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RESEARCH ARTICLE

Sharing, carrying, and tolerating the pain – A meta-synthesis of clinicians' experiences from working with adolescents who self-harm

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Abstract
Objective: This study aims to review and synthesise qualitative studies of the subjective experiences of clinicians working with adolescents (11–18 years of age) who self-harm.
Method: We conducted a systematic literature search and included 14 studies in a meta-synthesis, applying Noblit and Hare's (1988) [*Meta-ethnography – synthesizing qualitative studies*. SAGE Publications] seven analytical steps for meta-ethnography.
Results: The meta-synthesis resulted in three meta-themes that narrate a process of the emotional experiences of being in a professional relationship with adolescents who self-harm: (1) "Sharing the pain – The relationship as a vehicle to help, understand, and protect"; (2) "Carrying the pain – Self-harm evokes strong feelings"; and (3) "Tolerating the pain – To show a way out".
Conclusion: Working with self-harm may represent a challenging balance for clinicians between exploring the pain in the therapeutic relationship, while also managing their own ability to tolerate the difficult emotions in this work.

Keywords: adolescence; mental health professionals; meta-synthesis; qualitative research; self-harm

Clinical and methodological significance of this article: This qualitative meta-synthesis indicates that working with adolescents who self-harm can evoke complex and difficult emotions but also be a meaningful process for clinicians. On an institutional level, sufficient time and support appear to be important prerequisites for promoting helpful clinical encounters between clinicians and young people who self-harm.

The majority of adolescents who self-harm do not seek treatment (Gillies et al., 2018). This is concerning given the high prevalence, increased suicide risk, and relation to mental health problems in adolescence (Farkas et al., 2024; Gillies et al., 2018). Furthermore, negative experiences with staff can lead to feelings of increased risk for self-harm and discourage future help seeking in patients (Cadorna et al., 2024; MacDonald et al., 2020). The aim of this study is to increase our understanding of the subjective experiences of clinicians working with adolescents who self-harm, through a review and synthesis of qualitative studies. In the following, we will present theories and research on the function of self-harm as well as research on

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the experiences of patients and health personnel from treatment of self-harm.

The average age at which self-harm begins is 13 years old (Gillies et al., 2018). There is ongoing debate about whether to include suicidal intent in definitions of self-harm (Miller et al., 2019). Research on the function of self-harm can enhance our understanding of why only a minority of those who self-harm seek clinical care, as well as on the emotional dynamics between patients and clinicians. Systematic reviews have indicated that self-harm can serve various functions, including exerting interpersonal influence (e.g., seeking help; Edmondson et al., 2016), but also as a way of alleviating negative affect to obtain relief and a sense of control (affect-regulating function; Klonsky, 2007). Similarly, a meta-analysis of self-harm from all community-based studies of adolescents from 1990 through 2015 found that "to obtain relief from feelings or thoughts" was the most commonly cited reason for self-harm amongst adolescents, followed by "to punish oneself", and further "to let someone know or get a reaction" (Gillies et al., 2018). In a meta-synthesis of qualitative studies on young peoples' experiences of their own self-harm, Stänicke et al. (2018) found that young people harmed themselves to get release or a feeling of control of difficult emotions, but also as a means to express and share non-accepted feelings, or to connect with others. Because adolescence is a developmental period characterised by biological, cognitive, psychological, and social changes, Stänicke et al. (2018) argue that self-harm should be understood as a way to resolve a conflict between basic relational needs for attachment and safety, and developmental tasks of finding ways to represent and express affective experiences. In light of these findings, self-harm may serve as a means for young people to independently express and regulate unbearable emotions, in contrast to seeking help from peers, family, and mental health professionals. Thus, themes of attachment and affect representation may become relevant in clinical work with young people who self-harm.

Systematic reviews indicate that structured treatment models (e.g., Cognitive Behaviour Therapy, Dialectical Behaviour Therapy, and Mentalization-Based Therapy) are effective for the reduction of self-harm (Kothgassner et al., 2020; Witt et al., 2021). Further, a positive therapeutic relationship between the patient and the therapist can lead to a reduction in self-harm (Dunster-Page et al., 2017) and suicidal risk (Schultz et al., 2021), and help young people seek further help (Zhang et al., 2023). The importance of a trusted, therapeutic relationship is also highlighted in qualitative meta-syntheses of patients' experiences of treatment for self-harm (Haw et al., 2023; Sass et al., 2022). However, several systematic reviews of patients' experiences indicate negative encounters with the healthcare system following self-harm, including a lack of knowledge from staff and poor communication (Taylor et al., 2009; Uddin et al., 2024). Patients' experiences of emergency hospital care following self-harm can span from gentle to hostile, and negative experiences of treatment may increase the likelihood of future self-harm (MacDonald et al., 2020). Furthermore, a meta-synthesis of qualitative literature found that negative experiences (e.g., increased distress and feeling like a burden) of going to emergency departments for mental health support could lead to feelings of increased risk of self-harm and discourage future help-seeking in young people (Cadorna et al., 2024).

Systematic reviews indicate negative attitudes of clinical staff towards people who self-harm, though these attitudes vary across health professions. Saunders et al. (2012) found that psychiatric staff in different settings show more positive attitudes compared to general hospital staff, despite also expressing frustration. Across several studies, Ribeiro Coimbra and Noakes (2022) found that feelings of negativity, apprehensiveness, and fear of worsening symptoms in children and young people occurred across several healthcare professional groups in acute hospital settings. However, professionals working in mental health display greater effectiveness and positive attitudes towards children and young people who self-harm compared to other professional groups (Ribeiro Coimbra & Noakes, 2022; Cleaver, 2014). Qualitative studies also indicate that therapy with young people who self-harm evokes complex emotions in experienced therapists (Ramvi & Huvestad, 2019; Robstad, 2018).

Studies have also indicated positive attitudes towards young people who self-harm, amongst mental health nurses (Pintar Babič et al., 2020) and emergency care staff (Cleaver et al., 2014), suggesting that age may influence the relationship between patients and health professionals. Systemic factors may also play a role. A qualitative meta-synthesis of hospital staff experiences of relationships with adults who self-harm found that the theme "Fearing the harm from self-harm" was present across both mental health and physical health settings. However, mental health staff also experienced "Working alongside the whole person", which were explained by differences in systemic factors, such as access to time, supervision, and training (O'Connor & Glover, 2017).

Objective

Previous reviews of the experiences of health professionals working with children and young people who self-harm indicate that knowledge and work

setting can affect emotions and attitudes, but these reviews mainly include studies of acute settings (Ribeiro Coimbra & Noakes, 2022; Cleaver, 2014). Qualitative studies are well suited to explore the nuances of the relationship between clinicians and adolescents who self-harm and can complement quantitative surveys. We propose that a qualitative meta-synthesis examining the emotional reactions and experiences arising from therapeutic work with self-harming adolescents can contribute to increased understanding of how negative feelings in clinicians can be managed to improve the therapeutic alliance, including the emotional bond with patients. Thus, the present study aims to review and synthesise qualitative studies of the subjective experiences of clinicians working with adolescents who self-harm. Our study was guided by the following two research questions:

(1) How do clinicians experience the relationship with adolescents who self-harm?
(2) How do they describe and give meaning to emotional reactions in the therapeutic relationship?

The findings from the present study can have implications for clinical work. In this paper, the term "clinicians" refers to health personnel with a mandate to help, support, and treat people with mental health difficulties, who have the possibility to create a relationship with young people who self-harm. "Adolescents" refers to individuals aged 11–18 (Farkas et al., 2024), and "self-harm" refers to self-induced injuries, with and without suicidal intent (Witt et al., 2021). "Developmental tasks" refers to developmental challenges of developing affect regulation, problem solving, and a stable self-identity (Stänicke et al., 2018).

Method

A meta-synthesis is an established procedure of reviewing and bringing together findings from existing qualitative studies (Timulak, 2009). It can provide comprehensive descriptions and deeper understanding of a phenomenon (Malterud, 2017), as well as the opportunity to analyse concepts across different contexts (Levitt, 2018). To review and synthesise studies of clinicians' experiences of therapeutic relationships with adolescents who self-harm, we applied Noblit and Hare's (1988) seven analytical steps for meta-ethnographic method for meta-synthesis: (1) Getting started, (2) Deciding what is relevant to the initial interest, (3) Reading the studies, (4) Determining how the studies are related, (5) Translating the studies into one another, (6) Synthesising translations, and (7) Expressing the synthesis. We were also informed and inspired by some previous examples of qualitative meta-synthesis (e.g., Stänicke et al., 2018; 2024).

Literature Search

We conducted a systematic literature search, with assistance from a research librarian. The search was guided by terms related to (a) *qualitative studies*, (b) *health personnel*, (c) *adolescents*, and (d) *self-harm* (see Supplementary online material, Appendix A for literature search). We chose a broad search strategy that included health personnel in both psychiatric and somatic fields. Although our interest was in professionals in mental health, this approach ensured that all relevant references were captured in our search. The final literature search was conducted 18.03.2022, in databases PsychINFO, MEDLINE, EMBASE, CINAHL, and Cochrane Library, and resulted in 1252 articles (see Supplementary online material, Appendix A for literature search). After removing 341 duplicates, 911 records remained for screening (see Supplementary online material, Appendix B for flow diagram).

Inclusion and Exclusion Criteria

The criteria for inclusion and exclusion were discussed and revised among all authors throughout the screening process (see Table I). The two first authors (MHL & MFW) independently screened the articles' titles and abstracts against the broad inclusion criteria: qualitative methodology, topics on adolescent self-harm, and the perspective of professionals in mental health. Conflicts were solved through discussion to obtain consensus, following Levitt (2018) and Malterud (2017). Finally, we excluded 784 references.

Next, 127 references remained for independent appraisal of the abstract against the narrow inclusion criteria. In this phase, we included only references that investigated (1) the subjective experiences of mental health professionals from work with (2) adolescents who self-harm, that (3) could develop a relationship with the adolescent over time (see Table I for a list of excluded professions). We chose to include school counsellors, as this group can develop a relationship with young people over time (Moyer & Nelson, 2007) and often attend to adolescent mental health (American School Counselor Association, 2020). However, we did not include quotations from participants irrelevant for the meta-synthesis, such as parents and health personnel working in somatic medicine or adult psychiatry.

Table I. Inclusion and exclusion criteria.

Variable	Inclusion criteria	Exclusion criteria
Topic of interest	Experiences of working with adolescents who self-harm	Solely focus on suicide and attempted suicide, or indirect forms of self-harm Descriptive focus (e.g., focus on self-harm as a concept, views on the motives of self-harm, the influence of culture or parenting on self-harm) Experience with recruitment and screening for suicide risk Evaluations of therapeutic interventions, training programs
Methodology	Qualitative methodology Data-collection with open-ended questions or written text Mixed methods (if possible to extract qualitative results)	Quantitative methodology (e.g., effect studies, surveys with closed questions) Theoretical articles, case descriptions, review articles
Study population	Professionals who deliver mental health care to adolescents (11–18 years) who self-harm, and have an opportunity to develop a relationship over time	Parents or relatives Professionals who do not specifically work in mental health (e.g., paediatricians, general practitioners, pharmacists, paramedics, foster parents, school nurses, youth justice staff, midwives) Professionals who will only work briefly with adolescents (e.g., emergency department) or in online counselling
Patient group	Adolescents (11–18 years) who self-harm	Adult patients or age not specified Children (10 years or younger) Developmental disorders (e.g., autism spectrum disorders, intellectual disabilities)
Quotations	First-person quotations from participants	No direct quotations
Publications	Publications written in English, published and peer reviewed in an academic journal, or as a doctoral thesis Available in full-text	Studies reported in conference paper, or book chapters Not available in full-text

We also chose not to include general perspectives on the treatment or understanding of self-harm, or experiences specific to one workplace, since these were outside the scope of our research question. We excluded studies that solely described experiences with suicide or indirect self-harm (e.g., smoking or eating disorders). However, we included studies that used the term "suicidal behaviour" (Anderson et al., 2003, 2005) or "suicide-related behaviours" (Fu et al., 2021) in addition to "self-harm", prioritising quotations referring to self-harm in the analysis. Furthermore, we included references that describe experiences from work with children, in addition to adolescents (Davis, 2019; Hay et al., 2015; MacDonald et al., 2021). When possible, we selected quotations from experiences with adolescents. 100 studies were excluded.

Finally, 27 studies remained for full-text reading by the two first authors (MHL & MFW). We excluded 12 studies based on the inclusion criteria. Additionally, three studies were excluded because they were not available in full text (Beck, 2012; Kotsopoulou & Melis, 2015; Smith, 2016). Then, we searched the reference lists of the 12 included studies, as well as relevant reviews (e.g., Cleaver, 2014; Ribeiro Coimbra & Noakes, 2022) for grey literature (Malterud, 2017). One reference was included on this basis (Anderson et al., 2005). We included 13 articles for full-text review by the team.

An updated literature search of studies published between 2022 and September 2023 resulted in 207 new references. We excluded duplicates and screened 151 titles and abstracts against the inclusion criteria. Eight articles were included for full-text reading by the two first authors, five were excluded due to unavailability. Finally, we included one article for full-text review (Griffiths et al., 2023).

We assessed the quality of the 14 included studies using criteria from the Critical Appraisal Skills Programme (CASP, 2018). We emphasised explicit data analysis, the use of direct quotations, and ethical considerations (see Supplementary online material, Appendix D for CASP). The two first authors (MHL & MFW) extracted characteristics of the included studies (author, year, title, context, participant characteristics, methodology, and data analysis; see Supplementary online material, Appendix C for study characteristics).

The Included Studies

The included studies investigate the experiences and perspectives of clinicians working in mental health fields, with a mandate to help, support, and treat adolescents (11–18 years) who self-harm. The studies are published, peer-reviewed in academic journals or as a PhD thesis, and written in English.

Most of the studies were conducted in the UK (7), but also in Ireland (1), Finland (1), USA (2), Canada (1), New Zealand (1), and China (1). The studies represent different fields of knowledge, such as psychology, medicine, and school counselling, which makes this an interdisciplinary synthesis. All the included studies used qualitative methodology, with the majority (n = 12) employing semi-structured interviews. Furthermore, all articles included direct quotations from participants to illustrate findings. The included studies utilise different concepts for self-harm.

The number of participants is approximately 140. The age of the participants, where specified, range from 23 to 73 years. Of the participants whose gender was specified, the majority are female. The professions of the participants include nurses (58) and doctors (5; including 1 specialist trainee) working in mental health services, psychiatrists (16), clinical psychologists (1), counsellors (10), school counsellors (39), other staff members in mental health (7; including a teacher), and master students in counselling psychology (12). The setting of the included studies varies, including outpatient clinics, adolescent inpatient units, community services, hospitals, and schools (see Supplementary online material, Appendix C).

Analysis and Synthesis

The two first authors (MHL & MFW) read and reread the studies to extract relevant data. We organised the findings from the primary studies in meaning units, which included quotation from the participants (first order construct), the authors' metaphor/theme and interpretation (second order construct), as well as our understanding of the finding. When coding the meaning units, we focused on the emotional and relational aspects of working with adolescents who self-harm. The meaning units are the building blocks of the meta-synthesis (Britten et al., 2002; see Table II). Furthermore, we chose an index study (Leddie et al., 2022), due to high methodological quality, rich data presentation, and a relevant research question. The index study served as the basis for sorting the meaning units (Malterud, 2017). Then, we categorised and translated the meaning units into one another to create sub-themes (third-order constructs). Some subthemes were named based on concepts used in one of the constituent articles (e.g., 1.1.1 "The relationship with the adolescent is vital" is based on terminology from Roberts and et al. s' (2019) article), while other sub-themes emphasise meanings from the quotations (e.g., 3.3.1 "The work is enjoyable and meaningful"). We further synthesised and organised these translations in a hierarchy of subthemes, themes, and meta-themes. Throughout this process of analysis, and in consensus meetings with all authors, we took an interest in the complex nuances in the emotional and relational experiences expressed by clinicians working with adolescents who self-harm. Together, we developed a narrative to describe the relation between the themes and the subthemes. This narrative forms the basis for the meta-themes and can be viewed as representations of different aspects of the clinicians' experiences of a treatment process with adolescents who self-harm. In this way, the meta-synthesis took the form of "a lines of argument synthesis", where the selective studies of the parts are used to make inferences about the whole (Noblit & Hare, 1988).

Reflexivity

To enhance trustworthiness and transparency, we grounded our findings in the data from the original studies, by including quotations from the

Table II. Example of different levels in the analysis.

Authors	First order construct	Second order construct	Third order construct
Anderson et al., (2003)	"It is quite frustrating when you are making good progress … doing individual work and you feel that things are moving on then they do something like cut themselves … or take an overdose … quite frustrating … " (Anderson et al., 2003, p. 592)	Authors' metaphor/theme: Experiences of frustrations in practice: Insubstantiality of interventions. Interpretation: The feeling of not being able to help young people who engage in suicidal behaviour is also highlighted in the interview material from staff practicing in mental health care. The meaning here is less to do with not being able to attend to symptoms or putting a plaster on the problem, and more to do with giving help, but then things breaking down (p. 592).	Meta-theme: (2) Carrying the pain – Self-harm evokes strong feelings Theme: 2.1 Feeling inadequate Sub-theme: 2.1.1 Distress when patients continue to self-harm

participants, as well as the authors' interpretations of findings in the meaning units (Levitt, 2018). Moreover, we have included contextual information and page numbers from the primary studies to help readers in applying the findings in their own context. Throughout the research process, from developing the research question to creating the hierarchy of third-order concepts, the decisions were regularly discussed between all authors. To enhance reflexivity, we continually reflected on how our personal and theoretical perspectives influenced data collection and analysis. All authors are clinical psychologists with an interest in psychodynamic, emotion-focused, and developmental perspectives. The two first authors (MHL & MFW) recently finished their training in clinical psychology. RSJ is a PhD and works as a qualitative researcher. LIS is an experienced clinician and researcher at a university department that educates future clinical psychologists. We made notes of discussions, perspectives, changes, and thoughts throughout the process (Levitt et al., 2016). During the process of analysis and synthesis, we focused on understanding the findings in light of research and theory on the functions of self-harm. We were also inspired by theoretical perspectives on the relational dynamics in psychotherapy, especially the concept of containment (Bion, 1970), which describes how the therapist can take in and process psychological material that is emotionally overwhelming for the patient.

Ethics

We did not have direct contact with the participants of the included studies. Since the meta-synthesis is a secondary analysis of data from the included studies, ethical approvals were not necessary. However, we assessed the overall quality of the primary studies, including descriptions of ethical considerations using CASP (2018; see Supplementary online material, Appendix D for CASP). If the papers provided insufficient information on ethical considerations, we examined the journal's ethical guidelines. We reproduced quotations with respect. All participants in the included studies have consented to participating in the primary studies, and the clinical cases are anonymised.

Results

In the following, we present three meta-themes that represent the subjective experiences of clinicians working with adolescents who self-harm: (1) "Sharing the pain – The relationship as a vehicle to help, understand, and protect"; (2) "Carrying the pain – Self-harm evokes strong feelings"; and (3) "Tolerating the pain – To show a way out". These meta-themes form a narrative of relational and emotional aspects of working with adolescents who self-harm. Each meta-theme comprises themes and sub-themes (see Table III). The number of meaning units and articles that contained evidence of each theme are presented in parentheses (n = #, mu = #). This is to offer transparency to the reader, not to quantify or imply the validity of the findings (Jessen et al., 2021; Levitt, 2018).

First Meta-Theme: Sharing the Pain – The Relationship as a Vehicle to Help, Understand, and Protect

The first meta-theme emphasises how the therapeutic relationship can function as a means to understand and address the underlying needs behind self-harm. It also involves feelings of personal responsibility to help and protect the adolescents from self-harm.

Theme 1.1. Helping through the relationship (n = 7). The first theme highlights the importance of the therapeutic relationship in uncovering and understanding the young person's pain. Some studies convey how *the relationship with the adolescent is vital* (n = 4, mu = 10): "The relationship is important. The first thing you have to do is build that rapport, so they trust you. And once that wall is down, they tend to allow you to make discoveries about what's going on with them" (Roberts et al., 2019, p. 17). Participants regard personal contact, maintaining hope, compassion, and trust as important qualities in the helping relationship: "The point is that adults have a duty to help . . . any adult who has a good and trusting relationship can be of help" (Rissanen et al., 2012, p. 254). Furthermore, some studies describe how *clinicians seek to understand the needs communicated through self-harm* (n = 4, mu = 6): "I need to understand what my client is experiencing . . . I don't need to react; I need to respond appropriately" (Davis, 2019, p. 106). Self-harm is viewed as an effort to communicate, connect, and obtain help (e.g., Rissanen et al., 2012). However, some participants highlight that the meaning of the message is not always clear, which can create difficulties with connecting to patients (Anderson et al., 2005). Also, some clinicians find it difficult to relate to self-harm: "I can't get my head around it how anybody wants to hurt themselves. Nothing to me in life is that bad. And I've been at rock bottom, but I never, ever thought

Table III. Hierarchy of meta-theme, theme, sub-theme.

Meta-theme	Theme	Sub-theme	References
(1) Sharing the pain – The relationship as a vehicle to help, understand, and protect	1.1 Helping through the relationship (n = 7)	1.1.1 The relationship with the adolescent is vital (n = 4, mu = 10) 1.1.2 Clinicians seek to understand the needs communicated through self-harm (n = 4, mu = 6)	Anderson et al., (2005); Davis (2019); Fu et al., (2021); Hay et al., (2015); Rissanen et al., (2012); Roberts et al., (2019); Rouski et al., (2017)
	1.2 A personal responsibility (n = 9)	1.2.1 Clinicians feel responsible for protecting their patients from self-harm (n = 5, mu = 5) 1.2.2 A feeling of distrust towards other professionals (n = 6, mu = 8)	Anderson et al., (2003); Davis (2019); Fu et al., (2021); Griffiths et al., (2023); Hay et al., (2015); Leddie et al., (2022); MacDonald et al., (2021); Rissanen et al., (2012); Rouski et al., (2017)
(2) Carrying the pain – Self-harm evokes strong feelings	2.1 Feeling inadequate (n = 9)	2.1.1 Distress when patients continue to self-harm (n = 6, mu = 6) 2.1.2 Clinicians feel unprepared for working with self-harm (n = 6, mu = 8)	Anderson et al., (2003); Davis (2019); De Stefano et al., (2012); Dowling & Doyle (2016); Fu et al., (2021); Griffiths et al., (2023); Rissanen et al., (2012), Rouski et al., (2017); Te Maro et al., (2019)
	2.2 Something fatal can happen (n = 10)	2.2.1 A fear of suicidal risk (n = 6, mu = 6) 2.2.2 Balance risk management with a focus on therapeutic work (n = 7, mu = 12) 2.2.3 They bring the work home with them (n = 3, mu = 3) 2.2.4 Being a container (n = 2, mu = 2)	Davis (2019); De Stefano et al., (2012); Dowling & Doyle (2016); Hay et al., (2015); Leddie et al., (2022); MacDonald et al., (2021); Rissanen et al., (2012); Roberts et al., (2019); Rouski et al., (2017); Te Maro et al., (2019)
(3) Tolerating the pain – To show a way out	3.1 Establishing boundaries and encouraging autonomy (n = 3)	3.1.1 Balance to find the right distance in the relationship (n = 1, mu = 4) 3.1.2 Letting go of control of the adolescent (n = 2, mu = 3)	Davis (2019); Griffiths et al., (2023); Leddie et al., (2022)
	3.2 Finding something to lean on (n = 7)	3.2.1 Clinicians support themselves (n = 4, mu = 6) 3.2.2 Clinicians find support in each other (n = 5, mu = 10)	Davis (2019); Griffiths et al., (2023); Leddie et al., (2022); Rissanen et al., (2012); Roberts et al., (2019); Rouski et al., (2017); Te Maro et al., (2019)
	3.3 Developing an ability to endure strong emotions when working with self-harm (n = 4)	3.3.1 The work is enjoyable and meaningful (n = 2, mu = 2) 3.3.2 The work becomes easier with time (n = 4, mu = 10)	Davis (2019); Dowling & Doyle (2016); Leddie et al., (2022); Rouski et al., (2017)
	3.4 The system gets in the way (n = 11)	3.4.1 A lack of time and resources (n = 6, mu = 8) 3.4.2 Inner conflicts regarding cooperation with parents (n = 4, mu = 7) 3.4.3 Frustration related to a lack of support in the work (n = 7, mu = 10)	Anderson et al., (2003); Anderson et al., (2005); Davis (2019); Fu et al., (2021); Griffiths et al., (2023); Hay et al., (2015); Leddie et al., (2022); MacDonald et al., (2021); Rissanen et al., (2012); Rouski et al., (2017); Te Maro et al., (2019)

like that" (Rouski et al., 2017, p. 14). In sum, clinicians work to understand and connect to their young patients and the needs that they may communicate through their self-harm.

Theme 1.2. A personal responsibility (n = 9). The second theme highlights how several studies convey a sense of a personal responsibility for the adolescents. Some studies describe how *clinicians feel responsible for protecting their patients from self-harm* (n = 5, mu = 5):

> It is typical that she feels guilty about what she has done [self-mutilation], and so you must be very sensitive in what you say. That's because she might feel guiltier and think that she is bad, and this might cause extra traumatization. (Rissanen et al., 2012, p. 257)

Furthermore, some clinicians describe feeling responsible for adolescents' progress or relapse in

treatment: "But ultimately if you still fail … that particular time you think y'know, I haven't done my job today" (Rouski et al., 2017, p. 13). Additionally, several studies convey *a feeling of distrust towards other professionals* (n = 6, mu = 8): "Would I trust other people to do it (assessment) with the negative attitudes that exist about mental health? No" (Hay et al., 2015, p. 297). Differences in understanding between staff members, other agencies, and society can create challenging dynamics (e.g., Rouski et al., 2017), with colleagues in the emergency department being especially highlighted (e.g., MacDonald et al., 2021).

Clinicians seem to experience a responsibility to support and understand adolescents who self-harm. A feeling of being the only ones who are able to provide sufficient help may enhance this sense of a personal responsibility. This leads to the next meta-theme, which elaborates on the difficult emotions clinicians can experience in the work.

Second Meta-Theme: Carrying the Pain – Self-Harm Evokes Strong Feelings

The second meta-theme conveys how clinicians can become bearers of pain and difficult emotions when working with self-harm. Clinicians may feel inadequate when trying to help the adolescents, and fear can affect both the work and their personal life. Additionally, some clinicians struggle to contain the difficult emotions that arise in the work.

Theme 2.1. Feeling inadequate (n = 9). This theme highlights how several studies describe feelings of inadequacy when clinicians are struggling to help young people who self-harm. Several studies convey experiences of *distress when patients continue to self-harm* (n = 6, mu = 6): "It is quite frustrating when you are making good progress … doing individual work and you feel that things are moving on then they do something like cut themselves … or take an overdose … quite frustrating … " (Anderson et al., 2003, p. 592). Participants describe that emotions range from powerlessness to frustration, especially when they feel unable to stop self-harm (e.g., Fu et al., 2021). Some studies also illustrate how *clinicians feel unprepared for working with self-harm* (n = 6, mu = 8): "I don't feel like I was trained in any capacity at all to deal with self-injury" (Davis, 2019, p. 113). Feeling unprepared can lead to anxiety and feelings of failure, especially in the beginning: "I feel I failed him (student who was self-harming), but I was very young and I wasn't qualified or skilled enough" (Dowling & Doyle, 2016, p. 588). In sum, difficulties in helping young people can be hard to bear for clinicians.

Theme 2.2. Something fatal can happen (n = 10). The second theme conveys how fear of the danger and pain associated with self-harm can affect clinicians as well as the treatment process. Several studies describe *a fear of suicidal risk* (n = 6, mu = 6): "It's really dangerous and it's worrying – that person could die.." (Rouski et al., 2017, p. 14). Clinicians also describe stress related to assessing suicidal risk, distinguishing it from self-harm, as well as legal and ethical concerns regarding risk assessments (e.g., De Stefano et al., 2012). Furthermore, several studies describe how clinicians try to *balance risk management with a focus on therapeutic work* (n = 7, mu = 12). On the one hand, ensuring the physical safety of the adolescent is described as essential in several studies:

> I think my primary goal is just to make sure that they're going to be as safe as possible and that seems kind of like an oxymoron when you're talking about self-harm. But as long as we're reducing it, then I feel like we're moving in the right direction. (Davis, 2019, p. 110)

However, for some participants, the prioritisation of risk can sometimes interfere with focusing on the relationship or underlying mental health issues: "Forget the mental health, if they're going to be dead next week" (Leddie et al., 2022, p. 748).

Some studies describe how clinicians feel *they bring the work home with them* (n = 3, mu = 3):

> I remember one case, we got to hear about it on the Friday, dealt with the mother and the child but em the mother was getting some support on the Saturday, but I was actually going away, and I remember ringing, you know, I was going away and having to ring, it's not something you can leave. (Dowling & Doyle, 2016, p. 587)

Some describe that the emotional impact affected their personal relationships (Rouski et al., 2017). Others describe fear of burnout and apathy (Te Maro et al., 2019). In response to emotional reactions, some clinicians also stress the importance of *being a container* of their own and their patient's emotions (n = 2, mu = 2): "if you're anxious about them, you're not containing. Once you're seen to be a container … that is when you become really helpful to them" (Leddie et al., 2022, p. 748).

In sum, clinicians describe a need to ensure the safety of their patients in response to self-harm. However, they also strive to manage and contain difficult emotions that come up in the work with self-harm. This leads to the next meta-theme, which addresses how clinicians work to tolerate the pain, and hence show their patients that there is a way out of it.

Third Meta-Theme: Tolerating the Pain – To Show a Way Out

The third meta-theme conveys how the clinicians manage their own reactions to their young patients' inner pain. Institutional framework and inner emotional work contribute to their ability to endure the pain. However, systemic factors can also hinder these processes.

Theme 3.1. Establishing boundaries and encouraging autonomy (n = 3). This theme highlights how some clinicians strive to figure out the boundaries of emotional involvement while fostering autonomy for the young person. One study describes how clinicians *balance to find the right distance in the relationship* with adolescents (mu = 4): "it can be very difficult to figure out where the boundaries are between I am still a professional in this person's life, I am not a friend" (Leddie et al., 2022, p. 748). Some participants describe conflict and shame of either becoming too emotionally involved or being too emotionally detached. However, becoming desensitised can feel necessary to manage and cope with the work. Some stress the importance of *letting go of control of the adolescent* (n = 2, mu = 3): "I can't control my client. I can't control them, and I can't be with them all the time and so trusting that they're going to use the skills that we've learned, they're going to apply those interventions" (Davis, 2019, p. 110). They also describe the need for balance between autonomy and acknowledging the danger associated with self-harm. In relation to restrictive practices, participants in Griffiths et al. (2023) stress that restriction can prevent young people from developing their own alternative strategies to self-harm, and that a sterile environment does not reflect life in the community. In sum, clinicians work to determine the boundaries for their involvement in the work with these patients.

Theme 3.2. Finding something to lean on (n = 7). This theme describes how several studies convey a need for something or someone to lean on in the work with self-harm in adolescence. Some studies illustrate how *clinicians support themselves* in different ways (n = 4, mu = 6). Some clinicians describe how guidelines provide support in stressful situations:

> That's where a guideline would come in like as a checkbox like have you thought of this, this, this, this, this, this. We can actually work your way through because it can be quite an intense thing depending on the time, depending on the situation. (Te Maro et al., 2019, p. 11)

Support also involves self-care and validation, as well as letting go of responsibility: "Ultimately, you have to realise that it's not your fault, or the CAMHS service, sometimes mental illness is horrible" (Leddie et al., 2022, p. 749). Furthermore, some studies describe how *clinicians find support in each other* (n = 5, mu = 10):

> … because that gives me a sense of security—a little bit more sense of security in knowing that I'm not the only one whose working with this student. I'm not the only one who is keeping an eye out for this student (…). (Roberts et al., 2019, p. 14)

Supporting oneself, as well as sharing the responsibility with others through supervision and discussions with the team, seem to help clinicians feel more secure in their work.

Theme 3.3. Developing an ability to endure strong emotions when working with self-harm (n = 4). This theme describes the experience of gradually being able to tolerate the challenging work with self-harming adolescents, but also to find meaning in the work. Two studies convey that despite feelings of worry and frustration, some clinicians feel *the work is enjoyable and meaningful* (mu = 2). One participant said: "I do enjoy the work [with clients who engage in NSSI], it's not just a burden or something, I do, I actually enjoy the work with these folks" (Davis, 2019, p. 111). Some clinicians describe working with adolescents who self-harm as a "double-edged sword" (Leddie et al., 2022, p. 748), both challenging and rewarding. Finally, some studies illustrate how clinicians feel *the work becomes easier with time* (n = 4, mu = 10): "you come out the other side, with supervision, with support, with the parents on-board, with the young person, and grow as a clinician" (Leddie et al., 2022, p. 749). Although the first encounters with self-harm evoked strong reactions, clinicians describe increased tolerance and understanding of self-harm over time. For some, experience led to increased ability to support and empathise with patients (e.g., Rouski et al., 2017).

Theme 3.4. The system gets in the way (n = 11). This theme highlights that despite clinicians' efforts to manage difficulties related to their work, several studies describe frustration with a system where lack of resources can affect the quality of treatment, cooperation with parents, and availability of support. Several studies highlight how *a lack of time and resources* can lead to frustration for clinicians (n = 6, mu = 8): "In all settings, from family or college settings whatever setting they are in … lack of

understanding … lack of time … lack of communication … I know it's quite an adolescent choice … but you are losing that quality time … " (Anderson et al., 2003, p. 591). This can affect the relationship to the adolescents who self-harm, partly because their need for support may take time from other patients (e.g., Rouski et al., 2017), and because they can influence other patients to self-harm (Anderson et al., 2003). In sum, lack of time and resources can lead to concerns about the quality of treatment.

Some studies also convey *inner conflicts regarding cooperation with parents* (n = 4, mu = 7):

> I don't have capacity to work with the parents as well, yeah. So that's, part of, a rock and a hard place with that at the moment. Seeing that yes, they need to be part of the conversation, don't know how to do that well. (Te Maro et al., 2019, p. 8)

Clinicians stress the importance of good communication with caregivers. However, prioritising both the needs of adolescents and parents can be demanding, due to concerns regarding confidentiality, lack of understanding from caregivers, but also limited capacity to do so (e.g., Leddie et al., 2022). Finally, several studies describe *frustration related to a lack of support in the work* (n = 7, mu = 10): "it can feel quite lonely when you've got a really risky young person and you're the only one initially involved … You've got their life in your hands" (Leddie et al., 2022, p. 747). Clinicians describe not having time to use coping strategies; colleagues not being available; and a lack of supervision, training, and protocols (e.g., Te Maro et al., 2019). Furthermore, a lack of routines can lead to challenges within the team: "We can get into a bad routine, of bad mouthing clinical practice of other people and choices of other people when that time can be used appropriately to get together and say why did you do that" (Rouski et al., 2017, p. 15).

In the third meta-theme, we have outlined how clinicians work to develop an ability to tolerate their emotions in the work with self-harm, which in turn may contribute to showing adolescents that there is a way out of the pain. Practical and institutional conditions regarding sufficient time and resources are central prerequisites for this important inner work.

Discussion

The present review aimed to examine clinicians' relational and emotional experiences of working with adolescents who self-harm by synthesising the results from 14 qualitative studies. We found three meta-themes that highlight how clinicians use the relationship to uncover and understand the needs behind self-harm but also struggle to carry and contain the distress associated with self-harm. In the following, we discuss the findings in relation to research on self-harm and developmental tasks in adolescence, and the concepts of containment and correctional emotional experiences, before we outline the clinical implications and limitations of the study.

In the first meta-theme, we describe the importance of the therapeutic relationship in the process of understanding and helping adolescents who self-harm. This finding is in line with previous research suggesting that the therapeutic relationship is related to reduced self-harm and suicidal risk (Dunster-Page et al., 2017; Schultz et al., 2021), as well as qualitative studies on the experiences of patients in treatment of self-harm (Haw et al., 2023; Sass et al., 2022). A trusting relationship might be particularly significant in adolescence, a period marked by the development of independence and autonomy while the relational need for care remains (Stänicke et al., 2018). More specifically, the therapeutic relationship may be of special importance in work with adolescents who use self-harm, because inflicting pain upon oneself may serve as a way to manage difficult negative emotions independently. Self-harm in adolescence has been associated with loneliness (Gillies et al., 2018) and insecure attachment (Woo et al., 2020). Young people who self-harm describe feeling alienated, lonely, and isolated, while also desiring to be loved, accepted, and listened to. Instead of support from peers and family, self-harm can work as "the only friend" (Lindgren et al., 2022, p. 159). By working to understand and share the pain together with the young person in the therapeutic relationship, as indicated in this study, clinicians may offer an alternative strategy to self-harm for managing difficult emotions in adolescence.

Clinician's feelings of frustration, helplessness, and doubt when working with adolescents who self-harm can be considered a natural response. Similar emotions have been reported in studies of healthcare professionals' attitudes towards young people who self-harm (Pintar Babič et al., 2020; Ribeiro Coimbra & Noakes, 2022). Nevertheless, the difficult emotions described in our study might also be an expression of countertransference (Heimann, 1950; Gabbard, 2020). Self-harm may serve as a means to express and communicate non-accepted emotions, share thoughts and feelings, or to connect with others (Stänicke et al., 2018). Furthermore, Bion's (1970) concept of containment

describes how the therapist can take in and process psychological material that is emotionally overwhelming for the patient. Findings of difficult emotions in the work can indicate that the clinicians in our study pick up and experience some of the pain that adolescents may communicate through their self-harm. Additionally, some clinicians in our study stress the importance of managing their own emotions in order to *contain* their patients' overwhelming experiences.

In the third meta-theme, we describe how clinicians work to manage their emotional reactions in their practice. This includes actively engaging with the boundaries in their relationship with their young patients. How clinicians manage their emotional reactions and possible countertransference reactions can affect therapeutic outcomes (Hayes et al., 2018) and is particularly important since young people describe that negative experiences with staff can deter future help-seeking (Cadorna et al., 2024). Qualitative studies have indicated that balancing professional boundaries can be of importance and lead to increased tolerance for risk among staff working with patients who self-harm (O'Connor & Glover, 2017; Wilstrand et al., 2007). Thus, clarifying boundaries and responsibilities may contribute to increased tolerance to fear and inadequacy in response to patients' self-harm.

The findings in our study indicate that clinicians are seeking to establish a therapeutic relationship that can support the exploration of self-harm and difficult emotions. This may offer their patients a different opportunity to process intolerable difficult affect while still keeping the relationship intact, thus serving as a correcting emotional experience (Alexander & French, 1946). The development of a strong bond also requires the exploration of negative feelings and the establishment of boundaries in the relationship. The attempts to understand and connect relationally with adolescents who self-harm, as described in the first meta-theme, together with the emphasis on establishing boundaries and exploring autonomy (theme 3.1), may indicate an implicit understanding of the developmental tasks that adolescents who self-harm is relating to. More precisely, perhaps the therapeutic strategies described in the present study represent a balance between strengthening the adolescents' ability to handle negative emotions as a means to becoming able to establish boundaries and explore autonomy.

In conclusion, working with self-harm can represent a challenging balance for clinicians between exploring the pain within the therapeutic relationship, while simultaneously maintaining their own ability to contain the difficult emotions that come up in this work.

Clinical Implications and Future Research

The findings from this meta-synthesis indicate that clinicians who work with adolescents who self-harm can experience their work as meaningful, despite also having complex reactions. Understanding the factors that contribute to clinicians' empathy and tolerance for negative affect is important, as young people report that lack of empathy and punishing behaviour from staff can create feelings of shame, increase self-harm, and deter future help-seeking (Cadorna et al., 2024; Owens et al., 2016). The results from the present study indicate that the development of a therapeutic relationship with young patients, despite the challenges, is a priority for clinicians. The relationship may also contribute to making the work with adolescents who self-harm meaningful. Previous studies have suggested that experience, knowledge, and familiarity with self-harm, as well as time available to spend with children and young people, are factors that promote positive attitudes and empathy (Cleaver, 2014; Ribeiro Coimbra & Noakes, 2022). However, a meaningful therapeutic relationship also requires exploring the pain together with the patient, which may involve managing difficult reactions and emotions. The present study indicates a lack of support and adequate training to deal with self-harm. The importance of discussing patient cases and emotional reactions with the supervisor or the team is emphasised in effective treatment models for self-harm (Kothgassner et al., 2020; Witt et al., 2021). Thus, education, training, and supervision in how to manage self-harm and the emotional reactions that emerge are important implications of our findings. Also, having the time and opportunity to develop trusting relationships with young patients and their families are crucial implications for clinical practice. Future research should investigate how the relational dynamics described in the present study can play out for both clinicians and patients, as well as how meaningful clinical encounters can be promoted.

Limitations

The included studies in this meta-synthesis display methodological differences (e.g., methods for data collection and analysis, concepts of self-harm) and demographic differences between the participants (e.g., context, work setting, country, education and position, age, and sex; see Supplementary online material, Appendix C for study characteristics). One of the included studies was a doctoral thesis. The heterogeneity of the studies may represent a methodological limitation. However, diversity in

context can also contribute to a more nuanced understanding of the phenomenon under study. Furthermore, the aim of this study was analytic generalisation, to develop concepts that can be discussed according to findings in other studies, with different samples (Levitt, 2021). The quality of the included studies may represent a methodological limitation, as these constitute the data for the meta-synthesis. We assessed the quality of the included studies with CASP (2018), but did not exclude any studies on this basis (see Supplementary online material, Appendix D for CASP). Distance to the participants in the included studies may also represent a methodological limitation, as context and nuance can be lost in the new translations (Malterud, 2017). However, we aimed to ground our findings in the data from the original studies, by including quotations and the primary authors' interpretations in the meaning units.

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