of help received

Ineffectiveness of help meant undesirable results from the help adolescents received, and an impairment of health due to the treatment received. Adolescents felt that help sought from the internet didn't bring help, discussions with a

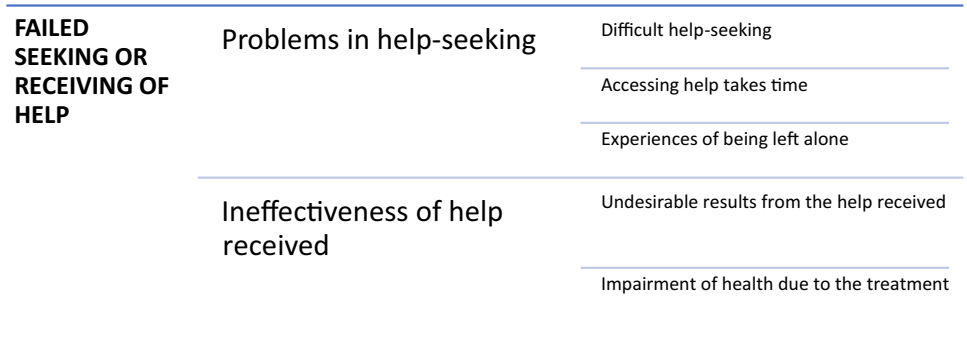

Figure 3. Failed seeking or receiving of help.

support person didn't produce relief, visits with a psychologist didn't produce help, a doctor's instructions for stopping cutting sounded just funny, and the help they received simply did not work. Some adolescents did not like therapy or felt that antidepressants only helped for managing the symptoms. Receiving an insufficient level of help and trying out multiple inoperative treatment options were also described.

> Various discussion forums and peer support stories have not brought comfort, sometimes the discussion is inappropriate, sometimes indifferent. (A15)

Some adolescents told that their self-harm was getting worse during in-ward periods, or becoming unpredictable because of the side-effects of their medication.

> The first course of treatment in the psychiatric ward lasted eight mouths, and my condition was nothing but worsened there. (A20)

Adolescent related barriers to help (Figure 4)

Adolescents' uncertainty

Adolescents were uncertain about the severity of their problems, the potential help available, and uncertainty in requesting help occurred. Uncertainty about the severity of their problems showed in the adolescents' uncertainty of whether they are being taken seriously, their own understatement of their problems, and the adolescents considering their self-harm as not serious enough.

> When I was younger, I didn't know I could get help with the problems—I didn't think self-harm was serious enough. (A23)

Uncertainty of potential help meant that adolescents were unaware of where to seek help, uncertain about what help is available, and they experienced an inability to request help because of their unawareness of the options available.

> It is impossible to ask for help if you do not even know what should be required, what are the options. (A27)

Uncertainty caused an inability to gather enough courage to go to a psychologist appointment, not having enough courage to ask for help, and lack of daring to take the initiative for getting help. It was hard for adolescents to tell their parents about their distress, and they were incapable of talking about cutting to their loved ones. Adolescents thought that somebody else should initiate and provide help, and that they were unable to seek help even though it would be available. A difficulty of receiving help without asking or demanding was also described, and requesting help was felt to become more difficult over time.

> As time goes on, it is only harder to ask for it. You always feel like someone else should come to help, to make something to happen. (A4)

Adolescents' reluctance

Adolescents described an unwillingness to burden their loved ones, unwillingness to get help, and an unwillingness to tell the truth. The concern of friends and parents made it difficult to speak openly about self-harm. Adolescents avoided speaking about cutting with parents because of the difficulty of the subject. They were unwilling to cause sadness to their loved ones by telling them about self-harm, and they didn't want anyone else to have to deal with their traumatic experience. Adolescents described that they no longer wanted help anymore, they didn't want to talk, and were tired of waiting for help. An unwillingness to tell the truth meant that adolescents didn't tell about the real reasons of their anxiety to school counsellors or social workers, they did not tell the psychologist about their sadness, and had an unwillingness to tell anyone about their traumatic experiences.

> I no longer want to open my self-harm to anyone close to me because I cause them grief. (A6)

Adolescents' fear

Adolescents described fear as a fear of the consequences of disclosing self-harm, and also a fear of not being taking seriously. Adolescents were afraid that they will become

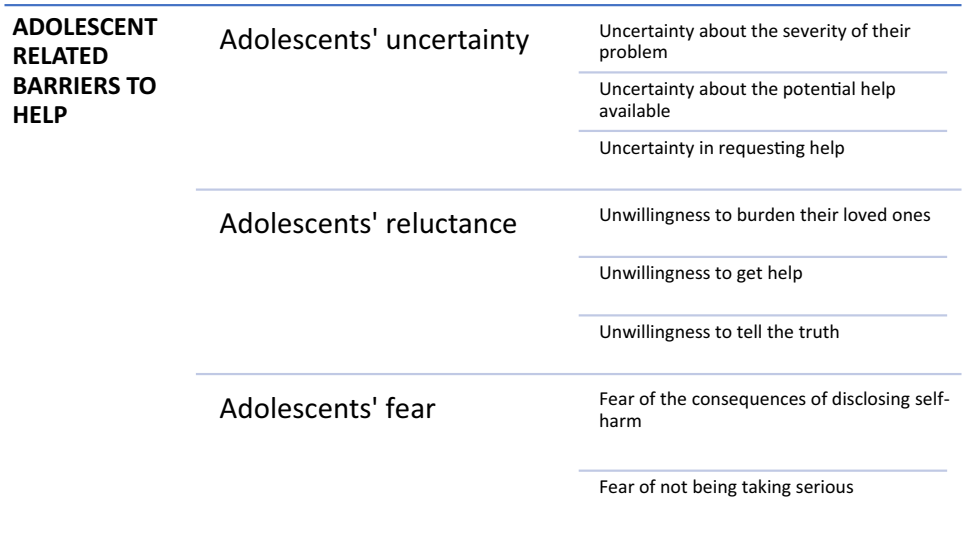

Figure 4. Adolescent related barriers to help.

labelled as 'crazy' if seeking help for their self-harm, and were also afraid of being ridiculed among friends. Fear that their parents will find out about their situation, fear of involuntary treatment, and a fear of consequential problems of going to a psychiatrist were also described. Adolescents were afraid that their situation would get worse if they talked to a school nurse, or if the nurse told their parents. Fear of the consequences that may arise because of talking about ones self-harm, fear of being forced into a child care institute if they talked about self-harming thoughts, and a fear of being sent to a facility if they sought help for self-harm were described. The fear of not being taking seriously included a fear that professional helpers might belittle adolescent's problems, a fear that the doctor would consider the adolescent as an idiot because of talking about self-harm, and a fear of just being urged to get a grip of oneself.

> As well as talking to a nurse, which would, however, make matters worse (nurses tend to tell parents against the will of adolescents, even if it should not be done). (A2)

Environment related barriers to help (Figure 5)

Negative impact of loved ones on getting help

Some parents were reluctant towards the adolescent's need for psychiatric treatment. It showed as a lack of parental support and an encouragement towards planning further care for the adolescents, as a negative attitude towards medication, parents' unconcerned attitudes towards adolescents' anxiety, and the parents' view of the adolescent being healthier than others.

> I just didn't get support and encouragement from my parents considering follow-up care—they thought I was much healthier than many others. (A27)

Parents' ignorance of psychiatric care reflected parents' old-fashioned or distasteful images of mental hospitals.

> When I mentioned psychiatric hospital to my parents, they were furious. They had, and perhaps still have, a very old-fashioned image of mental hospitals. (A27)

Friends' debilitating effects on adolescents' health were described as friends not reacting to cutting scars, and as being shamed in front of friends.

> I have thought sometimes that some of my friends would notice the scars—no one ever responded in any way. (A2)

The harmful attitude of fellow human beings meant reflected a perceived selfishness of people, and that people keep in touch with each other only for profit. Adolescents also described others as having too strong attitudes that complicated talking.

> They have always been very concerned, which has made it difficult to discuss this openly. Usually, other people's opinion is so strong, for example 'you must not do this, it is wrong and horrible, serious and sick'. (A6)

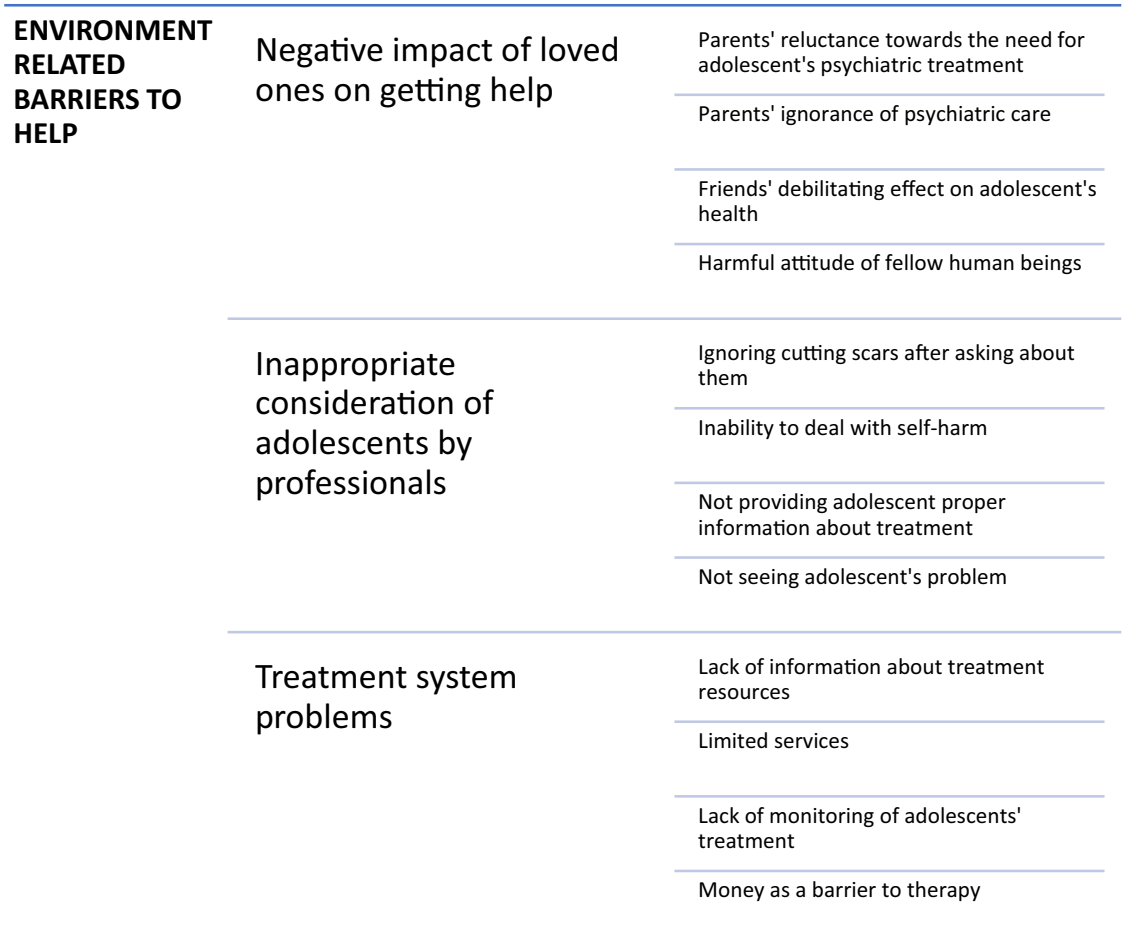

Figure 5. Environment related barriers to help.

Inappropriate consideration of adolescents by professionals

Adolescents told that cutting scars were ignored, despite first being asked about these. More specifically, professional people tended to leave the matter after asking to see the scars, and psychologists left the matter once they had asked about the scars.

> Once a psychologist saw my scar and asked what is it? I said, "a wound", to which she no longer responded anything. (A3)

Some professionals were incapable of dealing with self-harm. This was described in the way that school staff was not reacting to the scars and as a school nurse did not react after having seen the scars. Adolescents also described a case where professional simply ordered them to stop self-harming being unable to deal with it otherwise.

> In a high school, a nurse saw the cutting scars. She was supposedly worried, but left it at that. (A3)

Professionals did not provide proper information about treatment to the adolescent, and tended not to see the adolescent's problem. An adolescent was offered a treatment period at a psychiatric department without being given any further information about it, or was simply given driving instructions to get to the psychiatric in-ward treatment.

> Then they suggested an in-ward period in a psychiatric hospital, but no one has ever bothered to tell what it's like to be there, what is done there, etc. (A8)

Not seeing the adolescent's problem meant that no one said what was actually wrong with the adolescent, and that psychiatrists or social workers did not recognise the problems the adolescent had.

> I have gone through psychiatrists, social workers, etc., but they do not see anything wrong in me. (A21)

Treatment system problems

Treatment system problems included a lack of information about treatment resources, limited services, a lack of monitoring of adolescents' treatment, and money as a barrier to therapy. Adolescents described having an ignorance of outpatient treatment, psychotherapy, peer support groups, and day-care hospitals.

> The alternatives, then, are eternal anxiety, self-harm, and perhaps even suicide attempt against an involuntary treatment in a psychiatric hospital. Only the extremes are known, and there is a rather distorted image of them as well. Little is known about outpatient care, psychotherapies, etc. (A27)

Limited services resulted in waiting lists for accessing treatment, an undesirable familiarity with helpers in small communities, and a frequent change of doctors.

> Many helpers are familiar in a small locality. (A11)

Adolescents described a lack of monitoring in care as instructing adolescents to discuss issues with someone without controlling the visits, and the inaccessibility of help for many adolescents despite its availability.

> They wanted me to be sent to discuss things. In reality, I only went to the nurse twice, and she thought I went elsewhere too, but I never went. (A9)

Money as a barrier to therapy was described as obtaining a negative decision from KELA (Social Insurance Institution of Finland) or Valtava-funding (one kind of support from a hospital district for rehabilitation) for funding therapy.

> Hopefully now with the second application I will get the decision of the Social Insurance Institution of Finland that I could continue my therapy. (A22)

Discussion

Discussion of the results

The findings of this study indicate that self-harming adolescents received diverse help from other people, but participants did not prioritise any source of help. Many previous studies have found that self-harming adolescents seek help primary from friends and family (Doyle et al., 2015; Fortune et al., 2008a; Hasking et al., 2015; Lindgren et al., 2018; Michelmore & Hindley, 2012; Rowe et al., 2014) and also from school (Fortune et al., 2008b; Hasking et al., 2015). In this study, help from loved ones was described on general level, while help from professionals was defined primarily in terms of talking and visits. Confidential discussion with a non-judgmental professional is important, and this finding is consistent with previous literature (Idenfors et al., 2015a). As earlier stated, anyone who knows about an adolescent's self-harm can be a helper, and adults are duty-bound to help (Rissanen et al., 2009). Although friends and family are important in helping, it must be noted that adolescents think they can talk to professionals more seriously and about more difficult problems (Idenfors et al., 2015a). It is important that adolescents have someone to discuss their concerns with (Fortune et al., 2008b; Rissanen et al., 2009).

According to this study, there is help that functioned well, as well as failures in help seeking and receiving help. It is important to remember that the experience of good or bad help is individual, and that each adolescent should be helped in relation to their own needs. Experiences of effective treatments were described both at a general level and with great precision, e.g. electroconvulsive therapy, which may not have been described in previous studies by participants. Adolescent's self-help as a well-functioning form of help was reflected a helpful mental growth of the adolescent and the development of unconventional coping methods. These kinds of findings are quite unusual. Increased self-insight, activation, new coping strategies and medication have been considered as helpful by adolescents in the context of their perceived care and support (Idenfors et al., 2015a). Medication and therapy were described as both well-functioning and failed help, previously both positive and negative experiences with medication were identified (Idenfors et al., 2015a). Psychiatric in-ward treatment was particularly prominent in this study. It had helped in many ways, and it clearly emerged as being more helpful, although it was also described by some as failed help. In a previous

study, adolescents asked for more care in terms of inpatient treatment, but their experience of getting into adult psychiatric care was described as negative (Idenfors et al., 2015a).

In the stories when help had failed, adolescents found it difficult to apply for and access help. Adolescents were disappointed with a variety of issues related to either seeking or receiving help, and this should be considered in units that provide adolescent services. Previous research has found that the decision to seek help has been hampered by not knowing whom to ask for help (Fortune et al., 2008a; Rissanen et al., 2009). Our findings identify further problems in seeking or receiving help. It was perceived as being laborious and demanding several visits and the help received did not always produce the desired results, for example, the degree of help received was insufficient. It has been found previously, that some adolescents have experiences as being personally failed or let down by the system, caused, for example, by long waiting times, too few sessions, and ineffective interventions (Wadman et al., 2018). It has also emerged that self-harming adolescents have experienced treatment as ending too early, and that the promises made to them about the effects of medication or waiting times were not fulfilled (Idenfors et al., 2015a).

In this study, many adolescent related and environment related barriers to help emerged, as quite a few barriers have been identified in previous studies. Adolescents' uncertainty and the problems it causes have been described; considering self-harm as a less serious issue has emerged as the adolescents' thoughts of self-harm as something done on impulse, and therefore not serious (Fortune et al., 2008a); a lack of awareness needing help and inability to seek help has been described (Rissanen et al., 2009); not knowing where to go to for help has been identified as an impeding factor for self-harming adolescents' help-seeking (Rissanen et al., 2009; Rowe et al., 2014). Previous studies have found that when an adolescent wants formal help and has decided to apply for it, they often do not know where to turn (Lindgren et al., 2018). In this study, adolescents felt that it was difficult to take the initiative, and that someone else should come forward to help. This is a parallel finding to a previous study where a formal referral was considered as good because adolescents felt that making contact on their own was difficult (Idenfors et al., 2015a). However, uncertainties that may be affected by adults should be minimised (Rissanen et al., 2009).

The theme of unwillingness to burden loved ones has emerged in previous studies, and some adolescents want to protect their parents and consequently do not tell those close to them about their self-harm or seek help from parents (Rissanen et al., 2009; Wadman et al., 2018). Adolescents' unwillingness to seek help has been clarified, and the most common reason was that they did not feel that they needed any help (Doyle et al., 2015). Furthermore, adolescents felt that they could, or should be able to cope on their own (Fortune et al., 2008a; Rissanen et al., 2009). In this study, adolescents described their frustration with waiting for help, and therefore unwillingness to get it.

The adolescents in this study had different fears which hampered help. They described a fear that their parents would find out about their situation, and more specifically, the fear that the nurse would tell their parents without their consent. Therefore, it would be important that parents, professionals, and other adults do not talk and share information with each other without the adolescents' knowledge and permission. Previously, when studied self-harming adolescents' perceptions of help, it was found that they felt negative if health care staff made contact with other agencies without their participation or consent, and also if parents communicated with teachers and health care staff (Idenfors et al., 2015a). In this context, confidentiality is highly important and should only be broken if the adolescent's life is in danger. Fears relating disclosure also involved issues of stigma, that would require an attitudinal change at the societal level. Adolescents should be able to disclose their self-harm to people close to them who can provide help (Lindgren et al., 2018). Self-harming adolescents have been found to have beliefs and fears surrounding the possible negative consequences of disclosing their self-harm (Rowe et al., 2014) and a fear that seeking help would create more problems for them and hurt the people they cared about (Fortune et al., 2008a). In the past research has also identified fears related to confidentiality breaches, stigma, being appraised as 'attention seeking', and receiving negative reactions from others as barriers to help-seeking amongst adolescents (Curtis et al., 2018; Fortune et al., 2008b; Rissanen et al., 2009; Rowe et al., 2014).

Adolescents in this study described a negative impact of loved ones regarding getting help. Previous studies confirm this (Rissanen et al., 2006, 2009). Parents can offer unhelpful responses to adolescent's self-harm. These responses could impact on help-seeking, and were seen angry, dismissive and over emotional in nature (Rissanen et al., 2009; Wadman et al., 2018). The strong attitude of others was found as an aggravating factor in this study, but even more clearly the parents' reluctance to respond to the adolescent's need for psychiatric treatment, and their ignorance of psychiatric treatment was seen. This is quite worrying when thinking about parents' role as helpers and indicates that parents should receive appropriate information about psychiatric treatment and other treatment options.

One emerging theme regarding the inappropriate consideration of adolescents by professionals was the seemingly deliberate disregard of cutting scars after asking about them, and the professionals' incapability to deal with the issue of self-harm. Unresponsiveness and being left without any intervention after someone seeing a wound or scars have previously been described as help hindering factors (Rissanen et al., 2009), and in this study these factors were also related to adults other than professionals. The message is the same, and adolescents felt that adults did not react when seeing scars, and did not know how to or dare to deal with it.

Limited services included a typical problem in Finland: in small localities people tend to know each other and having a familiar person as a helper may not be a good thing.

Waiting lists were also named as a barrier. It has previously been stated that help should be easily accessible, and available without delay when the adolescent has decided to apply for it (Lindgren et al., 2018). A lack of monitoring in treatment describes the worrying fact that even if help were available, many adolescents in need of it would be left out. One adult may guide an adolescent to another, but no one monitors whether visits are even undertaken.

In this study, money played a role as a barrier to therapy. From a slightly different perspective, it has been found that a lack of money has led to prescribed medication not being purchased, and the health services' cumbersome administrative system has led to unnecessary costs for self-harming adolescents (Idenfors et al., 2015a). Money should never be an obstacle to the help of self-harming adolescents, and society-supported therapy for adolescents should be more easily available.

Trustworthiness of the research

The trustworthiness of research has been assessed through considerations of dependability, credibility, transferability and confirmability (Colorafi Jiggins & Evans, 2016; Holloway & Galvin, 2017). For dependability, the context of the study has been described as accurately as the anonymity and information provided by participants will allow. Individual contexts were not so easy to explain because of the heterogenous participant group, and because participants provided relatively little background information. The broader context of the study was Finnish society, in which adolescent services are quite diverse and regionally varied. Participants were drawn from all over Finland. The gender division cannot be reported because not all the participants provided their gender when answering the study.

Methodological clarity has been sought through an open description of the processes of data collection and analysis. The results have been described accurately, with quotations from the participants used to support credibility. Overall, the first level codes are described as close as possible to the language of the respondents. The data analysis process was reviewed several times, and even after writing the results, the corresponding author returned to the original data and first level codes to ensure the correctness of the analysis. Although the corresponding author dealt with the original material alone, others in the research team commented on the analysis and results on an ongoing basis. Any premature closing of the analysis was avoided with this re-reviewing of analysis (Holloway & Galvin, 2017).

The findings of this study can be transferred to similar participants with special attention given to the individual needs of self-harming adolescents. Although the results of this study cannot be generalised, they can be utilised in the development of help initiatives. Treatments that were perceived to be helpful can be strengthened, and when considering in-ward treatment more broadly, it must be taken into account that self-harming adolescents consider in-ward treatment as important. Because research on self-harming adolescents' experiences of help is quite scarcely studied in Finland, the results of this study increase the knowledge base on this topic, and also confirm the findings of previous Finnish studies (Rissanen et al., 2006, 2009).

To ensure the confirmability of the study, a transparent description of the data collection and analysis processes has been provided. The analysis process was long and multilayered, and it enabled the corresponding author to remain detached from the data and thus reduce their personal impact on the analysis. An example of the abstraction process is given for the purpose of illustrating the analysis, and the quotations from the original data are demonstrative of the participants' voice. The corresponding author has a background of strong mental health professionalism, which has helped her to manage her own prior assumptions and preconceptions.

Conclusions and implication for practice

In this study, Finns who self-harmed in adolescence described experiences of the help they had received for self-harm, and results revealed both positive and negative experiences. They had received formal and informal well-functioning help, and knowledge of this can be utilised when developing help for self-harming adolescents. The helper of a self-harming adolescent may be a loved one or professional, and it is important that they are non-judgmental and have a genuinely interested attitude towards the adolescent. There is no unambiguous guidance on how to promote an experience of 'good help' for a self-harming adolescent, as their needs are individual, and professionals must be able to respond to them. This requires listening to the adolescents sensitively, and asking for them assessment of the help given.

It is difficult for self-harming adolescents to seek information and help, and possibility for help is poorly accessible. Difficulties of help can be addressed by making help easier and faster to access, and many barriers to help can be alleviated by relatively simple actions; more information can be provided about self-harm, its severity and the possible help available; adolescents can be encouraged to disclose their self-harm and guided to seek help; other people's attitudes can be influenced by correct and readily available information; professionals' attitudes towards self-harm can be changed, and helpers' abilities to deal with self-harm can be increased with education. In the future, it would be important to explore more factors that promote and facilitate help from the perspective of self-harming adolescents.

Recommendations for nursing practice

Information on professional help should be easily available for self-harming adolescents. Help should be visible online, and information shared with those working with young people. Information should also be given to the parents of self-harming adolescents. Parents are an important source of help, and their reactions should not increase adolescents' anxiety.

Getting help should be easy. It should be possible to get help around the clock, even if it is just something online

and an ability to send a message that will be answered the next day. Sources of help should be easy to find and reach, and adults should be more willing to offer help or guide the adolescent to get help. Help for self-harming adolescents should be available without waiting times and costs. New sources of help should also be developed so that adolescents can get help immediately if needed.

There should be different treatment options available and adolescent should be told about these. Help must be based on the self-harming adolescents' individual needs. It is important to ask, listen and respect the wishes of the adolescent. Confirm good, and minimise bad. Remember confidentiality unless the adolescent's life is in danger.

Professionals should have the ability to both discuss and help with such a difficult issue as self-harm. Increasing knowledge of self-harm and talking to colleagues and other professionals about the topic may help learning to talk about self-harm more easily because you need to be able to talk with self-harming adolescent openly and fearlessly. If you can't help, redirect the adolescent elsewhere and make sure the treatment starts there. Self-harming adolescent should never be left alone.

Reducing uncertainties and fears about the consequences of disclosing self-harm or seeking help is crucial. These can be alleviated with transparency and knowledge. The stigma associated with self-harm should be dispelled.

Acknowledgements

We warmly thank all the participants for their valuable stories. Participants in this study received no financial or other compensation.

Disclosure of interest

No potential conflict of interest is reported by the author(s).

Funding

This study was partly funded by grants from the Finnish Cultural Foundation, the Häme Regional Fund, and the Finnish Nurses Association.

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