THE UNIVERSITY OF HULL

The Experiences of Stopping Self-Harm in Adults.

being a Thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology

by Chloe Margaret Rowland, BSc (Hons.)

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Some of us fall by the wayside,
And some of us soar up to the stars,
And some of us sail through our troubles,
And some have to live with the scars.
Circle of Life by Elton John.

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Overview

The portfolio has three parts. Parts one and two are conceptually linked by their focus on self-harm and the cessation of the practice.

Part one is a systematic literature review. Each individual's self-harm experience is unique to them but there has been research that has shown that there are similarities between each experience. The systematic literature review examines the views and experiences of those who practice the behaviour with a view to identifying any similarities and discrepancies.

Part two is an empirical paper. The therapies that have been studied for their effect on self-harm behaviours have failed to yield results that show that any one approach is consistent in decreasing the frequency and/or intensity of the behaviour. The empirical paper reports a study that explored the experiences of 8 adults who had previously self-harmed but no longer did so. It was hoped that the themes and any commonalities between the experiences would provide insight into what is poignant for the individuals when stopping the behaviour and that this would contribute to the on-going work helping people to no longer use the behaviour.

Part three comprises the appendices.

PART ONE

Self-harm: an understanding of the behaviour from the individuals - A systematic literature review

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Abstract

The experiences of those who have self-harmed have been studied in varying ways however the results of these have not yet been compiled to identify similarities between them. A search was carried out to find appropriate papers using synonyms for "self-harm" and "understanding". 24 papers were identified as appropriate for the review; 7 were quantitative, 3 had a mixed methodology and 14 were qualitative. A narrative analysis was carried out and the following themes were identified: role of professionals, function of behaviour, lived experience and recovery. The literature is limited in its methodological quality at times due to the nature of the topic being studied; self-harm is a secretive behaviour and individuals often report high levels of stigma so may be reluctant to come forward and talk about their experiences.

Keywords: *understanding, self-harm, adults*

Introduction

The literature has many definitions of self-harm; however, all of them are agreed that it is the act of deliberately harming one's self and the definition most often referred to in the literature is deliberate harm to one's self without conscious suicidal intent (Favazza, 1996). It can take many different forms (for example, cutting, burning, hair pulling or overdosing) but the aim is not death although in some cases death is an unfortunate and unforeseen consequence. The rates of self-harm in the general population are thought to be between 4-5% and this figure rises to 13-65% in a psychiatric population (Adshead, 2010). Rates of self-harm appear to differ between gender and age bracket also; Hawton and Harris (2008) found that 1.5 females self-harmed for every one male that self-harmed and 10-14 year olds self-harmed more than other age groups. However in adult age groups, there are still considerable rates of self-harm (for 20-24-year-olds the ratio was 1.6:1 and for 25-49-year-olds it was 1.3:1). Although the statistics for adult groups are not the highest, the group presents its own challenges. Despite there being no research evidence, using one's judgement one could assume that the opportunity adults have to find methods to self-harm and disguise it may present difficulties; young people can sometimes have less freedom and their self-harm may be more easily noticed. Additionally an adult that self-harms may have mixed feelings about their own self-harm knowing that it is thought to be an issue that mainly affects adolescents; this may be a further source of shame and embarrassment.

The individual's understanding of their self-harm can alter how they view their act. History has accounts of harm towards the self in various forms that were not considered self-harm in the modern sense. For example there are some accounts in

the bible of people trying to rid themselves of “demons” by inflicting injuries on themselves (Nock, 2010). More recently it has become more closely associated with mental health difficulties and seen as a psychiatric issue. Although the behaviours may appear to have outward similarities, it could be that there is a difference between the function of the behaviour and the individuals understanding of their act. There is evidence to suggest that self-harm is used in order to express emotions when unable to use language (Adshead, 2010). This has been reflected other studies which suggest that this is accurate (Russell, Moss and Miller, 2010; Polk and Liss, 2009; Straiton, Roen, Dieserud and Hjelmeland, 2013).

There have also been attempts from professionals to understand self-harm. There is an abundance of literature that primarily appears to focus on adolescents, although this is reflective of the largest age bracket which engages in the behaviour (Hawton & Harris, 2008). However, adult self-harm needs an equal amount of attention. Adults that self-harm can be challenging to professionals and are frequently seen in mental health services (Gratz, 2003). This can be due to the risk it presents – risk that requires action from the professionals to ensure safety whilst respecting the individual and their autonomy (White, McCormick & Kelly, 2003). Whilst the behaviour itself carries risk, there may be usefulness in a deeper understanding of adult self-harm in order to be better able to relate to the individual and collaboratively find alternative coping mechanisms. Whilst a full understanding of each individual’s self-harm cannot be reached, a general understanding may provide a helpful framework for professionals to begin with.

Research and literature reviews have been carried out to identify any therapeutic approach or treatment that has yielded results in decreasing self-harm behaviour

however no consistent results have been reported. A range of approaches, including psychosocial and pharmacological, have been studied, measuring the effectiveness of each approach on decreasing self-harm. A review (of 20 studies which used self-harm as an outcome measure) carried out in this area found anti-depressant medication and dialectical behaviour therapy to be two of the most effective methods of reducing self-harm (Hawton, Arensman, Townsend, Bremner, Feldman, Goldney, Gunnell, Hazell, van Heeringen, House, Owens, Sakinofsky and Traskman-Bendz, 1998). However the authors concluded that there still remained substantial uncertainty about what interventions are effective and that further larger trials are required.

Rationale for question

A similar systematic review had been conducted with an adolescent population (Webb, 2002) however no review has been conducted with an adult population. The rationale for this literature review is to seek an understanding of the perspectives of adults who self-harm and the important aspects of their experience. An understanding of the individuals' self-harm experience may help build a relationship between the individual who has the experience of self-harm and individual wanting to discuss this experience. For this reason, the term "understanding" is a broad term and is used to identify the pertinent aspects of the individuals. It relates to how the individuals make sense of their experience and which parts are the most important to them. By understanding what the most pertinent parts of the individuals self-harm experience are, professionals may be better able to build a useful relationship. This relationship may then be used to facilitate work to help the individual to stop self-harming.

Method

Search Strategy

A computerised search was carried out on Self harm and understanding of the behaviours. This was on databases up to and including January 2014. Databases used were CINAHL, PsychInfo, PsychArticles, Medline and ERIC. The search terms used were:

(self harm* OR self-harm* OR self-poison* OR self poison* OR self-mutilat* OR self mutilat* OR parasuicid* OR self injur* OR self-injur* OR para-suicid* OR para suicid*)

AND

(caus* OR reason* OR motiv* OR expla* OR understand* OR perspecti*)

These terms were applied to the title and if this was not conclusive, the terms were then applied to the abstract.

Some of the terms used to describe self-harm in the subject area can sometimes be understood differently. For example parasuicide is used to describe self-harm without suicidal intent and can sometimes be used to describe a suicide attempt. Although neither results in death, the motivations behind either are different and could affect the literature. Care had to be taken to ensure the meaning of all terms used in the review.

Inclusion and exclusion criteria

No restrictions were placed on the mental health status of participants as this seemed to be a factor that could not be controlled for in any study. Therefore those studies that were explicit about the mental health status of their participants were included.

Studies that focussed on the understanding of professionals were also not included. This was because the focus was not on the individual who was self-harming which was the focus of the literature review. There were no date restrictions placed on the search.

The synthesis of the review was done using a narrative approach. This was done by repeated reading of the papers and noting of the overall themes in the data and conclusions drawn by the authors all of which were noted in the data extraction forms. The papers were then organised to reflect the major themes noted in each paper, although not all themes were found in all papers. A theme was apparent when the data extraction forms had common elements primarily in the results and then discussed further in the discussion and conclusion. This further discussion provided clarity on the results. The overall theme was then established for each group of papers.

Study Screening.

Inclusion Criteria.

- Any form of self-harm
- Any mental health condition – as no study can completely rule out the presence of a mental health condition, all studies were included regardless of whether they were explicit about a mental health issue or not.
- Studies using either a qualitative or quantitative methodology

Exclusion criteria.

- Literature reviews
- Studies which are not written in English

- Adolescents – studies which looked at participants up to and including 18 years of age as part of or their entire sample.
- Studies looking at over 65's – a cut of limit of 65 years was include to limit the possibility of age related conditions having an effect on the sample.
- Learning disabilities – studies that looked at individuals identified as having a developmental condition were excluded as the motivation behind the behaviour is likely to be different.
- Any studies looking at suicide or suicidal intent – individuals who wish to die as a result of their behaviour have a different motivation for harming themselves.
- Forensic settings – those in forensic settings may have limited ways of expressing emotions and therefore their self-harming behaviour may be differently motivated.

Quality assessment

A quality assessment of the articles was completed to ascertain the quality of each article and therefore how reliable the articles were. For quality assessment of the articles, two dedicated checklists were used. Although each was dedicated to a particular type of methodology used in the study, they were both developed by the same body. The Methodology Checklist: Quantitative studies (NICE, 2006) (Appendix 10) was used for quantitative studies and The Methodology Checklist: Qualitative studies (NICE, 2006b) (Appendix 11) was used for qualitative studies. These were used due to the inclusions of qualitative and quantitative research in the review.

The Methodology Checklist: Quantitative studies (NICE, 2006) enables the rater to rate aspects of the papers using ++, +, - or Not reported or Not appropriate. The Methodology Checklist: Qualitative studies (NICE, 2006b) used descriptive categories of which reflected the strength and positivity of the particular aspect of the study (e.g. “reliable” or “ appropriate”) or the weakness and negative aspects of the study (e.g. “unreliable” or “inappropriate”). It also provided headings if the aspect of the study was not included or was not applicable to that study. All papers are given an overall score of ++, + or -. The results of the quality assessment are shown in Table 2.

Any studies which had a mixed methodology were looked at to identify the predominant methodology. These studies are indicated where necessary.

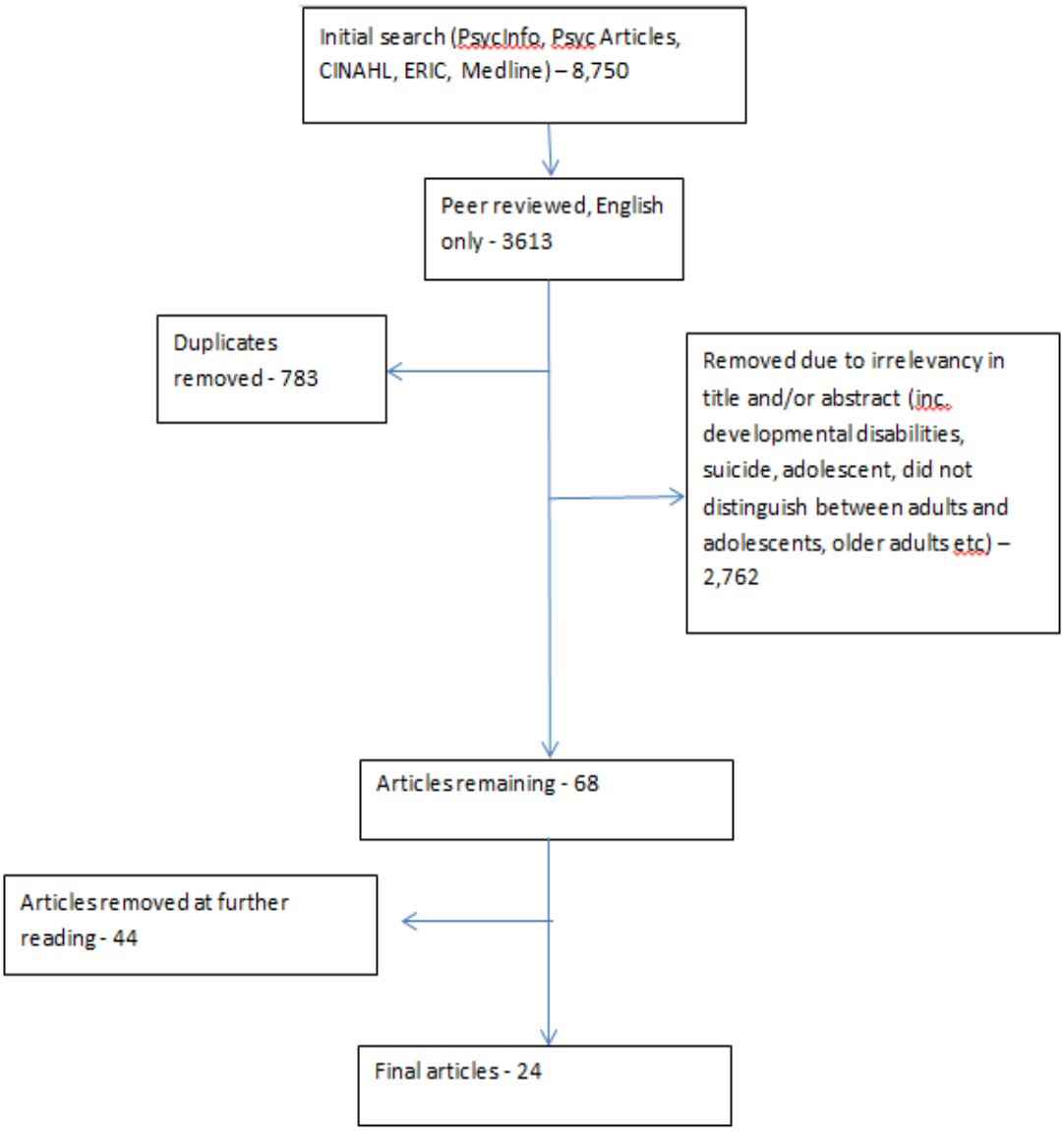
To reduce bias in quality assessment, 20% of the papers included were rated by a second marker. This equated to 5 papers, including quantitative and qualitative studies. For the results where there was disagreement, there was discussion of why this was. The majority of disagreement occurred when rating aspects which concerned

outcome measures and this was thought to be due to a difference of knowledge relating to the availability of other outcome measures. There was also some discussion about the applicability of studies from countries outside of the UK. It was agreed that this was not central to the review but should be considered and a consensus was reached about any other area of difference.

Results

Figure 1 below outlines the stages of the search strategies and the limitations that were used.

Figure 1. Results of search strategy.



Of the articles remaining, 14 were qualitative, 7 were quantitative and 3 had mixed methodologies

The Table below outlines the most important details of the studies included for the review.

Table 1. Details of studies included in the review.

Authors and date.	Study population (age, gender and setting)	Study Objective	Study design	Measures/ analysis used	Outcome/themes reported
Craigen & Milliken, 2010	18-23 years old, all female, 10 participants.	Not clear – to address the lack of understanding that counsellors may have about self-harm.	Qualitative – two interviews performed per person.	Categorical analysis, across-case analysis was interpretive, themes identified.	Emphasis on important relationships. Things interwoven with self-harm: description of cutting, a learned behaviour, privacy and eating disorders.
Gelinas & Wright, 2013	18-35 years old, 8 male, 46 female, University psychology students.	Examine reasons to engage in and stop self-harm.	Quantitative - Field.	Online survey.	61% report contact with mental health professionals and ¼ reported mental health diagnosis. Frequency and range of motivations reported. Reasons for stopping reported: behaviour not working, scarring, personal changes and coping strategies found.
Hamaz & Willougby,	Canadian College students, 88%	-Examine engagement in self-	Quantitative – within and between subjects.	ANOVA and Bonferroni correction	Majority of people who start in 1st year stop one year

2014	Canadian, mean age – 19.11 years old, 666 participants.	harm behaviour over time. -Does pattern affect risk. -Motivation to stop related to stopping of self-harm.		completed.	later. Those who continue have high psycho-social risk. Self-harm coincide with issues with parents, internalising problems and suicidal ideation. Those who stop report higher motivation to stop.
Harris, 2000	20-45 years old, all female, contacted through women's network.	Understanding why women self-harm.	Qualitative – women were asked to write letters about their experiences.	Analysis of the letters.	Links to religion and "soul in purgatory" (p.172). Emphasis on the social context of the women's lives. Discussion of the logic of self-harm, care received in emergency departments and significant life events.
Hunter, Chantler, Kapur & Cooper, 2012	Early 20's to early 60's, 6 female, 7 male, attended hospital for self-harming behaviour.	To see if hospital experiences affect future help seeking and interpretations of assessments.	Qualitative.	IPA analysis of interviews.	Themes identified: -Function of psychosocial assessment -Communication alleviates distress -Feeling ashamed/judged by staff -Need for contextualised and personalised follow-up care.

Kleindienst, Bohus, Ludascher, Limberger, Kuenkele, et al., 2008	18-51 years old (ave. 30.4 years), female, outpatients	To understand: 1.Function and motives 2.The different motives and if they are related to different groups 3.Emotional states before SH 4.Feelings whilst self-harming.	Quantitative - Field.	Descriptive statistics.	Majority of participants used more than one method of self-harm with cutting being most popular and primary method. Most reported reason was relief of tension. There was both positive and negative reinforcement of self-harm. Emotional states before and after self-harm similar to the motives reported for self-harm. Guilt only emotion that did not decrease after self-harm.
Kool, Meijel & Bosman, 2009	All female, 26-60 years old (mean age. 39 years), 12 participants, 5 no longer receiving treatment, 7 still receiving treatment.	How the process of stopping self-harm happens and what factors play a role.	Qualitative – interviews conducted.	Grounded theory analysis.	Identified the following 6 stages of recovery: 1. Connecting and setting limits. 2. Increased self-esteem. 3. Self-understanding. 4. Autonomy 5. Stopping self-harm. 6. Maintenance.

					(p.27)
Lindgren, OsterAstrom & Graneheim, 2011	All female, 21-37 years old (mean. 23.5 years old), 6 participants, on inpatient ward.	To understand the relationship between professionals and women who self-harm.	Qualitative - Ethnography – observations then informal interviews.	Interpretive repertoires.	Repertoires found: Caregivers -fostering -supportive Patients -victim -expert Nurses and patients communicating mean that they can take different roles when necessary but caregivers and patients prefer supportive and expert respectively.
Pierce, 1986	Female – 63, Male – 37, mean age – 34 years old, 100 participants, all admitted through accident and emergency.	1.To find out how people view their treatment in hospital. 2.Views related to the actual attitudes of doctors and nurses. 3.Compare views of patients, professionals and families. 4.Whether views of	Qualitative – interview with follow-up after one year.	Wilcoxon matched pairs, mann-whitney U.	Over half of the participants thought that doctors and nurses were sympathetic whilst 12-14% thought they were unsympathetic. Views of staff and patients different. 1/3 reported that their families were unsympathetic. No link between views of treatment and likelihood of

		treatment affect likelihood of future help seeking.			repetition of self-harm found.
Polk & Liss, 2009	Female – 139, Male – 16, 18-47 years old, 154 participants, 63% reported psychiatric diagnosis.	To understand the type of people who engage in self-harm behaviour and why they do it.	Qualitative – online survey with descriptive and open-ended questions.	Phenomenological analysis,	Engagement in self-harm to release emotion, to feel alive or decrease dissociation. Self-harm provides control and self-punishment. Engagement in self-harm to not commit suicide.
Rayner & Warner, 2003*	Not given, 5 participants (selected to representative of target population) interviewed, 40 completed Q sort.	To understand self-harm from a lay perception, to describe different accounts of self-harm and suggest further research.	Mixed - Q sort methodology – interviews conducted, Q sort cards created.	Factor analysis carried out on the results of the Q sort.	Themes of visual communication and survival, biological factors, interpersonal communication, and attention seeking.
Redley, 2003	24 female, 26 male, 50 participants, all resident in a social inclusion area.	To assess the effect of living on an estate on people's lives and how this influences self-harming behaviour.	Qualitative – interviews conducted.	Constructivist analysis used.	Participants did not lead life they wanted, social networks not helpful and when discussing why take overdoses, participants could not find a reason not to.
Russell, Moss	All male, 37-58	To engage as far as	Qualitative – two	Hermeneutic	Each man interviewed

& Miller, 2010	years old, 4 participants, in contact with mental health services.	possible with the experience and phenomena of men's self-harm.	interviews one week apart.	phenomenology.	presented separately. Overall discussion of self-harm as communication, mixed feelings about the behaviour, sense of being "public property" and the conflict of vulnerability and invulnerability.
Ryan, Heath, Fischer & Young, 2008	All female, 18-46 years old (mean. 21.8 years old), 96 participants, mainly UK participants.	Investigating the views of young women about support and how others can help.	Quantitative – Field (online survey).	Descriptive statistics.	Most frequently reported behaviour was cutting. Perceptions of how to help reduce the behaviour – Acknowledgement of distress Talking with friends helpful, but when talking about why self-harm this was better done with professionals.
Shaw, 2006	All female, US college students, 5 participants.	To understand how women stop self-harming and the role of professional help.	Qualitative – "open-ended format", interviewed 3 times each.	-Grounded theory -Voice-centred interpretive poetics analytic strategies. -Cross-case analysis -Visual displays	Descriptions of salient factors described, including: Deciding to stop. Relational ties and support. Professional treatment. Deterrents. Momentum.
Schoppmann,	All female, 18-35	To explore the 'lived'	Qualitative -	Hermeneutic	The following themes were

Schrock, Schnepp & Buscher, 2007*	years old, some inpatients.	experience of people who self-harm.	Observations and informal interviews conducted 8 years previously.	phenomenology	found: Triggers for the experience of, transition into, experience and ending of alienation. Helpful interventions delivered by nurses. Helpfulness of physical reassurance.
Straiton, Roen, Dieserud & Hjelmeland, 2013*	18-35 years old and "a few over 35 years old", 122 participants.	To understand how those who had self-harmed understood the experience.	Online questionnaire – quantitative and qualitative aspects.	Thematic analysis (inductive).	Participants discussed what constitutes as self-harm, what leads to self-harm and managing stigma.
Taylor, 2003	All male, 18-40 years old, 5 participants, accessing services for self-harm.	To identify the support and services available to men who self-harm.	Qualitative – semi-structured interviews carried out.	Not described.	Experiences of both specific and general services for self-harm described. Suggestions given as to how services and professionals can improve and specific ways to help men who self-harm.
Tyler, Melander & Almazan, 2010	19-26 years old (mean. 21.45 years old); Female – 69, Male – 103, 172 participants in total	To investigate whether gender and sexual orientation increase risk of self-harm beyond the	Quantitative – within subjects.	T tests performed after coding of gender and sexual orientation.	Gay, lesbian and bisexual individuals at higher risk of self-harm. Rates of self-harm in the general population similar to

	who were homeless or had a history of being homeless.	stress of being homeless.			those in homeless population – predictors involve sexual abuse and neglect. Stressors varied on location.
Walker, 2009	All female, 30 – 54 years old, all had a diagnosis and history of self-harm.	Examine and explore the subjective experiences of women who self-harm with a diagnosis of BPD.	Qualitative – face-to-face interview.	Narrative thematic approach, performance approach.	Insight into women's self-hood; Discussed the effects of scars and being known as a "self-harmer".
Weber, 2002	All female, 21 – 48 years old (mean. 32 years old), 9 participants, range of co-morbid diagnoses.	To understand the narratives of "self-abusive" women with a diagnosis of BPD.	Qualitative – interviews over a four month period for a total of 43 interviews.	Narrative analysis of interviews.	Description of why participants self-harm and what helps stop engagement in self-harm: Communication, distraction, comfort and hope.
West, Newton & Barton-Breck, 2013	Female – 17, Male – 8, 28 – 52 years old, 25 participants.	The role of time frames in the understanding of self-harming behaviours and how this contributes to their understanding of their risk.	Qualitative - interviews.	Timelines created during interviews and themes in timelines identified.	Following time frames identified: -In the moment -In everyday life -Moving on -When and if required -Imagined futures -Retrospective evaluation
Whipple &	133 female	Two hypotheses:	Quantitative –	Analysis of medical	Hypotheses 1: greater

Fowler, 2011	participants, all with a diagnosis of BPD. Control group – all female, no self-harm behaviour.	relating to social cognition and object relations and whether these relate to vulnerabilities in self-harming behaviour.	independent groups design.	records and administration of Thematic Apperception Test.	difficulties in relationships and expressing anger. Hypothesis 2: greater difficulty with relationship boundaries. Difference between the two groups.
Zanarini, Laudate, Frankenburg, Wedig & Fitzmaurice, 2013	18-35 years old, inpatients, 290 participants.	Building on previous research utilising a group of inpatients; a 16 year follow-up.	Quantitative – between subjects.	Long linear regression model using generalised estimated equations (GEE).	Three main findings: 1. Despite extensiveness of history, both groups had similar rates of decline. 2. Both report interpersonal issues. 3. The more extensive the history of self-harm, more likely to report internal motivators for the behaviour.

* A study with mixed methodology

Quality Assessment

The table below outlines the salient aspects of the quality assessment and the apparent strengths and weaknesses of each paper.

Table 2. Table of quality assessment

	Design	Overall quality score	Strengths	Weaknesses
Craigen & Milliken, 2010	Qualitative	-	Data collection and analysis rigorous.	Qualitative approach may not have been appropriate. Unclear of overall aim of the study.
Gelinas & Wright, 2013	Field	Not provided	Aim of the study clear and relatively unique.	Less than ideal control of extraneous variables and limited applicability to the UK.
Hamaz & Willougby, 2014	Quantitative	Not provided	Large sample and accurate longitudinal design.	Participants may not have been completely representative of population.
Harris, 2000	Qualitative	-	Aims of the study clearly outlined and the approach was appropriate.	The analysis and conclusions weak and unreliable; a number of important factors not reported.
Hunter, Chantler, Kapur & Cooper, 2012	Qualitative	+	Participants involved in analysis of data.	Unclear demographics and description of participants. Role of researcher not accurately described.
Kleindienst, Bohus, Ludascher, Limberger, Kuenkele, et al., 2008	Field	Not provided	Appropriate analysis looking at a range of aspects.	Retrospective and self-developed measures.
Kool, Meijel & Bosman, 2009	Qualitative	++	Well described	Role of researcher not clear.

			methodology and analysis. Conclusions appropriate and convincing.	
Lindgren, OsterAstrom & Graneheim, 2011	Qualitative	++	Data gathered over a long time period.	Analysis process unclear. Aims of the study not adequately described.
Pierce, 1986	Mixed	Not provided	Standardised measures and evaluation from a range of sources.	Ethical considerations around methodology.
Polk & Liss, 2009	Qualitative	+	Rigorous analysis and rich data. Findings convincing and accurate.	Inaccurate calculations of participants. Bias of participants possibly due to recruitment method.
Rayner & Warner, 2003*	Mixed	Not provided	The methodology was used rigorously and the findings appeared to be generalizable to the wider population.	The participant demographics were not described and there does not appear to be any criteria for who was included.
Redley, 2003	Qualitative	+	Good number of participants.	Analysis unreliable. Aim of the study unclear.
Russell, Moss & Miller, 2010	Qualitative	++	Good description of participants and applicable to UK mental health services.	Only one analyst used at analysis.
Ryan, Heath, Fischer & Young, 2008	Field	Not provided	Well-described participant demographics looking at a range of topics.	Outcome measures were self-developed and had not been validated.
Shaw, 2006	Qualitative	+	Findings convincing and	Rationale for research

			relevant to the research aims.	methodology not clear. Analysis not rigorous.
Schoppmann, Schrock, Schnepp & Buscher, 2007*	Qualitative	++	Clear aims and rationale for the study.	Participants' context and role of researcher not clearly described. Historical information used.
Straiton, Roen, Dieserud &Hjelmeland, 2013*	Mixed	+	Findings convincing and defensible in target population.	Not clear regarding applicability to UK. Cannot control for mental health issues in general population.
Taylor, 2003	Qualitative	-	Participants experienced a range of services.	Analytic approach not described and richness of data not outlined. Findings not clear.
Tyler, Melander & Almazan, 2010	Quantitative	Not provided	Sound theoretical basis and appropriate and comprehensive outcome measures.	Some issues with participants and method of recruitment.
Walker, 2009	Qualitative	++	Applicable to the UK. Method and context clearly described.	Limited sample size.
Weber, 2002	Qualitative	-	Participants from range of backgrounds.	No clear definition of aims of study. Analysis unreliable.
West, Newton & Barton-Breck, 2013	Qualitative	++	Range of participants and described with good detail.	Method of self-harm not described.
Whipple & Fowler, 2011	Quantitative	Not provided	Outcome measures, range of measures and follow-up times all appropriate.	Participants may not have been representative of wider population.
Zanarini, Laudate, Frankenburg, Wedig &	Quantitative	Not provided	Has a sound theoretical	More information could have

Fitzmaurice, 2013	background and used reliable measures.	been included regarding the participants.

Synthesis of findings

The following themes were found:

- Role of professionals.
- Gender
- Lived experience.
- Function and reasons for self-harm
- Recovery

These will be looked at in further detail below.

Role of Professionals

A number of studies found that participants discussed their experiences of professionals in relation to their self-harm. Pierce (1986) found that 12-14% of participants thought professionals delivering care in a hospital setting were unsympathetic. However this study did not adequately outline the type of self-harm included, the suicidal intent behind the behaviour or the working patterns of the staff (which may have a bearing on the availability of the staff to deliver appropriate care), and this is reflected in its quality assessment score. Harris (2000) also found that participants reported hostile attitudes when receiving emergency care in hospital but again, this study has a low quality rating. Schoppman, Schrock, Schnepp and Buscher (2007) found that participants were able to identify nursing interventions that they had received that had been helpful to them. These included looking after the emotional wellbeing of the individual having self-harm urges and physical interventions that provided comfort. Taylor (2003), using a sample of men, explored the experiences of services for self-harm (both specific and general). It was found that

more involvement from self-harm specialists to develop self-harm provision in medicine, nursing and social work would be useful. They also found that it would be helpful for professionals to understand the individual who is self-harming and not allow their own anxiety regarding issues of risk to hamper an effective and individualised intervention. Unfortunately this study had a number of limitations including ambiguity as to the method of analysis that was used. However, a strength of the study is that the participants had experienced a range of services. Lindgren, Oster, Astrom and Grandheim (2011) looked at the relationship and nature of the communication between women who self-harm and the professional caregivers they interact with. The study found that each party appeared to take a role in the relationship; caregivers operated in a more fostering and supportive manner whilst the women tended to fulfil more victim and expert roles. Of these the "supportive" and "expert" roles were preferable. However this study was carried out using ethnography where the researcher was required to be around the participants for some time. This may have had an effect on the behaviour of all parties, including altering the perceptions of the researcher.

Lived experience

A number of the behaviours focussed on the role of self-harm for individuals diagnosed with personality disorders, primarily Borderline personality disorder. Walker (2009) discussed the effects of self-harm on identity with women who also had a diagnosis of Borderline Personality disorder. Results found that participants were aware of being labelled as a "self-harmer" and the effect this had on them. A theme of the effect of scars was also present; participants reported that the physical effect of their self-harm had taken over their identities. Stigma was found to be an issue whilst

self-harming in a non-clinical population (Straiton, Roen, Diesenid and Hjelmeland, 2013) and participants appeared to have found ways of managing this stigma. This included distancing themselves from the experience possibly in an attempt to minimise shame. The study highlighted a bigger issue as to the way self-harm is conceptualised and the views of wider society of self-harm behaviours. West, Newton and Barton-Beck (2013) looked at the time frames involved with people's experiences of self-harm. They identified that the act of self-harm was a small part of their experience and that participants spoke about the role of self-harm in everyday life and their understanding of their self-harm acts in the past. The authors discussed how self-harm seemed to take on different roles during different times of the participants' lives. This appears to show that self-harm cannot be thought of as one static act but open to change. In a study of why young women harm themselves superficially, participants reported that talking about their self-harm was helpful, particularly with friends (Ryan, Heath, Fischer and Young, 2008). However, they reported that when discussing the reasons why they self-harm they preferred to do this with a professional. However this study utilised a questionnaire that was put together by the authors and therefore had not been normed before being used in this research.

Function and reasons for self-harm

Russell, Moss and Miller (2010) found that men reported their self-harm as a form of communication. Polk and Liss (2009) explored the motivations behind self-injury for a relatively large sample of men and women. A range of motivations were reported, the most prominent of which appeared to be around the use of self-harm to release emotion. This was found to be related to alleviating the self of a negative emotion through a physical act of harm. This was reported as the sole reason for self-harm for

68% of respondents. The second most salient theme found was “to feel alive and real” (p.236) which in turn reduced feelings of dissociation and numbness. The authors noted that this is different to the previous theme as it is concerned with the creation of a feeling as opposed to an attempt to relieve the self of an emotion. Hamza and Willoughby (2014) found from their longitudinal study that those who self-harmed reported more difficulties at home, particularly issues with parents and internalising of emotions. Unfortunately this study was conducted on a university population with participants with an average age of 19.11 years old; therefore the results of this study may not be readily applicable to all adults that self-harm. Despite the limitations of this study, the authors outline the need for consideration of social risk when working with self-harm. Tyler, Melander and Almazan (2010) looked in particular at whether sexuality and gender increased risk of self-harm in a population of homeless people. Their study found that rates of self-harm, although higher in the gay, lesbian and bisexual population, were not further exacerbated by being homeless. The issues identified here were concerning factors which could lead to self-harm (e.g. “sexual victimisation” and drug use) and the authors suggest that efforts should be made in these areas in order to decrease incidence of self-harming behaviours. In a longitudinal study of individuals with a diagnosis of Borderline personality disorder, it was found that participants who regularly self-harmed and those who only did so occasionally both reported interpersonal reasons for self-harm (Zanarini, Laudate, Frankenburg, Wedig and Fitzmaurice, 2013). They reported anger/frustration with other people and trying to get attention from others as reasons for self-harming. In addition the study found that those who more regularly self-harmed also reported more internal reasons for their self-harm and this was mainly concerned with self-soothing. In a further study looking at the motives of individuals with Borderline personality disorder, Kleindienst,

Bohus, Ludascher, Limberger, Kuenkele, Ebner-Priemer, Chapman, Reicherzer, Stieglitz and Schmal (2008) found that the motives that have been reported for self-harm reflected the emotion states experienced by participants before and after self-harming. Participants also reported that they used self-harm in order to relieve tension. Whipple and Fowler (2011) also looked at borderline personality disorder and the motives for self-harm and found that participants also talked about difficulty expressing anger in a relationship and with relationship difficulties in terms of the boundaries.

Gender

The papers included in the review often looked at the role of gender in the behaviour or looked at the behaviour in the context of either men or women. Russell, Moss and Miller (2010) conducted a study that looked at the experience of men who had self-harmed. The results did not mention gender specific factors but discussed more issues of vulnerability. Despite not finding themes that were directly related to gender, the authors identified the need to look at this area as there is a gap in the literature. Taylor (2003) also interviewed a sample of men in his study seeking to understand the perspectives of men who self-harm. The results of this study looked at the improvements that could be made to services. Although this is not gender specific, it was also identified that men may benefit from a greater understanding of self-harm in an effort to reduce feelings of unacceptability relating to their gender and the fact that they self-harm. Unfortunately the majority of findings in this study were not clear which is reflected in the quality assessment score.

Recovery

Kool, van Meijel and Bosman (2009) were able to identify 6 stages to the recovery process as a result of the study. The fifth step was found to be stopping self-harm which signifies that a number of changes must take place before stopping self-harm can take place. According to Kool *et al.* (2009) exploration of feelings, increasing self-esteem, an understanding of self and increase of autonomy were all found to precede the cessation of self-harm. The results of Kool *et al.*'s work can be thought to be reliable as their methodology was rigorous which was reflected in their quality assessment score. Shaw (2006) found that again there was a clear difference between the emotional elements of stopping self-harm and the physical stopping of self-harm. Shaw discussed in her conclusion that cessation of self-harm should not be considered a direct reflection of mental health or "robustness" and it should be recognised that further help may be required. It was also suggested that the degree of motivation to stop may help decide which therapeutic approach is appropriate. Weber (2002) found that participants reported that communication and distraction were helpful when trying not to self-harm. Participants also reported that feelings of comfort and hope were helpful. Weber (2002) also suggested that hope could be used as an intervention by nurses. Hamza and Willoughby (2014) found in their longitudinal study that those who had the highest level of motivation to stop at the first point of assessment were those who had stopped at the second suggesting that motivation is important for recovery. Kleindienst, Bohus, Ludascher and Kuenkele et al. (2008) found that guilt was not helpful when trying to decrease urges to self-harm. Gelinas and Wright (2013) found that a sample of university students reported a variety of reasons for stopping self-harm including the behaviour not fulfilling the purpose they intended it to, scarring and finding new coping strategies. Whilst one strength of this study is its

relative uniqueness in looking at the reasons to stop self-harming behaviour the generalizability of the study is limited as it was carried out with a university population.

Additional findings relating to methodological quality

The majority of participants were recruited from higher education establishments or via mental health services. This is likely to bias the individuals who take part. Individuals from these backgrounds may be more able to articulate their feelings as they are likely to have been exposed to more opportunities to express themselves. As self-harm is a behaviour sometimes used to communicate feelings of distress (Adshead, 2010) this may not be representative of the wider population that self-harms. There were also a number of studies that were carried out online. Although it is appreciated that this is carried out to find participants despite the secretive nature, unfortunately this opens up the research to participants that are not truthful or alter their results.

Discussion

The aim of this study was to understand the experiences of individuals who self-harmed. The results that were yielded by the study found that participants spoke about the role of professionals, lived experience, functions and reasons for self-harm, gender and recovery. Overall the research suggests that the actual act of self-harm is a relatively small part of their experience. In general, emotions surrounding the experience appeared to be more significant to the individual. The research also identifies a split between the individual who self-harms and the people around them, particularly with any professionals involved in their care. Mackay and Barrowclough (2005) found that accident and emergency staff, particularly medical staff and men, had negative views of patients who had self-harmed, and suggested further training may be useful. Hopkins (2002) found that nurses struggled to understand the reasons for people self-harming. The reason for difficulties is not yet known, however the issues mentioned (e.g. not understanding) and reference in the review to stigma and judgements from others may be a part of this.

A considerable number of studies looking at self-harm did so in context of women with Borderline Personality disorder. This is reflective of the importance of self-harm in borderline personality disorder as both a diagnostic criteria and in the management of on-going difficulties. It is important to understand the experience of individuals' with the diagnosis who self-harm in order to inform professionals and improve treatment options and quality. However the literature did not pay the same amount of attention to other mental health difficulties and diagnoses. To increase understanding of the role of self-harm in the context of other difficulties may also inform professionals and improve treatment options and quality.

The emphasis on gender in the studies is also reflective of the statistics in the area. Many of the studies focussed on either men or women and the unique experiences of either gender, with studies focussing on women outnumbering those focussing on men. Again, whilst this is reflective of the demographics of those who self-harm, more research needs to be carried out to look at the experiences of men.

Overall the results of the literature review seemed to reflect the finding that participants wanted other significant factors in their lives to be considered and responded to as seriously as their self-harming behaviour. Sinclair and Green (2005) found that individuals spoke about self-harm being a "symptom" of other issues which need to be addressed. This was supported by a report published by the Mental Health Foundation (2006). Chapman, Gratz and Brown (2006) found that self-harm could be a response to negative emotions being experienced. They found that these negative emotions occurred before any self-harm had taken place and that self-harm was used to distract from these feelings. When the cause of the negative emotions is established and addressed it may be that incidents of self-harm lessen, which may not have happened if self-harm had been looked at in isolation without context.

Overview of methodological quality in the area

Whilst the overall quality of research in this area is good, there are some areas that could be improved upon across most of the literature included in this review. Ascertaining the suicidal intent the individual felt and the type of self-harm behaviours employed was information that was not consistently reported. This information may be useful when trying to put the information into context.

There is also an acknowledgement that this is a difficult area to research due to secrecy of the behaviour and the benefits participants may experience from the anonymity that is given by methods such as online surveys. However, with methods where there is anonymity there is the potential that participants might not be truthful when answering the questions or they might over-exaggerate their answers. This should be considered when looking at studies that have utilised these online methods of data collection.

A limitation of a number of studies in the area is their reliance on self-report and the circumstances of the participants. A number of studies required participants to talk about experiences retrospectively (Tyler, Melander & Almazan, 2010; Ryan, Heath, Fischer & Young, 2008; Gelinas & Wright, 2013); because of this participants may have found it difficult to accurately remember aspects of their experiences. There were also studies which used samples of participants who were currently self-harming, sometimes being conducted in inpatient units (Whipple & Fowler, 2011; Schoppman, Buscher, Schrock & Schnapp, 2007; Kool, Meijel & Bosman, 2009; Lindgren, Oster, Astrom & Graneheim, 2011).

Weaknesses of the review

A weakness of this review is the considerable amount of studies that focus on Borderline Personality disorder when discussing self-harm. As self-harm is a listed symptom of the disorder, this focus is understandable however this means that this review is not as readily generalizable to the general population of individuals who self-harm as would be ideal.

A further weakness of the review is the quality assessments which were used. They were suitable for use as they were shown to have construct validity despite looking at two different methodologies (qualitative and quantitative studies). However the quantitative assessment did not provide an overall score which the qualitative assessment did. This meant that the two types of studies were not readily comparable.

Conclusions

Whilst there are some methodological limitations of the studies involved in this literature review, some clear themes have emerged. The role of professionals and the importance of their role for individuals who self-harm emerged. It was evident in the literature that participants felt that professionals were lacking adequate empathy. The importance of empathy is regardless of therapeutic or treatment approach so should be considered by all professionals who come into contact with individuals who are currently self-harming or have done so in the past. Empathy can be considered as important as any other intervention for self-harm and could be employed by any professional in a range of settings. This relates back to the core conditions for effective therapy as outlined by Rogers (1957), of which empathy is one.

The literature also provided information as to the reasons and functions for participants' self-harm. Whilst there were many reasons reported, it appeared that negative emotions that were difficult to express were often described as a motivation for self-harm; whether this was anger or difficulties in relationships, participants felt they were not able to express this in any other way.

Recommendations regarding future intervention studies

This review highlighted the need for studies to find consensus using one particular method of investigation. During the course of the review studies appeared to use many different types of approaches, some of which are not common (for example, Q-sort or ethnography). By using one approach across a range of settings, a better understanding can be gained.

Further research looking at the experiences of adults with no mental health diagnosis or other diagnoses other than Borderline Personality disorder would be helpful. A deeper understanding of self-harm in other contexts may provide alternative views of self-harm or yield similar results to those already existing. If the latter occurs, this may indicate that self-harm is an experience that transcends many diagnoses and situations.

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PART TWO

The Final Cut: Experiences of stopping self-harming behaviour in adults.

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Abstract

Self-harm is an activity that can become an important aspect of a person's life. When a person moves to no longer engage in the behaviour, this can bring about a number of differing emotions and a range of experiences. This study looked at the experiences of 8 participants who had previously self-harmed but had not self-harmed for at least 12 months at the time of the study. Participants' interviews were carried out and analysed in line with Interpretive Phenomenological Analysis (IPA). The themes found were: self, change, understanding, judgements and other people. Of all themes participants most often discussed the role of stigma and stereotypes at the time of their self-harm, when attempting to find help to stop self-harming and in the times afterwards. To be better able to help individuals to stop self-harm, a reduction in stigma and an increase in understanding and acceptability may transcend any therapeutic modalities available.

Keywords: *self-harm, stop, experiences*

Introduction

Self-harming behaviour (often referred to as self-injurious behaviour) can take many different forms. It can be defined as deliberate harm to one's self without conscious suicidal intent (Favazza, 1996). The following behaviours fall into the above remit: Cutting, burning and branding, scratching, self-inflicted dermatitis, reopening wounds, biting, head banging, hitting (with an object), swallowing or embedding objects, breaking bones or teeth, tearing or severely biting cuticles and chewing inside of mouth (Taken from Adler & Adler, 2011). A distinction is made between those who wish to die as a consequence of their behaviours and those who do not. It is appreciated that although the purpose of self-harm behaviours is not death, it can sometimes be an unforeseen accidental consequence. A study found that attendance at Accident and Emergency following self-harm was a strong predictor for completed suicide in the following years (Hawton, Zahl and Weatherall, 2003).

Although self-harming behaviours have been in existence for many years in terms of various religious practices (e.g. self-flagellation predominantly in Christian practices) (Johnstone, 1997), the term "self-mutilation" (another variant on self-harm) was coined in 1913 by L. E. Emerson. Self-harm in the form that it is widely understood and recognised in the present day appears to have been defined by Pattinson and Kahan (1983) when they categorised and defined different types of self-harming behaviours. In retrospect there appears to have been various other famous instances of self-harming behaviours in history which have been labelled "madness" or received similar titles e.g. van Gogh cutting off his ear.

Self-harming behaviours occur in clinical and non-clinical populations although rates between the two groups differ. Self-harming behaviours often occur in the presence of a mental health issue but they do not require one to be present; it is

thought that 4-5% of people in the community engage in some form of self-harm but in a psychiatric sample this figure rises to between 13-65% (Adshead, 2010). Self-harm that occurs in non-clinical populations is understood in a social context by those who engage in the behaviour (Straiton, Roen, Dieserud and Hjelmeland, 2013); their social circumstances and experiences were reported to lead to self-harm.

Onset of the behaviour is commonly in the teens with the average age of onset being between 15 and 16 years of age (Favazza, 2007). Self-harm behaviours are also prevalent in the older adult population; it is thought that the rate of self-harm resembles the rate of suicide, and the methods of self-harm used involve greater levels of lethality compared to other age groups who self-harm (Hawton and Harriss, 2008a; Murphy, Kapur, Webb, Purandare, Hawton, Bergen, Waters and Cooper, 2011).

Models

Reliable models that can be used to fully understand why an individual may self-harm appear to be somewhat rare in the literature. One model used to understand self-harm is the experiential avoidance model (Chapman, Gratz and Brown, 2006). The model postulates that self-harm is used to avoid a difficult internal emotion state; self-harm provides a way of not experiencing the unwanted emotions or thoughts by distraction. However, this avoidance negatively reinforces the self-harm and perpetuates the difficulty. This model is supported by the behavioural theory of negative reinforcement in which the aversive action is strengthened by avoiding the negative feelings (Skinner, 1953). Support for this model comes from Anderson and Crowther (2012) who found that those who were more accepting of their emotional

states were less likely to have engaged in self-harming behaviours in contrast to those who were found to be more avoidant of their emotions.

Self-harm could also be considered in terms of self-defeating behaviour patterns. Baumeister and Scher (1988) looked at self-defeating behaviours and found that there were three distinct types of behaviours; primary self-destruction (foreseen and desired harm to self), "tradeoffs" (foreseen harm to self but not desired) and counterproductive (neither foreseen nor desired). The authors discuss the reasons why an individual may not foresee harm to the self (e.g. understanding of consequences or possible gains) or why it may be desired for a range of reasons, linking it to thinking patterns, and how these impact on choice of behaviour. It is concluded that self-defeating behaviours occur frequently in a "normal" population.

Nock (2009) considered explanations in line with different therapies for self-harm, including psychoanalytic and empirical work. In his own work he proposed a model, one part of which views self-harm as a method of regulating one's own emotions using a maladaptive coping method. This model appears to have some overlap with that proposed by the experiential avoidance model (Chapman, Gratz and Brown, 2006). The psychoanalytic view of self-harm conceptualises the behaviour as having different motives, namely a compromise between life and death drives; the individual who self-harms both wants to die but also to live and as a compromise mutilates their own body (Firestone and Seiden, 1990). An environmental model, such as that described by Suyemoto (1998), considers self-harming behaviour to be the result of early social learning affecting the individual's concept of self-care, together with vicarious reinforcement as a result of observing those in their immediate environment. All of these models appear to share a commonality; a desire to resolve a negative emotion state and the attempts to remedy that, which include harm to the

self. However the models show that there are complex interactions between intra- and inter- psychic difficulties.

Treatments

Treatments are discussed in line with the therapy used to understand the behaviour, however not all therapeutic understandings lend themselves to a clear treatment (for example, a psychoanalytic approach). van Vliet & Kalnins (2011) looked at a compassion focused approach to non-suicidal self-injury, outlining how it may be used and what aspects of the therapy may be helpful, however they did not conduct empirical research. James, Taylor, Winmill & Alfoadari (2007) looked at the effectiveness of dialectical behaviour therapy on reduction of self-harm with follow-up assessment in which they found reductions in self-harming behaviours and an increase in functioning. Although they found that it was somewhat effective, they acknowledged the need for further research in this area and for research into a broader population (it was conducted solely with adolescent females in the community). A behavioural approach to self-harm has also been utilised to decrease self-harming behaviours however this has been found to disempower people and ultimately to be unhelpful in psychiatric care (Rayner and Warner, 2003).

Treatments in terms of medications have also been investigated. Pharmacological treatments are usually anti-depressants. A review of studies looking at the effect of anti-depressants compared to placebos found there was no difference but found that there was a difference between the effectiveness of antidepressants and antipsychotics with antipsychotics being the more effective of the two (Hawton,

Arensman, Townsend, Bremner, Feldman, Goldney, Gunnell, Hazell, van Heeringen, House, Owens, Sakinofsky and Traskman-Bendz, 1998).

Despite the type of therapy (talking or pharmacological) undertaken with respect to self-harm it may be useful to bear in mind Prochaska and DiClemete's (1992) "stages of change" model. The model stipulates that an individual will go through a range of emotions, behaviours and attitudes with regard to changing their behaviour to benefit their physical and/or mental health.

Rationale

The literature describes the act of self-harm as being a small part of the overall experience and that there is more to consider than the act itself. As the literature has been unable to discern any therapy or treatment that is consistent helpful in the reduction of self-harming behaviour, the answer as to a helpful and possibly effective intervention may lie in the understanding of self-harm itself and the experiences of individuals who have stopped self-harming. This approach is in keeping with the core conditions for therapy set out by Roger (1957) of which "empathetic understanding" is one and without this any type of therapy will not be effective. Any common themes and notable aspects of the experience that are shared amongst individuals may be of use to professionals looking to work in a therapeutic way with individuals who self-harm. The question this study aimed to address was what are the common elements of individuals' experiences of stopping self-harm?

Method

Design

The study used a qualitative approach to explore the experiences of individuals. This approach was taken as it lends itself to understanding the thoughts, emotions and prominent features of the experience better than quantitative approaches. Interpretive Phenomenological Analysis (IPA) was chosen as the qualitative approach as it places importance on understanding an individual's experience. In order to use this approach, a semi-structured interview was developed; this allowed relevant data to be gathered but allowed further conversation to take place (Smith, Flowers and Larkin, 2009). The semi-structured interview questions were developed with service users who were contacted through the university's service user panel. A number of questions were proposed and service users gave advice as to changes that could be made to the questions to facilitate a meaningful conversation. The final questions were approved by the service users.

Participants

This study interviewed individuals who had self-harmed in the past but had not engaged in the behaviour for at least 12 months.

Eight participants took part in the study. This was a community sample; although advertising was done through the university using emails and posters, a number of participants heard about the research and asked to take part. A table of participants and essential information is presented below.

Participant Pseudonym	Age	Gender	Duration since last self-harm act	Frequency when did self-harm	Contact with services
Megan	22	Female	2-5 years	More than once per week	Yes
Claudia	24	Female	5-10 years	Once a week	No
Bob	26	Male	5-10 years	Less than once per month	Yes
Elizabeth	25	Female	5-10 years	Once daily	No
Beth	23	Female	2-5 years	More than once per week	No
Marcus	45	Male	12-24 months	More than once per week	Yes
Allison	39	Female	12-24 months	Less than once per month	Yes
Lily	26	Female	5-10 years	More than once per week	Yes

Table 1. Characteristics of participants.

Two participants came forward stating that they would like to take part but did not complete interview. One of these participants felt that the study may reactivate self-harming behaviours whilst another did not respond to the offer of an appointment.

One participant's contribution was not included as it did not fit the parameters set out; their behaviours appeared to be more in line with suicide attempts which they now viewed as self-harm however the behaviour's motivation is very different to that which is the focus of this study.

Procedure

Following ethical approval from the University of Hull, Faculty of Health and Social Care Ethics Committee, posters with information about the study and further details of how to contact the researcher for further information were placed around the university. An email advertisement was emailed to departments in the university to be forwarded on to staff and students associated with that department. Although there was opportunity and the availability for participants to discuss participation via telephone call, all participants communicated solely via email. Before commencing the interview, any questions or concerns that participants had were addressed as far as possible by way of information sheet and the opportunity to answer questions. Individuals who had come forward to take part but who had not replied when offered

a time or date were emailed once more to inquire as to whether they still wished to take part. If they did not reply, no further contact was made. An informed consent form was then signed (Appendix 3). Demographic information was then collected; this information looked at the interval since they last self-harmed, the frequency with which they self-harmed when they did, the method used, and any services they may have been or may still be in contact with (Appendix 4). This form was completed on the day of the interview prior to the interview taking place. Participants were given the form and asked to fill it in themselves but were able to ask for clarification if required. Their consent to proceed and be audio-taped was then sought. The interviews lasted between 30 – 60 minutes and were conducted on the university campus and only one interview was conducted at the participant's own home. The recordings were than transcribed. The transcription was done in the style recommended by Smith, Flowers and Larkin (2009) and included significant non-verbal features such as laughing and long pauses. They were then analysed using IPA (the rationale for using IPA is given in Appendix 14). An example of the analysis process is outlined in Appendix 15. Analysis was also carried out according to the guidance set out by Smith, Flowers and Larkin (2009); transcripts were read and re-read, in order to identify sub-themes (based on ideas, feelings and concepts etc.). Similar subthemes were then further organised into appropriate superordinate themes.

Data analysis

Approaches to validity

Results were analysed using IPA. Analysis of the transcripts was conducted by the Author but a sample was checked by the Supervisor.

In line with guidelines, a summary of the author's point of view has been provided. This is in order to provide the reader with an understanding of any possible biases.

Statement of Position

My interest in self-harm and suicide behaviours developed when I began to work clinically with these issues. I wanted to understand how people who were extremely strong and resolute could turn to harm themselves; I was interested as to whether they were aware of the consequences of their actions, both immediately and on their lives in the longer term. Working with these people taught me a great deal about the complexities of both the behaviours and of inter- and intra-personal processes, and the holistic approach that must be brought to the therapy. If self-harm can be better understood then I hope that individuals can be better served by services so as to avoid the continuation of the behaviour for any longer than is necessary.

Results

The total number of participants used was 8. This was in line with the work by Smith, Flowers and Larkin (2009) who suggest between 8 and 12 participants.

Themes

A number of emergent themes were found during analysis which could be grouped into 6 superordinate themes; self, personal change, change of behaviour, understanding lasting change, and other people.

Table 2. Table of themes found.

Superordinate theme	Subordinate theme
Self	
	Acceptance of self and circumstance
	Understanding self and own needs
Personal change	
	Motivations to commence change
	Function of the behaviour
	The possibility of change
	Responsibility
Change of behaviour	
	Facilitators
	Barriers
	Techniques to not self-harm
	Changing for life
Understanding	
	Understanding the self-harm
	Unique ability to help those in similar situation
Lasting changes	
	Reconciliation of consequences
	Lasting physical changes
Other people	

	Relationships & communication Understanding Stigma Stereotype

Self

From speaking to participants, there emerged a theme of the self. Participants spoke about a sense of self and discussed awareness of themselves which possessed a quality of being objective about their situation; they were able to discuss themselves honestly.

Acceptance of self and circumstances

A number of participants spoke about learning to accept their past self who self-harmed and being able to relate to this person in a caring and compassionate way as part of their experience of stopping self-harm.

> "I'm more accepting of my situation I was tremendously angry" – Marcus (P.8, Ln.11).
>
> "I've learned to accept myself and accept my faults and accept I can't get everything right" – Megan (P.15, Ln.16).
>
> "I don't know how I learned to accept it just its begun to spread out that I do accept who I am and that's the way I am and erms gotta still gotta lead my life with that" – Bob (P.10, Ln.11).

A number of participants spoke about self-acceptance and acceptance of circumstances as a key part of their experience. For some it was an obvious part of their journey however for some this was a less conscious change and was a concept that ran through the conversation.

Understanding self and own needs

Participants also discussed an understanding of themselves and the needs associated with that. They were able to identify what they require in their lives, which they may have been previously lacking, in order not to self-harm. This understanding of their

own needs appeared to have arisen from their experience of self-harming, as if without that experience they would not have been able to find what they need.

> "I think I understand why I did it and I don't feel like it was an unreasonable thing to do" – Claudia (P.5, Ln.6).
>
> "It [dealing with difficulties] can't just be more egocentric I've gotta be more sympathetic about how I approach things" – Bob (P.17, Ln.1).

Some participants appeared to have made changes in their life after gleaning an understanding of their needs from the experience; these included the need for friends whom they felt that they could talk to when previously friendships had been avoided and felt like something that was unhelpful. It could be extrapolated from this that the reason for the self-harm was a lack of understanding of themselves and needs. Some participants felt that their experience of self-harming had changed their views of self-harm and the uses of it. These changes were both personal and with regards to other people.

> "Feeling like I do deserve to be comforted instead of punished" – Claudia (P.8, Ln.6).
>
> "I always thought there was just certain people who didn't want help…but now I realise that it's a lot more complex than that". – Beth (P.8, Ln.4).

This is in keeping with the understanding that there is much judgement around the subject however this demonstrates that the judgement is also within this individual too.

Personal change

Participants all discussed changes that took place within themselves before the stopping self-harming took place. This was in varying degrees and for various reasons but all participants discussed deviations in their approach to their self-harm.

Motivations to commence change

The majority of participants reported some motivation for change, from things that may be considered small to those which are very important in life. One participant reported knowing she "wanted to wear that dress" (Megan) for an event and that this would not be possible if she continued to self-harm as she would not have felt comfortable exposing her arms. Here a specific focus was important and there was clear evidence of it being achieved (being able to wear the dress). For some there was an influence from others:

> "…having someone who will see you naked as well so erm someone is going to be a witness to scars to cuts even if you try to hide them" – Lily (P.2, Ln.15).

> "my concern is more for the people around me and because now I have this close knit family and my children are very very close to me erm I don't want to do that to them" – Allison (P.4, Ln.4).

Only one participant also reported an intrapersonal motivation to stop self-harming:

> "I don't want that to be how I cope" – Lily (P.4, Ln.4).

It appears that external and interpersonal motivations are the most salient for individuals when attempting to not rely on the behaviour any longer and that the self and wellbeing is not at the forefront of consideration.

Function of the behaviour

There was a theme about the functionality of the behaviour, in particular when the behaviour was no longer serving the function that it was when they began self-harming.

> "This isn't where it started this wasn't my secret that I cared for anymore where I looked after my injuries this was something that was being made to humiliate me" – Megan (P.4, Ln.8).

> "Kinda thought this isn't this isn't going to get me anywhere erm you know nothing is going to come of this" – Beth (P.5, Ln.1).

When the behaviour no longer fulfilled its purpose, the use was questioned. This would suggest that for some people, cessation of self-harm is not something that can be encouraged, but rather is brought about by unfolding events.

The possibility of change

For the participants there appears to have been a time when it was realised that there might be another possibility to self-harm or a life where it was not a main coping strategy even if what that was, was not yet clear.

> "I think at times it doesn't feel like it is possible erm that the urges do just kind of … the urges do get better and also acknowledging that yeah it might be something they do carry on thinking about for a while I think" – Lily (P.12, Ln.3).

For some it was the realisation of what could happen if the behaviour continued based on reflections of their experience so far after previously not seeing any alternatives to self-harm.

> "It was a want to stop 'cos I realised probably how bad it could get" – Bob (P.9, Ln.3).

For the majority of participants it appears as though this was a turning point in how they related to themselves and their behaviour. It also appears to have been a time when things were particularly difficult; knowing that a change had to be made but not knowing how this might take place and how they would cope. However the emergence of a possibility appears to be a key component in their journey to not relying on self-harm.

Responsibility

Participants discussed their responsibility in relation to their self-harm.

> "They have to want to stop it themselves someone can tell you to stop all they want but it has to be your decision to stop it otherwise you'll probably make it more secretive about it in the end" – Bob (P.8, Ln.16).

> "If you want to change you're the only person who can really bring that about and I think in order to do that you know develop some kind of self-esteem" – Claudia (P.13, Ln.14).

Responsibility and taking ownership of their behaviours was important to the participants. They acknowledged their effect upon other people and that they were the ones with the power to alter things.

Change of behaviour

Participants discussed the relatively more practical changes that occurred. This was mainly related to the self-harming behaviour itself. This ranges from practical techniques in the immediacy of trying not to self-harm to longer-term life changes.

Facilitators

Participants reported a range of things which facilitated their move away from reliance on self-harm.

> "Time was the biggest healer and it's ironic because time heals how you feel and time heals your scars" – Megan (P.15, Ln.2).

> "I think cos you get older your mechanisms change anyway" – Beth (P.7, Ln.12).

> "I think as you get older your feelings are less intense erm you're more accepting of things I don't know if that's true for everybody but certainly when I was in my early 20's late teens early 20's it was all heavy duty and intense all that sort of thing I'm more prepared to ride the waves a bit now" – Marcus (P.22, Ln. 10).

Time emerged as a facilitator to stopping self-harm. This was in terms of both distance from the self-harm and the events that caused the self-harm.

> "It feels more sort of like soul rather than a brain response it feels like a heart more of a nurturing response rather than a thinking response" – Lily (P.7, Ln.5).

> "The kind of offering of help wasn't helpful but the understanding of it and acceptance of who I was anyway was I think that was helpful actually" – Claudia (P.23, Ln.8).

A number of participants spoke about their responses to themselves changing to allow themselves to be more caring towards themselves. This allowed them to utilise other approaches when coping with their distress. Others discussed the usefulness of their setting.

> "It's a safe environment anonymous trusting you know without judgement" – Marcus (P. 26, Ln. 5).

> "Their judgement doesn't matter on a personal level because they're nothing they're no one to you so they can't effect you" – Bob (P.15, Ln.4).

For other people their environment facilitated their decision to not self-harm. An environment conducive to stopping self-harm was something that participants valued.

Barriers

Some of the barriers that were described were less tangible and more emotional in nature.

> "I think it does get to a position where you do just feel guilty that you can see you're upsetting other people as well which isn't something I like to do and I'd say that's maybe one of the reasons I started in the first place is that I don't like upsetting either people so I won't tell them if they've done something to upset me so it just drives the cycle really" – Claudia (P.6, Ln.13).

Participants described the attempted interventions from friends and family to be unhelpful and often placed them under pressure, which then contributed to further urges to self-harm. This was conceptualised as a cycle that they found themselves in when attempting to move away from self-harm.

> "Lack of being able to access something anonymously was the biggest barrier I had because it is so secretive and you don't want everybody knowing" – Megan (P.7, Ln.8).

A number of participants accessed or attempted to access professional support when stopping self-harm. Whilst doing this they were aware that if they disclosed their self-harming behaviour, there would be "repercussions" (Marcus) so did not.

The lack of skills which led to self-harm, if they have not been learnt, can lead to the behaviour continuing to be used.

Techniques to not self-harm

Participants discussed the use of specific techniques that helped them stop self-harming. In the immediacy of wanting to stop, participants spoke about using techniques which quelled the urge or took away the option to self-harm "like a tool kit" (Lily) of things to help with urges.

> "[what helped] when I was really struggling….when I was trying to stop was the things that…replaced the sensation like holding ice cubes was one of the things because that really hurts but it doesn't do any damage" – Lily (P.6, Ln.1).

> "I had to throw out anything associated with it erm and I consciously got rid of or hid a lot of my tops with longer sleeves" – Megan.

Many participants spoke about the use of self-talk when in upsetting situations or when distressed. The event becomes more intellectualised and easier to breakdown. By breaking down what it is that is upsetting, participants reported feeling more able to identify what the issues were and deal with it without resorting to self-harming behaviours.

> "I kind of broke down the process of when I felt you know sad instead of instinctively hurting myself I'd think right what's this about is it worth doing anything about it and what I should do" – Claudia (P.9, Ln.5).

Practical techniques seem to change over time. Those which are less immediate and practical such as the self-talk appear to be still be used by participants.

Changing for life

Participants also described techniques that are practical but are less centred around the self-harm itself and were more changes for life. This included finding hobbies such as baking "you've got to read the recipe to measure things out you can't have thoughts going on in the background of other things its completely you have to concentrate on this" (Allison).

Participants did report that in order to move away from self-harm changes in their life had to be made that lasted for life.

> "I've got a support network now where if my partner's away I will call on friends and say shall we go to lunch and that is my means of escapism now" – Allison (P.4, Ln.8).
>
> "My whole life kind of changed from that point and I never really looked back and it never really became an option I had from that point on I had different support networks" – Beth (P.18, Ln.6).

Some participants reported the introduction of a support network to their life as a new technique for coping with difficult feelings. By having a network to turn to, they no longer turned inwards which resulted in self-harm.

> "I'd use them [urges] more as a as a thermometer for how I'm feeling and it feels okay for wanting to do that" – Lily (P.9, Ln.8).
>
> "I changed how I was thinking about myself and then stopped [self-harming]" – Claudia (P.2, Ln.15).

Changes also took the form of changing how participants relate to themselves. With a change in how they experience internal struggles, self-harm was not relied on as a

coping mechanism. The internal struggles which may have given rise to the urges seemed to be no longer present after this change.

> "You have to learn to live with yourself and therefore you have to learn to live with yourself otherwise it's like having an annoying housemate and if you can't live with yourself then you know so you have to learn to get along by yourself so I suppose that changed a lot as well" – Bob (P.10, Ln.6).

There was an acknowledgment that these changes had to be permanent and not just in the immediacy in order to sustain the cessation of self-harm; without their continued use there was the realisation that they could repeat previous patterns of coping.

Understanding

A number of participants spent a portion of the interview discussing the time they were self-harming. They appeared to have thought about this quite a bit since ceasing self-harm and spoke about having insights into what was happening at that time which they did not have at that time.

Understanding the self-harm

Participants spoke about understanding the influences that led to self-harm and what the experience itself means in their lives.

> "When I look back everything was always a big drama life was always a huge roller coaster real highs and crushing lows there was never any stability" – Marcus (P.14, Ln.10).

> "I think it was mainly to do with kind of relational problems at the time with friends and things like that" – Claudia (P.1, Ln.9).

Understanding what led to the self-harm and why it happened appeared to be a large part of the experience for the participants. For some this understanding came over

time and some found it useful to access services to get this help. For a number of people this was a large part of their recovery and an on-going task.

Participants also spent time considering and talking about what the purpose of self-harm was for them.

> "I think it was like the whole the whole self-harm thing was because I needed people to see how bad I had it I needed people to recognise how horrendous my life was and I needed people to be aware of it" – Elizabeth (P.9, Ln.1).

Understanding the end that self-harm was used to achieve also seemed important to the participants.

Unique ability to help those in similar situation

As a result of their experiences, participants had found that they felt in a position to help others and accordingly many of them were in occupational positions where this possible.

> "I think it's one of the things that helps me [in my job] like having like knowing what it is like to feel really overwhelmed by anxiety or sadness and knowing how hard that is and also knowing how it feels to not particularly want to change and stuff" – Lily (P.11, Ln.5).

> "I think it gave me far more insight into I could spot things a bit more maybe" – Marcus (P.15, Ln.11).

Many participants spoke about knowing people in similar situations and feeling that they could offer some advice based on their own experience. They often found that they would help anyone who was struggling with difficult and overwhelming feelings.

Lasting changes

Participants discussed alterations that occurred in their life as a result of their self-harm. These were not always positive changes and were on-going difficulties.

Reconciliation of consequences

A theme emerged of having to reconcile past difficulties with their present lives. People often spoke of self-harm or the experience as being "a part" of them and feeling as if they are not cut off from the person who self-harmed.

> "So I still have those thoughts but it doesn't necessarily mean that I act on them" – Bob (P.9, Ln.8).
>
> "It'll always feel like a part of who I am how I've coped and something that did help that does that would help is some ways with feelings that are difficult" – Lily (P.4, Ln.4).
>
> "I can see its part of you know what I'm capable of doing buts it's not something I'd like to go back to" – Claudia (P.7, Ln.11).

The reconciliation of past urges and experiences with present circumstances is a theme that emerged amongst participants. It appeared to be something that became a consideration with some distance from the self-harm behaviour.

Lasting physical changes

There was some discussion of scars and the role that they play after stopping self-harm. For some scars were something that stopped them from self-harming.

> "I think that's sort of…kind of a reminder of not [to self-harm]" – Lily (P.10, Ln.5).
>
> "There's two huge scars on my arm she's gonna notice them so I had to explain what they were" – Bob (P.6, Ln.5).

The consequences of the behaviour still played a role in their lives however there was no consensus as to whether this was good or bad.

> "I'm not remotely like slightly ashamed of like the scars I think it's like kinda cool that your body represents what you've been through" – Elizabeth (P.14, Ln.9).

For a number of participants, their self-harming behaviour had not resulted in permanent scaring which is obvious to other people.

Other people

Other people appeared to play a large role in participants' experiences of self-harm both whilst they were self-harming and in the time afterwards. Participants communicated what appeared to be a split between themselves and their own difficulties and the people around them and the difficulties that they could bring.

Relationships & communication

Participants discussed the role of relationships in their experiences of stopping self-harm. Some participants remained aware that their self-harm experiences had the potential to destroy close relationships with family and friends.

> "I've been with my boyfriend now for nearly eight years and I don't think I would ever tell him …. I know he would be one of these people who would have the kind of opinion of well why you know like were you trying to kill yourself… it wouldn't matter how much I said no" – Beth (P.11, Ln.12).
>
> "There is absolutely no way on earth I would disclose that to anyone" – Marcus (P.6, Ln.5).
>
> "If things aren't really talked about you don't think it's acceptable to bring them up or talk about them" – Claudia (P.15, Ln.3).
>
> "People I cared about didn't talk to me about it" – Megan (P.14, Ln.11).

Close relationships, particularly with partners, appeared to struggle when discussing self-harming behaviour. Although having not self-harmed for a number of years, one participant's partner still struggled with the idea that her partner would not do it again after arguments in the relationship. They were unable to communicate about the

experience openly and honestly which in some ways led to the perpetuation of the individual struggling to accept their experience.

> "There's that feels like a lot of distance there's been a lot that's happened to me or friends and family in that time… its not actually something that kind of meant that they look at me differently… relationships change over time anyway" – Lily (P.11, Ln.11).

Participants spoke about people close to them being aware of the behaviour and difficulties. Other participants discussed similar feelings and that although being a strain on the relationship when engaging in the behaviour, in the long-term relationships had been strengthened and did not bear any marks of being altered negatively by the self-harm.

There was also a theme of helpful relationships which alleviated some of the struggle when stopping self-harm. These stable and open relationships enabled the self-harming individual to discuss the issues that were causing distress and not rely on their self-harm behaviour. Without "being with my friends and having a bottle of wine" (Beth), some feared that they would return to self-harming.

Understanding

Some participants found the lack of understanding about their self-harm to be a difficulty. Whether this was what the behaviour itself meant or what had caused it, when this was clearly being misunderstood by people, they noticed that recovery from self-harm was difficult.

> "They don't understand it they just know that I cut myself open" – Bob (P.5, Ln.2).
>
> "Couldn't understand what would lead me to that and the fact that I'd got children it was like you shouldn't have done that" – Allison (P.15, Ln.14).

The understanding of the behaviour was important to participants. They did not wish for this understanding to lead to change; an understanding was important in itself. Understanding the unique situation which led to self-harm meant they were more able to accept the circumstances which in turn meant there was less negativity towards them and their actions. Without this understanding and acceptance, participants spoke as though they may not be able to accept what had happened.

Of all the themes that emerged, stereotypes and stigma were often two of the most emotive subjects for participants often bringing back painful memories. They were also the two aspects of the experience that they most wished other people to learn from.

Stereotypes

Many participants had encountered the difficulty of stereotypes of "self-harmers" (Bob) during their experience.

> "I think about people's response to self-harm is kind of attention seeking…I didn't want attention for how I was feeling" – Claudia (P.11, Ln.11).
>
> "You know it's just presented to us as you know the teenagers with black eyes feeling sorry for themselves" – Beth (P.22, Ln.12).
>
> "I just think that overall its far more wide spread than people imagine it to be and also I think we have this stereotypical view it's got to be anorexic seventeen year old girls and it isn't it's wide spread across community" – Marcus (P.24, Ln.8).

The participants who spoke of stereotypes felt that the people who did this had no regard for them and did not consider the behaviour seriously. It was discussed that the purpose of the behaviour is unique to individuals; although there might be overlap, people had their own reasons for self-harming. Stereotypes allowed no expression for difficulties and in some cases perpetuated difficulties.

Stigma

In the time following stopping self-harm, participants had found that the stigma associated with the behaviour could be a reminder of their difficulties and stood in their way of recovering completely. It either hampered their efforts to find help in the first place or got in the way of completely honest treatment.

> "They were frightened of me so frightened of me because I came in with these marks" – Megan (P.8, Ln.3).

Stigma had been a barrier to accessing help to stop self-harm.

> "People aren't informed about it enough at all really so yeah definitely still a taboo" – Beth (P.12, Ln.5).
>
> "People are judgemental aren't they and there is just no way [I'd tell someone] absolutely not" – Marcus (P.6, Ln.2).
>
> "I think if people were completely accepting of it and weren't you know judgemental I'd feel happy talking about it but in general its not something people tend to be understanding of" – Claudia (P.5, Ln.11).

Participants discussed how the reactions of people so far had put them off discussing their self-harm and put them off doing that in future.

> "I still am ashamed and highly embarrassed highly ashamed of it and I wonder how long that will take to go.
>
> *-Do you think it will ever go?*
>
> I wonder if it won't and I wonder if a lot of that has come from my experience of trying to get help" – Megan (P.9, Ln.13).
>
> "I would have hated for that to be on my record even though they're not supposed to discriminate I think they do with the [occupational] field I'm going into" – Beth (P.7, Ln.15).
>
> "It's a stigma that you will carry and does that help you recover I don't know" – Bob (P.13, Ln.17).

Stigma was discussed as a contributing factor to on-going difficulties with self-harm and being open about their experience. A number of participants reported feeling comfortable with their experience if they were sure the other person would not judge them. However it was raised that this was difficult to do as even those close to them had views of self-harm. The wider issues appeared to be in society rather than people; as a society people are not aware of self-harm and what it means to people and this can get in the way of close relationships even if “it’s not deliberately done” (Bob).

Discussion

This study highlighted a number of commonalities between individuals' experiences, and raised a number of issues that need to be considered when helping individuals move away from self-harming to methods of coping that are less maladaptive. Bearing these things in mind fits especially well with Roger's (1957) principle of "empathetic understanding", and can be useful irrespective of the desired mode of therapy.

Participants often spoke about motivations to change being external and often focussed on other people rather than themselves. This finding may be in line with the apparent disregard for the self when harming the self. It also supports the idea that the behaviour is not attention seeking and is to help the person cope with their difficult feelings (Gelinas & Wright, 2013). Kress and Hoffman (2008) identified the benefits of motivational interviewing for developing reasons to cease self-harm. Also when discussing motivation, participants appeared to describe a staged approach. Parallels can be drawn here to Prochaska and DiClemente's (1992) model; this is particularly evident when considering making changes as participants described a time when they were considering alternatives to their current behaviour. This model should be considered when working with individuals who are seeking to stop self-harming as the experience described by participants often appeared to mirror the model. This model could be especially helpful when there is some motivation to change but with a weaker impulse than that present on previous occasions when change was considered.

It became evident that self-harm was used as a coping method as other options were not available to them; either they were not known to the person or they could not use them at that time. In the instances where they are not known and the

individual is self-harming, techniques and coping strategies should be taught before it can be hoped that they will no longer resort to self-harm.

Many of the themes that emerged relate to aspects of a person's life that cannot be manipulated by a professional. Many participants commented that their self-harm was a response to events in their life which were upsetting and over which they had no control. This was also reflected in the literature (e.g. Gelinas and Wright, 2013). If this is the case, work centred on the self-harm behaviour may not be the most useful and instead work to alleviate the stress of the situation will create an environment where they no longer feel the need to self-harm. Alternatively work may need to be done to create control over their situation where possible to alleviate urges to self-harm. Many participants commented on their need to have compassion for themselves and the development of this compassion over time. Therapy such as Compassion Focussed Therapy (CFT) may assist understanding of past and present aspects of the individual's life that they cannot change and their reactions to these. CFT focuses on the reduction of shame and self-criticism and encourages individuals to look at their life as a set of circumstances. These circumstances can sometimes result in actions that may have been necessary at the time in order to cope (Gilbert, 2009). A reduction in shame and self-criticism may also be of benefit for reducing negative feelings and avoiding relapse in future. CFT also promotes the use of mindfulness where an individual can be encouraged to observe thoughts and feelings without passing judgement on them and staying in the moment.

Regardless of the therapy approach chosen, participants all spoke of understanding and a non-judgemental stance as being important. This fits with the core conditions for therapy outlined by Rogers (1957), specifically empathy. Holding in

mind the experiences of those who have self-harmed and being empathetic will help facilitate any therapy modality. The therapist may find it easier to access an empathetic understanding when considering Baumeister and Scher's (1988) work, which proposes that everyone engages in self-defeating behaviours to some degree.

Participants discussed an on-going experience of coming to understand what had happened to them and processing this knowledge. This was understood by the participants to be something that had taken time and would continue in the future. They identified that as more time elapsed since their self-harm experience, the intensity of their feelings decreased. For this reason, CFT, again, may be helpful as therapy which seeks to accept situations and events as they have happened may be useful for facilitating this process. Another therapy that may help to facilitate acceptance is Acceptance and Commitment therapy (ACT). ACT helps a person distance themselves from unpleasant feelings and not to act on the feelings (Zettle, 2005).

One of the strongest themes and difficulties that participants discussed was the judgements received from other people, both stigma and stereotypes. The difficulties of judgements were also interwoven in other areas of their experiences both presently and in the past. Corrigan (2004) discussed the detrimental effects of stigma when receiving help or working towards recovery and its ability to hinder progress. Participants discussed wider issues in society and not necessarily just how it affected them. Their experiences of stigma and stereotypes appeared to have made them aware of wider issues in society that need to be addressed such as the way people view their bodies in relation to diets or the function of unhelpful behaviours such as smoking. The need for greater understanding and less stigma is also outlined by Corrigan (2004).

This research is helpful when considering that there appears to be more empirical research focussed on treatment aspects rather than looking at the qualitative experience of self-harm. This was evident in a literature review conducted by Ward, de Motte and Bailey (2013), in which there were no articles that included service user involvement. They also highlighted that this was at odds with recommendations put forward by National Institute for Health and Clinical Excellence. Hawton et al. (1998) noted that improvement is needed in order to increase the quality and scope of self-harm research. It would be difficult to speculate as to why this particular area has not been looked at further although it should be noted that the need for further investigation has been recognised by organisations such as the Mental Health Foundation in their report "Truth Hurts" (2006).

Limitations

A weakness of this research is that the majority of the participants were recruited through and therefore were associated with a university. It could be assumed that these individuals have a better vocabulary in order to express themselves and so the behaviour was only used as a very last resort or at a serious time of crisis. Those less able to express themselves may have experienced self-harm in a very different way. For this reason, the results should be considered bearing in mind a relatively high level of education.

A further influence on the data gathered is that a number of participants reported engaging in the behaviour in adolescence and report stopping in late adolescence/early adulthood. Studies show that the behaviour is usually taken up

during adolescence (Favazza, 2007). This is likely to be a different experience to those who used and stopped the behaviour in adulthood or only stopped in adulthood after having used the behaviour throughout adolescence. In line with this, research that looks only adults that began self-harming and ended it in their adult years may find themes more applicable to the age groups. This would require excluding those who only self-harmed in their adolescent years as this research did not do. Also research which specifies a greater time period between ceasing self-harm and participation in the research may yield different results. A number of participants' last self-harm experience was relatively recently. More time between self-harm and discussing it may be helpful as this have allowed time for more thought and processing of own experience.

This study did not include all types of self-harm and did not distinguish between the different types of self-harming behaviours. This was not done as there were no exclusion or inclusion criteria for method of self-harm, as per the IPA methodology. The majority of participants used methods which did not result in any lasting damage. For example, participants may have had scars but did not report that this had adversely affected their lives as they were not obvious. Research involving individuals who have used methods such as bone breaking, overdose, hair pulling or more severe scars which have permanent and serious consequences may be useful. They may have different views on their experiences of stopping self-harm and the repercussions of this. Research should be undertaken to fully understand the repercussions of more serious consequences in order to help individuals with these particular difficulties.

The majority of participants were in a restricted age range and from restricted socioeconomic and cultural backgrounds. Therefore the findings here cannot be generalised to the wider population.

The majority of participants were female. Whilst this is reflective of trends in the behaviour in the wider population (Hawton and Harris, 2008b) more experiences from men may have been very different or at least have provided a well-rounded view of the behaviour. Research into men who self-harm is still limited and it is possible that they have different experiences.

A number of participants struggled to discuss their feelings and experiences at times during the interview. This was due to becoming emotional during interview, feeling unable to convey their point or in some cases not feeling able to take part in the research. It is suggested that self-harm is utilised when an individual is unable to express themselves using words (Adshead, 2010). In view of this, the difficulty encountered is reasonable and should be considered both in future research and therapy; it may be useful to employ various methods to aid in the expressing of emotions.

A further consideration of the possible limitations on the data is the author's personal position. This was an extra factor that had to be considered during interpretation and although careful consideration was taken to make sure that there was no influence there may still have been some effect. Consideration was taken through the use of supervision and another party also looked at the data to confirm the themes found.

Conclusions

The findings of this study largely reflect that which the literature has found . This study also finds similar conclusions as other studies in similar areas. However participants' experiences appear to suggest that further changes need to be made to societal views of self-harm. This emerged as a prominent theme when discussing their experiences of stopping and their experiences since, a number noting that they would have and would now feel more able to discuss their feelings if there was less stigma attached to the behaviour.

Participants also appeared to outline the different stages which accompany stopping self-harm. Whilst participants discussed various techniques or facilitators for this, all participants discussed a realisation that there may be an alternative way to cope with their distress even if they did not know what this might be. This appears to be a stage even before motivations to stop self-harm have been identified.

There are still areas that could be improved in order to facilitate individuals moving away from self-harm and choosing more adaptive methods of coping.

Implications

The importance of other people in the motivation for stopping was evident. This may be important for professionals seeking to foster motivation in their self-harming clients. Professionals should be aware that interpersonal issues are usually the most pertinent. However care should be taken to ensure their client is not being made to feel guilty about their self-harm; guilt may actually perpetuate the issue.

Striking the balance between finding a reason to stop and something to aim towards whilst not pressuring the individual may be helpful. Having options may also be a crucial part of the solution; either in other ways to express or feel emotion, or in bringing about circumstantial changes.

Aside from research, the dissemination of information about self-harm and the experience to the general public and those who self-harm may be useful. This may decrease stigma and stereotypes and promote an environment where people are able to share their experiences. By being able to share their experiences, a number of people may find that they are more able to disconnect from difficult feelings about their self-harm. A disconnection enables them to be able to see it as a time in their life as any difficult time is and not feel continuously judged for their experience. The themes identified have found that judgement is not helpful to on-going recovery.

Services should be aware for the need for anonymity. Although it is appreciated that this cannot always be provided due to reasons of risk, an awareness of the limitations that full disclosure may place on recovery may be helpful. Given the parallels between alcohol-dependency and self-harm it may be useful to consider an Alcoholics Anonymous type group to support those who no longer wish to self-harm; using the same principles of anonymity and provision of support, individuals could feel able to seek help in a comfortable environment. Another hallmark of the anonymous groups is the twelve step approach to help; a staged approach that is understood by all but can be personalised may be helpful. As outlined in the literature regarding alcoholism and approaches to treatment, the controlled drinking and total abstinence is echoed here; some participants discussed the need to find something less damaging

to do in the immediacy of stopping self-harm whilst others discussed stopping suddenly and not engaging in any behaviour that causes a sensation of pain.

It is noticeable that there are parallels between the two behaviours in other aspects but as yet not in treatment.

Recommendations regarding future research

Further research in this area is necessary to aid prevention of the behaviour instead of focussing on the ways in which people can be helped to stop. A number of participants described the conditions that led to the self-harm beginning. It is possible that a number of people could have been helped avoid the difficult experiences of self-harm if they had had access to support and more helpful coping mechanisms at or before their times of distress.

Further research should also be completed to look at stopping behaviours in a larger non-clinical community sample with more variation. The unique experience of stopping self-harm has commonalities across different populations which may be generalizable to a greater understanding of the behaviour. This may lead to the behaviour not being understood as something that people only do if they have a mental health diagnosis but that can affect anyone in distress or with limited options for coping.

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PART THREE

APPENDICIES

Appendix 1

Reflective statement

This research was a learning curve in reconciling one's passion with reality; my original ideas for the research were not feasible given the time and resources available to me. When it came to the point of data collection, I was excited to begin talking to real people about their experiences. However at times this could be difficult and I noticed how difficult this could be for me personally; speaking to people who once were feeling in such a way that they saw self-harming as an option was difficult. Participants were sometimes able to discuss their experiences in such a way that I felt what I assume to be a fraction of the difficulties they experienced. This became most evident to me when discussing stigma and stereotypes; discussion of these things would often occur towards the end of interviews and by this point I felt I had a good understanding of why people were self-harming so to the go on to talk about the judgements they received was frustrating. Equally difficult was talking to people who had dramatically different opinions on the topic. At this point it was helpful to remind myself of the purpose of the topic and appreciate the many different experiences and views that exist on the topic.

I also found the experience of planning and writing a systematic literature review difficult. The first step was to identify a question and unfortunately I found this to be the hardest. On four occasions I generated a question only to find it was published a few weeks later. This quickly became very frustrating, stressful and I doubted whether I would find something that I was interested in. Eventually a question was found and the difficulty became keeping my focus on the question and

not being swayed by interesting looking articles. I was dismayed to see that at some point my passion for the subject area had got lost in “ticking boxes” however after this experience I was much more able to remember the purpose of this research.

At times I found the process of writing up my work difficult. As I am Dyslexic this was a process that took a long time and could be difficult. In particular, I struggled with the tables. I found that using shading meant that I could follow my own tables with ease.

When I conduct further research in the future I will endeavour to make sure the purpose of the study is clear to me and kept in mind at all times. Further to this, with future projects I hope that I am able to be somewhat ready for the range of emotions and the difficulty of some of these emotions that are discussed by participants; although I appreciated that these would evident in the subject area, the raw emotions that remained for some participants was more than I anticipated. This is something I would not take for granted in future research.

Appendix 2

Information sheet

UNIVERSITY OF Hull

Experiences of stopping self-injurious behaviour in adults.

You are being invited to take part in a research study. Before you decide whether or not you want to take part in the study, it is important that you know what the study is about and what it will involve. Please take some time to read the following information.

The research is being carried out by Chloe Rowland, Trainee Clinical Psychologist at the University of Hull, as part of a Doctorate in Clinical Psychology, supervised by Dr Nick Hutchinson, Clinical Psychologist.

If you have any questions, please contact the researcher, Chloe Rowland, on 07757500770 or c.m.rowland@2008.hull.ac.uk.

What is the purpose of the study?

The purpose of this study is to try to understand the experiences of adults whose self-injuring behaviour has stopped. Research into the area previously has looked at what modes of therapy are effective in aiding a person to reduce or stop the behaviour. This study aims to identify any common themes, regardless of method or reason of stopping the behaviour.

Why have I been chosen?

The research requires 10 adult (18 – 65 years old) participants who identify themselves as having stopped self-injuring for a minimum of 12 months.

What will I be asked to do?

For the main part for this research you will be asked to take part in an interview which will last approximately one hour. During this time you will be asked about your experience of stopping self-injuring; how this change came about, how you felt about it, what was helpful at this time, what was unhelpful and how you feel about it now. It will only be you and the main researcher at the interview. The interview will also be audio-recorded. Although this can be a difficult subject, it is important that you be as open and honest as you can be.

The interview will take place at a time and location that is convenient for both you and the researcher.

Do I have to take part?

You do not have to take part. If you decide at any stage that you do not want to take part anymore you can withdraw at any point up to the time that the research is submitted for publication.

Will it be kept confidential?

All information will be kept confidential. The information will be transcribed after the interview during which all identifiable information will be removed. Direct quotes from the interview may be used in the write-up of the research and subsequent publication but you will never be personally identified. In normal circumstances only the researcher and their supervisor will be allowed to see the information. No information will be disclosed to your GP or other health professional.

However, in exceptional circumstances, if during or after the interview the researcher has concerns regarding your wellbeing or somebody else's then confidentiality may have to be broken. If this is the case, the researcher will discuss this with you where possible before having to make their supervisor aware of the situation. After this, a conversation will be had with the participant where they will be encouraged to seek support through their GP, University Counselling service or other appropriate person.

After all information has been used for research purposes it will be kept at the University of Hull for 10 years after which time it will be destroyed.

What are the potential 'costs' of taking part?

There are no direct costs involved in you taking part although given the sensitive nature of the topic, it may be that you become upset talking about your experiences. A list is attached of sources of support available to you if you have concerns in this respect.

What are the potential benefits of taking part?

It is hoped that this research will help to inform professionals of ways in which they can help other individuals going through these changes in their lives. It may also be of benefit to other individuals who find themselves reducing or stopping their self-injurious behaviour or who would like to reduce or stop their self-injurious behaviour.

What will happen to the research?

When the research is completed it will be written up as a thesis to be submitted to the department of Psychological Health and Wellbeing at the University of Hull. It will also be submitted to an academic publication with the aim that it will be published and available to help other professionals.

Who has reviewed the study to ensure it is safe to carry out?

The study has been favourably reviewed by the University of Hull Faculty of Health and Social Care ethics committee.

Who can I contact for further information?

You can contact Chloe Rowland, Trainee Clinical Psychologist, on 07757500770 or c.m.rowland@2008.hull.ac.uk. Thank you for your time.

Sources of Support and Information regarding self-injury.

University counselling/wellbeing service – can offer help and support to students. They offer a number of services and can signpost people to helpful and relevant services.

http://www2.hull.ac.uk/student/counselling.aspx

MIND – A good source of information around self-injury including information around treatments and support and tips that can be used by individuals to help themselves.

http://www.mind.org.uk/mental_health_a-z/8006_understanding_self-harm

National Self-Harm Network – a charity that offers a helpline and online support.

http://www.nshn.co.uk/whatis.html

You can also seek advice and help from your GP.

Appendix 3

Consent form

Consent Form

<u>Experiences of stopping self-injurious behaviour in adults.</u>

Researcher: Chloe Rowland

☐ I confirm that I have read and understand the information sheet for the above study on the experiences of adults stopping self-injury. I have had the opportunity to consider the information, ask questions and have had any questions answered.

☐ I understand that I do not have to participate in this study if I do not want to, and that I am free to withdraw at any point, without giving any reason for withdrawing and that this can be done up until the research is submitted for publication. I understand that if I wish to withdraw any information I have supplied will be withdrawn and destroyed.

☐ I understand that my participation and personal details will be kept confidential. However, in exceptional circumstances, if during or after the interview the researcher has concerns regarding your wellbeing or somebody else's then confidentiality may have to be broken. If this is the case, the researcher will discuss this with you where possible before having to make their supervisor aware of the situation and GP and/or Crisis team will be informed if the risk is very high.

☐ I am willing to take part in the above study.

Name ……

Signed ……

Date ……

Appendix 4

Demographics form

Study number:

Participant Identification number for this study:

Demographic Form

Background Information Questionnaire

Demographics

This section looks at general information about you

Please tick the appropriate box or insert an answer

1. **participant gender**
   Male ☐ Female ☐

2. **Age**
   _____

3. **Are you in education or employment?**
   Education ☐ Employment ☐

Self Harm

This section looks at details of your self harm

University of Hull
Hull Campus
Cottingham Road
Hull, HU6 7RX

www.hull.ac.uk

4. **Approximately how long did you self harm for?**

_____

5. **Approximately how often did you self harm?**

Once ever
Less than once a month
Once a month
More than once a month
Once a week
More than once a week
Once daily
Several times daily

Other _____

6. **What methods of self harm did you use previously?**

Cutting/scratching ☐
Skin picking ☐
Burning ☐
Hair pulling ☐
Drug/alcohol abuse ☐
Overdose ☐

Other (s)_____

7. **How long has it been since you last self-harmed?**

12 Months ☐
12 – 24 Months ☐
2 – 5 Years ☐

5-10 Years ☐

10 Years + ☐

Services

This section looks at your past with services.

8. Have you ever had any involvement from mental health services?

THANK-YOU FOR COMPLETING THIS FORM

Appendix 5

Interview schedule

Experiences of stopping self-harming behaviour in Adults – Interview Schedule.

- Beginning the interview:
  - *"What do you think triggered you to start using the behaviour in the first place?"*
  - *"Has that had any effect on noticing warning signs now/coping with urges to do it again?"*
- Current situation;
  - *Where do you see yourself now in terms of SI?*
- Facillitative Factor;

  - any turning points?
- What prompted someone to reduce/stop;
  - *What prompted you to make this decision?'*
- Deciding to reduce/or stop SI;
  - *'What helped you make the decision to reduce/stop?'*
  - *'Was there any reason it was important for you to make this change and stick with it?'.*
- Implementing the change;
  - *'What helped you put into action the change you decided was going to happen?'*
  - *'What adjustments did you have to make?'*
  - *'What techniques did you use (if any)?'*
- Obstacles/facilitators;
  - *'What was helpful to you when you decided to make this change?',*
  - *"What support (if any) did you have? Professional, friends, family?"*
  - *'What was unhelpful?',*

- *'If you were to give someone advice in doing what you've done, what would it be?'.*

- Prominent emotions;
  - *'Can you remember how felt at that time?'.*

- Differences;
  - *'How is your life different to how it was before?'*
  - *'Did people treat you differently?'*
  - *'What differences did you notice in your life?'*

- Ending the interview;
  - *Looking back – is there anything you would recommend to other people to help them?*
  - *Is there anything that you would like to have been asked about in this interview that you feel we have missed out?*

Appendix 6

Author Information Pack

Guidelines for contributors

About the journal

The Journal of Mental Health and Well-being addresses the promotion of physical and mental health and well-being, through research, policy and best practice. It brings together a wide range of different disciplines and perspectives, which put well-being and quality of life at the heart of the mental health agenda.

Published quarterly and peer-reviewed, each issue features articles, reflective critiques and focus pieces, plus expert perspectives and comment on all areas of mental health and well-being.

Key journal audiences

The Journal of Mental Health and Well-being is vital for everyone working in mental health service delivery. It is a hugely valuable source of information and intelligence for academics, universities and colleges, commissioners, practitioners, policy-makers, managers, health boards, education and mental health services, local authorities, NHS and clinical commissioning groups, the voluntary and community sectors, service users, carers and students.

The journal will cover:

- major contemporary issues in the mental health field
- latest research on the design and management of services
- service evaluation, research and methodology
- innovations in service developments in the UK and internationally
- new models of (clinical) practice and their implications
- good practice in relation to gender and race
- contributions from mental health service users and carers.

Preparing for submission

Papers and articles to be submitted to the journal include:

- research and theory papers (4,000–7,000 words)
- opinion/comment pieces (1,000–2,000 words)
- literature reviews (250–500 words)
- practice papers (case studies) (2,000–3,000 words)
- policy papers (2,000–3,000 words)
- reports (2,000–3,000 words)

- letters.

All submissions will be acknowledged.

Research and theory papers

Research and theory papers are subject to independent double-blind peer review and the final decision to publish rests with the editor. Following peer review, papers may need to be amended.

- Papers should be between 4,000 and 7,000 words.
- Provide a concise title for your paper.
- Include an abstract of no more than 250 words. The purpose of the abstract is to summarise the contents briefly and clearly. You should also provide up to five key words.
- Include the following sections: abstract, introduction, methods, results, discussion and references.
- To preserve anonymity for the peer review process, please ensure that you do not include your name anywhere within the main document.
- Provide details of author or co-authors with submission, including names, affiliations, addresses, email address and telephone contact details.
- Wherever possible include original charts, graphs or diagrams as an aid to clarity.

References

The journal uses the Harvard system.

For citations within the text, use single quote marks around any text that is copied verbatim and cite the author's name and the date of the publication. For example: (Ansell-Jones, 2012). Where there are more than two authors, you can use 'et al', for example: (Ansell-Jones *et al*, 2012).

When listing the references at the end of the paper use the following rules:

Referencing a book

Grainger R (2012) *The Shape of Bereavement: Working through*. Brighton: Pavilion Publishing.

Referencing a book with multiple authors (et al references)

Note: Please list all author names rather than using et al.

Holt G, Hardy S & Bouras N (Eds) (2011) *Mental Health in Intellectual Disabilities: A reader* (fourth edition). Brighton: Pavilion Publishing.

Referencing a chapter in a book

Hearne M (2011) Challenging behaviour. In: G Holt, S Hardy & N Bouras (Eds) *Mental Health in Intellectual Disabilities: A reader* (4th edition) pp161–177. Brighton: Pavilion Publishing.

Referencing a journal article

Emerson E, Beasley F, Offord G & Mansell J (1992) An evaluation of hospital-based staffed housing for people with seriously challenging behaviours. *Journal of Intellectual Disability Research* **36** (3) 291–307.

Referencing a web article

CIPD (2008) Management Development Factsheet [online]. London: CIPD. Available at: www.cipd.co.uk (accessed November 2012).

Referencing a newspaper

Smith J (2000) Why Pavilion won the day. *The Times* **24 March**.

Referencing a legal case

Re F (wardship: adoption) (1984) 13 Fam Law 259, CA.

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Editing and proofing

All submissions will be subject to editing for clarity, elimination of redundancies and conformity with house style.

Authors will be supplied with proofs to check for typesetting or conversion errors and the completeness and accuracy of texts, tables or figures. Please be aware that authors will have five days to check proofs and we will not be able to make any amends submitted after the allotted time.

Submission of copy

Submit your work by email. Please use minimal formatting and layout (bold, italics, capitals only), other than for figures and tables. Completed contributions and general queries about submissions should be addressed to Catherine Ansell-Jones at

Catherine.Ansell-Jones@pavpub.com. They will then be forwarded onto the editor, David Palmer.

Appendix 7

Ethical Approval

Removed for hard binding

Appendix 8

Sample of transcript

I; its very much you against everyone else

M; yeah

I; is that how it felt

M; yeah it felt as though I was backed into a corner it like all of a sudden everybody knew everybody was cornering in on me erm I felt really attacked by everyone and very alone

I; what kind of things helped then I know you said you got your manager on side at this point and hes trying to help out what else was helpful what wasn't helpful can you remember anything getting in the way

M; what wasn't helpful was erm the lack of being able to access something anonymously was the biggest barrier I had because it is so secretive and you don't want everybody knowing and you know I didn't I didn't want to go to a doctor or a I just wanted to go to this place where I wouldn't have to give my name and I could just get some help but it wasn't that easy at all and I don't whether it was because of my age or or what but it was so hard but erm peoples judgement was also the hardest thing and is still the hardest thing now that I struggle with erm I can cope with people talking about it but it's when people put judgement on it that I find it so hard and it was really hard back then erm self-help sites helped erm I went on a lot of forums as well Erm talk could it be anonymous erm and I think that service would have helped me an awful lot if I had been in a better place I think having more anonymity for people because as soon as anybody knows it immediately has to be passed on to somebody else cos its risky and it's this you know I felt like I was this great big risk and I thought am I am I risk to myself I started questioning myself am I suicidal I didn't think I was why is everybody telling me I'm a risk and that was terrifying that they were frightened of me they were so frightened of me

because I came in with these marks and no one knew my name and oh my god it's obvious that they were terrified id kill myself yet that was never my intention

I; it sounds like it didn't even occur to you that that was something that you wanted to do

M; yeah yeah and then you start questioning yourself you think am I is that what I am am I doing this because I'm suicidal I didn't think I was and em and that was awful that was really frightening

I; it sounds like it was a pretty big barrier like you said it was barrier and if you were to give advice to somebody who's trying to stop themselves what would you say to them now

M; erm… if they were trying to stop because they wanted to stop I think you have to look past what it is you're doing and look at why why are you doing it and I know it might seem an obvious question and It really isn't and I really didn't think about why it was that I would care for them and yet I know hut myself and I think people really have to look at where they are in their life and what do you need to change what – because it's going to have to be more than that more than just stopping your whole life is going to have to change

I; so it's more than just you know burning yourself cutting yourself it's actually what's going on around you

M; because it becomes your whole life its it became your focus you know I knew that I could get through a day because I would probably cut myself I made strange rules and all kinds of things and I don't think people realise that they do I made all kinds of rules about I couldn't cut in the same place that place had to heal before I could cut somewhere else I had to care for them and I think people do have them ritualistic things that they just don't realise that they do until it's too late and I can see how people end up going to a&e all the time because they want someone to do that for them they want someone to make it better for them and that was what I was doing for myself and I think you have to look at what it is you haven't got what is

missing in your life because that is why you're doing it and your trying to block it out form something else that's horrendous that's probably going on

Appendix 9

The Methodological Checklist: Quantitative studies (NICE, 2006)

Checklist

Study identification: Include full citation details		
Study design: • Refer to the glossary of study designs (appendix D) and the algorithm for classifying experimental and observational study designs (appendix E) to best describe the paper's underpinning study design		
Guidance topic:		
Assessed by:		
Section 1: Population		
1.1 Is the source population or source area well described? • Was the country (e.g. developed or non-developed, type of health care system), setting (primary schools, community centres etc), location (urban, rural), population demographics etc adequately described?	++ + – NR NA	Comments:
1.2 Is the eligible population or area representative of the source population or area? • Was the recruitment of individuals, clusters or areas well defined (e.g. advertisement, birth register)? • Was the eligible population representative of the source? Were important groups underrepresented?	++ + – NR NA	Comments:
1.3 Do the selected participants or areas represent the eligible population or area? • Was the method of selection of participants from the eligible population well described? • What % of selected individuals or clusters agreed to participate? Were there any sources of bias? • Were the inclusion or exclusion criteria explicit and appropriate?	++ + – NR NA	Comments:
Section 2: Method of selection of exposure (or comparison) group		
2.1 Selection of exposure (and comparison) group. How was selection bias	++	Comments:

minimised? • How was selection bias minimised?	+ – NR NA	
2.2 Was the selection of explanatory variables based on a sound theoretical basis? • How sound was the theoretical basis for selecting the explanatory variables?	++ + – NR NA	Comments:
2.3 Was the contamination acceptably low? • Did any in the comparison group receive the exposure? • If so, was it sufficient to cause important bias?	++ + – NR NA	Comments:
2.4 How well were likely confounding factors identified and controlled? • Were there likely to be other confounding factors not considered or appropriately adjusted for? • Was this sufficient to cause important bias?	++ + – NR NA	Comments:
2.5 Is the setting applicable to the UK? • Did the setting differ significantly from the UK?	++ + – NR NA	Comments:
Section 3: Outcomes		
3.1 Were the outcome measures and procedures reliable? • Were outcome measures subjective or objective (e.g. biochemically validated nicotine levels ++ vs self-reported smoking −)? • How reliable were outcome measures (e.g. inter- or intra-rater reliability scores)?	++ + – NR	Comments:

• Was there any indication that measures had been validated (e.g. validated against a gold standard measure or assessed for content validity)?	NA	
3.2 Were the outcome measurements complete? • Were all or most of the study participants who met the defined study outcome definitions likely to have been identified?	++ + – NR NA	Comments:
3.3 Were all the important outcomes assessed? • Were all the important benefits and harms assessed? • Was it possible to determine the overall balance of benefits and harms of the intervention versus comparison?	++ + – NR NA	Comments:
3.4 Was there a similar follow-up time in exposure and comparison groups? • If groups are followed for different lengths of time, then more events are likely to occur in the group followed-up for longer distorting the comparison. • Analyses can be adjusted to allow for differences in length of follow-up (e.g. using person-years).	++ + – NR NA	Comments:
3.5 Was follow-up time meaningful? • Was follow-up long enough to assess long-term benefits and harms? • Was it too long, e.g. participants lost to follow-up?	++ + – NR NA	Comments:
Section 4: Analyses		
4.1 Was the study sufficiently powered to detect an intervention effect (if one exists)? • A power of 0.8 (i.e. it is likely to see an effect of a given size if one exists, 80% of the time) is the conventionally accepted standard. • Is a power calculation presented? If not, what is the expected effect size? Is the sample size adequate?	++ + – NR NA	Comments:

4.2 Were multiple explanatory variables considered in the analyses? • Were there sufficient explanatory variables considered in the analysis?	++ + – NR NA	Comments:
4.3 Were the analytical methods appropriate? • Were important differences in follow-up time and likely confounders adjusted for?	++ + – NR NA	Comments:
4.6 Was the precision of association given or calculable? Is association meaningful? • Were confidence intervals or p values for effect estimates given or possible to calculate? • Were CIs wide or were they sufficiently precise to aid decision-making? If precision is lacking, is this because the study is under-powered?	++ + – NR NA	Comments:
Section 5: Summary		
5.1 Are the study results internally valid (i.e. unbiased)? • How well did the study minimise sources of bias (i.e. adjusting for potential confounders)? • Were there significant flaws in the study design?	++ + –	Comments:
5.2 Are the findings generalisable to the source population (i.e. externally valid)? • Are there sufficient details given about the study to determine if the findings are generalisable to the source population? • Consider: participants, interventions and comparisons, outcomes, resource and policy implications.	++ + –	Comments:

Appendix 10

The Methodological Checklist: Qualitative studies (NICE, 2006b)

Checklist

Study identification: Include author, title, reference, year of publication		
Guidance topic:	**Key research question/aim:**	
Checklist completed by:		
Theoretical approach		
1. Is a qualitative approach appropriate? For example: • Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings? • Could a quantitative approach better have addressed the research question?	Appropriate Inappropriate Not sure	Comments:
2. Is the study clear in what it seeks to do? For example: • Is the purpose of the study discussed – aims/objectives/research question/s? • Is there adequate/appropriate reference to the literature? • Are underpinning values/assumptions/theory discussed?	Clear Unclear Mixed	Comments:
Study design		
3. How defensible/rigorous is the research design/methodology? For example: • Is the design appropriate to the research question? • Is a rationale given for using a qualitative approach? • Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used? • Is the selection of cases/sampling strategy	Defensible Indefensible Not sure	Comments:

theoretically justified?		
Data collection		
4. How well was the data collection carried out? For example: • Are the data collection methods clearly described? • Were the appropriate data collected to address the research question? • Was the data collection and record keeping systematic?	Appropriately Inappropriately Not sure/inadequately reported	Comments:
Trustworthiness		
5. Is the role of the researcher clearly described? For example: • Has the relationship between the researcher and the participants been adequately considered? • Does the paper describe how the research was explained and presented to the participants?	Clearly described Unclear Not described	Comments:
6. Is the context clearly described? For example: • Are the characteristics of the participants and settings clearly defined? • Were observations made in a sufficient variety of circumstances • Was context bias considered	Clear Unclear Not sure	Comments:
7. Were the methods reliable? For example: • Was data collected by more than 1 method? • Is there justification for triangulation, or for not triangulating? • Do the methods investigate what they claim to?	Reliable Unreliable Not sure	Comments:
Analysis		
8. Is the data analysis sufficiently rigorous?	Rigorous	Comments:

For example: • Is the procedure explicit – i.e. is it clear how the data was analysed to arrive at the results? • How systematic is the analysis, is the procedure reliable/dependable? • Is it clear how the themes and concepts were derived from the data?	Not rigorous Not sure/not reported	
9. Is the data 'rich'? For example: • How well are the contexts of the data described? • Has the diversity of perspective and content been explored? • How well has the detail and depth been demonstrated? • Are responses compared and contrasted across groups/sites?	Rich Poor Not sure/not reported	Comments:
10. Is the analysis reliable? For example: • Did more than 1 researcher theme and code transcripts/data? • If so, how were differences resolved? • Did participants feed back on the transcripts/data if possible and relevant? • Were negative/discrepant results addressed or ignored?	Reliable Unreliable Not sure/not reported	Comments:
11. Are the findings convincing? For example: • Are the findings clearly presented? • Are the findings internally coherent? • Are extracts from the original data included? • Are the data appropriately referenced? • Is the reporting clear and coherent?	Convincing Not convincing Not sure	Comments:
12. Are the findings relevant to the aims of the study?	Relevant Irrelevant Partially relevant	Comments:

13. Conclusions For example: • How clear are the links between data, interpretation and conclusions? • Are the conclusions plausible and coherent? • Have alternative explanations been explored and discounted? • Does this enhance understanding of the research topic? • Are the implications of the research clearly defined? **Is there adequate discussion of any limitations encountered?**	Adequate Inadequate Not sure	Comments:
Ethics		
14. How clear and coherent is the reporting of ethics? For example: • Have ethical issues been taken into consideration? • Are they adequately discussed e.g. do they address consent and anonymity? • Have the consequences of the research been considered i.e. raising expectations, changing behaviour? • Was the study approved by an ethics committee?	Appropriate Inappropriate Not sure/not reported	Comments:
Overall assessment		
As far as can be ascertained from the paper, how well was the study conducted? (see guidance notes)	++ + –	Comments:

Appendix 11

Data extraction form

Title	
Author	
Date	
Journal/page & issue	
Aims of the study	
Other research questions	
Country	
Study sites	
Target population	
Characteristics of participants	

Definition of self-harm	
Theory referred to or conceptual model used	
Sampling/recruitement procedures	
Info (age, gender, ethniticity etc)	
Self-harm methods included	
Study design	
Control group if any	
Method of data collection	

Research tools/outcome measures used	
Analysis used	
How many analysts used at analysis stage	
Details of findings	
Strengths of the study	
Weaknesses of study	

Authors conclusions	
Suggestions for further research	

Appendix 12

Table of quality assessment for qualitative studies

		Craigen & Milliken, 2010	Harris, 2000	Hunter, Chantler, Kapur & Cooper, 2012	Kool, Meijel & Bosman, 2009	Lindgren, OsterAstrom & Graneheim, 2011	Polk & Liss, 2009	Redley, 2003	Russell, Moss & Miller, 2010
Theoretical Approach	1	Not sure	Appropriate	Appropriate	Appropriate	Appropriate	Appropriate	Appropriate	Appropriate
	2	Unclear	Clear	Clear	Clear	Unclear	Clear	Unclear	Clear
Study Design	3	Defensible	Defensible	Defensible	Defensible	Defensible	Defensible	Defensible	Defensible
Data Collection	4	Appropriately	Appropriately	Inappropriately	Appropriately	Appropriately	Appropriately	Appropriately	Appropriately
Trustworth-iness	5	Not described	Unclear	Not described	Not described	Clearly described	Not described	Unclear	Clearly described
	6	Clear	Unclear	Clear	Clear	Clear	Unclear	Clear	Clear
	7	Reliable	Not sure	Reliable	Reliable	Reliable	Unreliable	Reliable	Reliable
Analysis	8	Rigorous	Not sure	Not sure	Rigorous	Rigorous	Rigorous	Rigorous	Rigorous
Ethics	9	Rich	Rich	Rich	Rich	Rich	Rich	Rich	Rich
	10	Reliable	Not reported	Not reported	Reliable	Unreliable	Reliable	Unreliable	Reliable
	11	Convincing	Convincing	Convincing	Convincing	Convincing	Convincing	Convincing	Convincing
	12	Relevant	Irrelevant	Relevant	Relevant	Relevant	Relevant	Relevant	Relevant
	13	Adequate	Inadequate	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate
	14	Not reported	Not sure	Inappropriate	Appropriate	Appropriate	Not sure	Appropriate	Appropriate
Overall		-	-	+	++	++	+	+	++

Table of quality assessment for qualitative studies, contin.

		Shaw, 2006	Schoppmann, Schrock, Schnepp & Buscher 2007*	Straiton, Roen, Dieserud &Hjelmeland, 2013*	Taylor, 2003	Walker, 2009	Weber, 2002	West, Newton & Barton-Breck, 2013
Theoretical Approach	1	Appropriate	Appropriate	Appropriate	Appropriate	Appropriate	Appropriate	Appropriate
	2	Clear	Clear	Clear	Clear	Clear	Clear	Clear
Study design	3	Indefensible	Defensible	Defensible	Not sure	Defensible	Defensible	Defensible
Data collection	4	Appropriately	Appropriately	Appropriately	Appropriately	Appropriately	Appropriately	Appropriately
Trustworthiness	5	Unclear	Unclear	Not described	Clearly described	Clearly described	Unclear	Unclear
	6	Unclear	Unclear	Clear	Clear	Clear	Clear	Clear
	7	Reliable	Reliable	Unreliable	Not sure	Reliable	Reliable	Reliable
Analysis	8	Not rigorous	Rigorous	Not sure	Not rigorous	Not rigorous	Not rigorous	Rigorous
	9	Rich	Rich	Rich	Not sure	Rich	Rich	Rich
	10	Unreliable	Reliable	Not sure	Unreliable	Unreliable	Unreliable	Reliable
	11	Convincing	Convincing	Convincing	Convincing	Convincing	Convincing	Convincing
	12	Relevant	Relevant	Relevant	Relevant	Relevant	Relevant	Relevant
	13	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate
Ethics	14	Not reported	Appropriate	Not sure	Appropriate	Appropriate	Not sure	Not sure
Overall		+	++	+	_	++	_	++

*A mixed method of study.

Appendix 13

Table of quality assessment of Quantitative studies

	Population			**Method of selection of exposure**					**Outcomes**					**Analyses**				**Summary**	
	1.1	1.2	1.3	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4	3.5	4.1	4.2	4.3	4.6	5.1	5.2
Gelinas & Wright, 2013	++	++	+	+	++	NA	+	+	++	++	++	NA	NA	NA	++	++	+	++	++
Hamza & Willoughby, 2014	++	++	+	+	+	++	+	++	++	NA	NA	++	+	NA	++	NA	++	+	++
Kleindiest, Bohus, Ludascher, Limberger et al., 2008	++	+	+	-	++	NA	+	+	-	+	++	NA	NA	NA	++	++	++	++	++
Pierce, 1986	++	+	++	NR	-	-	++	++	++	+	++	++	+	NR	++	+	++	++	++
Rayner & Warner, 2003*	-	NR	NR	-	++	NR	NR	++	++	+	+	NA	NA	NA	++	+	+	+	++
Ryan, Heath, Fischer & Young, 2008	++	++	++	+	+	NA	+	++	-	++	+	NA	NA	NA	+	++	NA	++	++
Tyler, Melander & Almazan, 2010	++	++	+	++	++	NA	+	+	++	+	+	NA	NA	NA	+	++	++	+	++
Whipple &Fowler, 2011	+	+	-	+	++	+	-	++	++	++	++	++	+	NA	+	++	++	+	+
Zanarini, Laudate, Frankenburg, Wedig & Fitzmaurice, 2013	+	+	+	+	++	+	+	+	++	++	+	NA	+	NA	+	++	++	+	+

*A mixed method of study.

Appendix 14

Epistemological statement

Establishing an epistemological position is important in research and particularly qualitative work, as analysis can be influenced by the researcher. The epistemological position adopted in this study was a position of constructivism. In this position, it was assumed that knowledge was not objective but instead is subjective and is constructed by each individual whom has the knowledge. Creswell (2003) states that research being conducted from this position is not started with a theory in mind, but works towards induct a theory or its finding as it relies on the data that is gathered from participants to reach conclusions. This is reflected in the research's awareness that the data is an interpretation of another's perspective on their experience. This is also in line with the qualitative approach taken in the research, Interpretive phenomenological analysis (IPA). The aim of the research was to understand how another had understood their experience whilst remaining aware of their own view points at all times.

Other viewpoints such as postpositivism were not used at such positions postulate that there is an objective way of viewing the world that cannot be influenced (Mertens, 2005). This was at odds with the aim of the research and the IPA which was best placed to achieve the aim of the research.

IPA was chosen as the approach for this study, as stated above, due to the unique ability the approach has to understand an individual's experience whilst remaining aware of any viewpoints the researcher may hold. The approach is also in line with constructivist viewpoint.

The approach is based on the work of philosophers who focussed on phenomenology such as Husserl, Heidegger and Satre (Smith, Flowers & Larkin, 2011). Each of the philosophers, although sometimes differing in their views, all share a central idea that an individual has their own experience and that this is thought of and experienced in the world. Additionally, IPA is influenced by hermeneutics which looks at the way information is interpreted. This

interpretation is (at the very least) two-fold; how the individual makes sense of their experience and describes in and how the researcher understands and describes how the individual understands and describes their experience. Together and simply put, IPA can be understood as the interpretation of an individual's experience and how they understand this in the wider context of the world. This was central to the research question being asked here.

References

Creswell, J.W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches.* (2nd ed.) Thousand Oaks: Sage.

Lyons, E. & Coyle, A. (Eds.). (2007). Analysisng Qualitative Data in Psychology. (1st ed). London, United Kingdom: SAGE Publications Limited.

Mertens, D.M. (2005). *Research methods in education and psychology: Integrating diversity with quantitative and qualitative approaches.* (2nd ed.) Thousand Oaks: Sage

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*: SAGE Publications Limited.

Appendix 15

Example of analysis

Superordinate themes	Transcript	Emergent themes
Role of others Accessing help when stopping	M; yeah it felt as though I was backed into a corner it like all of a sudden everybody knew everybody was cornering in on me erm I felt really attacked by everyone and very alone I; what kind of things helped then I know you said you got your manager on side at this point and hes trying to help out what else was helpful what wasn't helpful can you remember anything getting in the way M; what wasn't helpful was erm the lack of being able to access something anonymously was the biggest barrier I had because it is so secretive and you don't want everybody knowing and you know I	Lack of help when trying to stop Barriers to help

Judgements Judgements	didn't I didn't want to go to a doctor or a I just wanted to go to this place where I wouldn't have to give my name and I could just get some help but it wasn't that easy at all and I don't whether it was because of my age or or what but it was so hard but erm peoples judgement was also the hardest thing and is still the hardest thing now that I struggle with erm I can cope with people talking about it but it's when people put judgement on it that I find it so hard and it was really hard back then erm self-help sites helped erm I went on a lot of forums as well Erm talk could it be anonymous erm and I think that service would have helped me an awful lot if I had been in a better place I think having more anonymity for people because as soon as anybody knows it immediately has to be passed on to somebody else cos its risky and it's this you know I felt like I was this great big risk and I thought am I am I risk to myself I started questioning myself am I suicidal I didn't think I was why is everybody	Judgements limiting How I see myself and how others see me

	telling me I'm a risk and that was terrifying that they were frightened of me they were so frightened of me because I came in with these marks and no one knew my name and oh my god it's obvious that they were terrified id kill myself yet that was never my intention I; it sounds like it didn't even occur to you that that was something that you wanted to do M; yeah yeah and then you start questioning yourself you think am I is that what I am am I doing this because I'm suicidal I didn't think I was and em and that was awful that was really frightening I; it sounds like it was a pretty big barrier like you said it was barrier and if you were to give advice to somebody who's trying to stop themselves what would you say to them now	
Method for change	M; erm… if they were trying to stop because they wanted to stop I think you have to look past what it is you're doing and look at why why are you doing it and I know it might seem an obvious question	Reasons behind the change

Life changes	and It really isn't and I really didn't think about why it was that I would care for them and yet I know hut myself and I think people really have to look at where they are in their life and what do you need to change what – because it's going to have to be more than that more than just stopping your whole life is going to have to change I; so it's more than just you know burning yourself cutting yourself it's actually what's going on around you M; because it becomes your whole life its it became your focus you know I knew that I could get through a day because I would probably cut myself I made strange rules and all kinds of things and I don't think people realise that they do I made all kinds of rules about I couldn't cut in the same place that place had to heal before I could cut somewhere else I had to care for them and I think people do have them ritualistic things that they just don't realise that they do until it's too late and I can see how people end up going to a&e all the time	Whole life changes

Understanding self.	because they want someone to do that for them they want someone to make it better for them and that was what I was doing for myself and I think you have to look at what it is you haven't got what is missing in your life because that is why you're doing it and your trying to block it out form something else that's horrendous that's probably going on	Reasons for self-harm/less obvious problems