A qualitative study into people's experiences of interventions and support for non-suicidal self-injury (NSSI): Stigma, shame, and society.

Lorna Robinson

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Department of Health and Social Sciences, Faculty of Health and Applied Sciences
University of the West of England, Bristol

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Contents

Acknowledgements

Abstract

In this qualitative study, semi-structured interviews were used to gain an in-depth knowledge of individuals' experiences of interventions and support on their journey to ceasing non-suicidal self-injury (NSSI). Twelve adults from the general public participated and their interviews were analysed using thematic analysis. Four main themes were generated from the data. These were Experiences of professional support, Experiences of informal support, Identity: Impact on sense of self and Importance of relationships. Participants spoke about unhelpful, detrimental interactions when attending accident and emergency (A&E) and when on mental health wards. They also spoke about their fear of reaching out as they worried about the consequences of being sectioned under the mental health act and being forced to take medication. Overall, participants found therapy beneficial except for those aspects of interventions where support was withdrawn following NSSI. Participants valued informal support such as self-help, family, and support from the community. The detrimental impact on sense of self that unhelpful interventions/support afforded was evident, creating or exacerbating feelings of shame, stigma, internalised oppression, low self-worth, alienation and social isolation. The opposite effect was evident when positive and helpful interactions occurred. Participants shared the importance of consistency and connection when forming relationships, enabling feelings of safety and trust. Implications include the need for professionals and the community to reflect on how they respond to people presenting with NSSI and adjust their responses accordingly as well as the need for more education, training and supervision.

Introduction

Background to the research

Non-suicidal self-injury (NSSI) is a behaviour that has been defined as the intentional, direct injuring of one's body tissue without suicidal intent and for purposes not socially sanctioned (Klonsky & Muehlenkamp, 2007; Muehlenkamp, 2005). This behaviour has also been defined as self-wounding (Tantam & Whittaker, 1992), moderate self-mutilation (Favazza & Rosenthall, 1993), parasuicide (Ogundipe, 1999) and deliberate self-harm (DSH) (Pattison & Kahan, 1983), to give a few common examples. It is important to note that these definitions may also include suicidal intent (Hagell, 2013).

The most common method of NSSI is skin cutting. This is achieved using a sharp implement, while the main areas of the body to be cut are the arms, legs and stomach. Other forms of NSSI include banging, burning, scratching, hitting body parts and interfering with wound healing (Klonsky & Muehlenkamp, 2007; Whitlock, Muehlenkamp, & Eckonrode, 2008), although people who self-injure may use more than one method (Gratz, 2001; Whitlock et al., 2011). Estimates of how many times an individual self-injures in their lifetime are variable, but it is reported to be a mean of 50 times (Favazza & Conterio, 1989), although some individuals have reported as many as 400 separate acts of NSSI (Ross & McKay, 1979).

Age of onset is typically between 12 and 24 (Cerutti, Manca, Presaghi, & Gratz, 2011; Muehlenkamp & Gutierrez, 2007; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006), although NSSI behaviour has also been reported in children under the age of 12 (Barrocas, Hankin, Young, & Abela, 2012). It is believed that NSSI in adolescents and the younger population is increasing, and although a lack of empirical data from earlier cohorts makes it hard to support this trend, scholars have found that 17% of the student population has exhibited self-injurious behaviours (Whitlock, Eckenrode, & Silverman, 2006). Indeed, authors of meta-analysis and meta-review cited lifetime NSSI prevalence rates as 17% among adolescents (Swannell, Martin, Page, Hasking, & St. John, 2014).

The majority of NSSI knowledge has been gained from research conducted with the patient population (Klonsky & Muehlenkamp, 2007). However, many who engage in NSSI may not present at hospital, as NSSI is often private (Hagell, 2013). This factor has possibly contributed to the varying estimates in studies of the prevalence of NSSI (Nock, 2010). Amongst some studies from the general public, it has been reported that approximated that 13%-45% of adolescents (Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007; Plener, Libal, Keller, Fegert, & Muehlenkamp, 2009) and 4% of adults (Klonsky, Oltmanns, & Turkheimer, 2003) have engaged in NSSI at some point in their lives.

However, some clinical samples report NSSI percentages of between 40%-60% (Darche, 1990; DiClemente, Ponton, & Hartley, 1991) in adolescents and 21% in adults (Briere & Gill, 1998).

There is conflicting evidence about the rates of NSSI for men and women. In one study conducted with a college sample, it was found that women self-injure more than men (Whitlock et al., 2006), whereas authors conducting studies with the general population and clinical samples reported similar overall rates for men and women (Briere & Gil, 1998). There is evidence to suggest that women engage in cutting more than men (Rodham, Hawton, & Evans, 2004; Whitlock et al., 2006; Whitlock et al., 2011), while men are more likely to hurt themselves by punching objects (Klonsky, Muehlenkamp, Lewis, & Walsh, 2011) and engaging in self-battery (Whitlock et al., 2008). Whitlock et al. (2006) suggest that women may be more likely to injure their thighs and wrists, whereas men may be more likely to injure their hands.

It is important to consider ethnicity and NSSI. However, research in this area is scant (Klonsky et al., 2011). Rates of NSSI in a college sample have been reported as higher in Caucasians than non-Caucasians (Gratz, 2006), although Whitlock et al. (2006) reported a modest significant effect for ethnicity amongst their college sample. In the UK, researchers not exclusively focusing on NSSI suggest that self-harm (including that with suicidal and non-suicidal intent) is highest in Asian women (Bhugra, Desai, & Baldwin, 1999). Authors of a systematic review conducted in Australia (Black & Kisely, 2018) reported that NSSI rates are not significantly different between indigenous and non-indigenous Australians. They also highlighted that cultural differences should be considered when assessing rates of NSSI, as some forms of NSSI have a cultural purpose, meaning what is defined as NSSI may vary.

Klonsky (2009) and Nock, Prinstein and Sterba (2009) each found support for affect regulation to be the primary function of NSSI, regardless of the different research methods used. Other intrapersonal reasons for engaging in NSSI reported include self-punishment (Klonsky, 2009), an anti-suicide function to extinguish suicidal thoughts, and an attempt to feel something when experiencing depersonalisation or numbness (Gratz, 2007; Klonsky, 2007; Klonsky & Glenn, 2009). Social reasons have also been identified as an NSSI function, albeit on a lesser scale (Lewis & Arbuthnott, 2012). One such reason is to communicate internal distress to others (Klonsky, 2007; Lewis & Santor, 2008).

Researchers have shown that individuals who self-injure are more likely to exhibit psychological characteristics such as negative emotionality, deficits in emotion skills and self-derogation. Andover, Pepper, Ryabchenko, Orrico and Gibb (2005) found that non-suicidal self-injurers from a non-clinical sample reported significantly more symptoms of depression and anxiety than the control group.

Gratz (2006) found that individuals who self-injure are more likely to have difficulties expressing their emotions compared to those who do not, and many scholars have linked self-derogation to NSSI (Herpertz, Sass, & Favazza, 1997; Klonsky et al., 2003; Soloff, Lis, Kelly, Cornelius, & Ulrich, 1994). Indeed, it has been suggested that self-derogation and self-punishment may drive NSSI (Klonsky et al., 2011).

Individuals who engage in NSSI appear to have an increased online presence compared to those who do not (Mitchell & Ybarra, 2007). Mitchell and Ybarra (2007) suggest that increased online activity has the potential to increase the likelihood of placing individuals in risky situations. During the past decade, Lewis and colleagues have researched activity on the internet in relation to NSSI (De Riggia, Lewis, & Heath, 2018), albeit predominately focusing on adolescents and young adults. This has allowed a window into various online communities such as on YouTube (Lewis, Heath, Sornbeger, & Arbuthnott, 2012; Lewis, Seko, & Josh, 2018), Tumblr (Seko & Lewis, 2018), and Yahoo! (Lewis, Rosenrot, & Messner, 2012). This has highlighted individuals' motivation to seek support online (De Rigga et al., 2018; Rodham, Gavin, Lewis, St. Denis, & Bandalli, 2013), as well as the need to seek validation (Lewis et al., 2012). It was also found that some responses were invalidating (Lewis et al., 2012), and the nature of some activity may maintain NSSI, rather than offering narratives of recovery (Lewis et al., 2012).

There has been much interest in including NSSI as a separate disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013; Muehlenkamp, 2005), where it is currently classed as a symptom of borderline personality disorder (BPD). In the DSM-5, NSSI is identified as a condition for further study (DSM-5; American Psychiatric Association, 2013; In-Albon, Ruf, & Schmid, 2013). There is robust evidence that individuals who engage in NSSI show more symptoms of BPD than those who do not (Andover et al., 2005), but there is also an increased likelihood of NSSI from other diagnoses.

However, NSSI does not itself necessarily imply the presence of another disorder (Klonsky & Muehlenkamp, 2007). For example, in a study on impulsivity in NSSI behaviour, Herpertz et al. (1997) explored psychometric and biological findings to find that many individuals were left without a primary diagnosis when NSSI was controlled statistically. Of those who did engage in NSSI, only 28% met the diagnostic criteria for BPD.

Further, Favazza and Rosenthal (1990) reported that many individuals no longer meet diagnostic criteria for BPD when their NSSI stops. Favazza and Rosenthal (1990) identified a bias in the field that means personality disorders are diagnosed according to whether individuals engage in NSSI or not,

which has led to NSSI being thought of as an associated, rather than separate syndrome. Muehlenkamp (2005) proposed that adopting an NSSI syndrome would increase the quality and amount of focused research on NSSI itself. Indeed, the idea that NSSI is an indicator of BPD has been refuted (Klonsky et al., 2011), further suggesting that NSSI is not indicative of a single diagnosis (Klonsky & Olino, 2008; Whitlock et al., 2008).

In contrast with the above, some researchers believe that NSSI represents a lesser form along a continuum shared with suicidal behaviours (Linehan, 2000; Stanley, Winchel, Molcho, Simeon, & Stanley, 1992). More recently, Kapur, Cooper, O'Connor and Hawton (2013) expressed concern that creating a new diagnosis of NSSI could stigmatise many young people unnecessarily, especially given that NSSI generally reduces in adolescents as they mature. Lewis, Bryant, Schaefer and Grunberg (2017) asked individuals who had lived experience of NSSI for their views on including NSSI in the DSM-5 as a condition warranting further study. Several advantages for doing so were identified, including an increased understanding of and reduction in the stigma associated with NSSI, encouragement for seeking help and facilitation of NSSI treatment, including validation of the NSSI experience. Disadvantages identified included the fear of increased stigma attached to NSSI and less focus on underlying concerns (Lewis, Bryant, Schaefer, & Grunberg, 2017).

Most authors have focussed on the younger generation, with comparatively fewer studies being conducted with adults (Kapur et al., 2013). Nevertheless, Lamprecht, Pakrasi, Gash and Swann (2005) suggested that there may be an increase in NSSI in elderly men, although a further longitudinal study to confirm these findings was suggested.

Researchers suggest that those who engage in NSSI are at increased risk of losing their lives. Although individuals engaging in NSSI may not intend to end their lives (Klonsky, 2007), if NSSI becomes more frequent and intense, it may lead to accidental death (Favazza, 1998; Favazza & Rosenthal, 1993). Many authors have suggested that NSSI may be an especially important risk factor for suicidal behaviour (Klonsky et al., 2014). Klonsky, May and Glenn (2013) found NSSI to be more strongly associated with a history of suicide attempts than other established risk factors for suicide such as BPD, anxiety, depression and impulsivity. Also, there is a growing body of longitudinal evidence to show that NSSI is a strong predictor of future suicide attempts, more than even a history of past suicide attempts (Guan, Fox, & Prinstein, 2012).

Taking into account the number of people who engage in NSSI (DiClemente et al., 1991; Klonsky et al., 2003; Lloyd-Richardson et al., 2007; Plener et al., 2009), it is perhaps surprising to find that little research has been conducted around interventions and support for NSSI, especially research that

gives a voice to those with lived experience. Much of the research into NSSI interventions has also included different criteria for inclusion into the study or applied treatments primarily developed for related conditions, such as BPD or suicidality (Klonsky, Victor, & Saffer**,** 2014).

Given the implications of NSSI for individuals, it is vitally important that more research into interventions and support for NSSI is undertaken. Although NSSI is said to decrease with maturity (Walsh & Rosen, 1988), and some individuals manage to cease naturally (Buser, Pitchko, & Buser, 2014), others increase their NSSI (Andrews, Martin, Hasking, & Page, 2013), highlighting the importance of early intervention. As stated earlier, it is approximated that 13%-45% of adolescents in community samples (Lloyd-Richardson et al., 2007; Plener et al., 2009) and 4% of adults (Klonsky, Oltmanns & Turkheimer, 2003) state they have self-injured at some point in their lives.

NICE guidelines and evidence-based interventions

Psychotherapies that appear to be the most effective interventions for people who engage in NSSI are those that call on emotional regulation, functional assessment and problem-solving. As many of the existing studies are focussed on NSSI in the context of individuals diagnosed with BPD, it is sensible to think of those studies as research-informed rather than research-supported (Klonsky et al., 2011).

NICE guidelines on interventions for self-harm recommend an individual should be offered three to 12 sessions of a psychological intervention, specifically structured for people who self-harm, with the aim of reducing that behaviour. The intervention should be tailored to individual needs and may include cognitive behavioural, psychodynamic or problem-solving elements. NICE also suggest that therapists should be trained and supervised in the therapy they are offering and should also be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm (NICE, 2011). The NICE guidelines do not stipulate whether self-harm is without suicidal intent, but instead refer to self-harm and attempted suicides (such as under the guideline for BPD) (NICE, 2009), therefore inferring self-harm is non-suicidal alone.

There is a growing body of evidence to support the use of cognitive behavioural interventions for people who engage in NSSI (Klonsky et al., 2011). Such interventions have been tested more than any other approach (Klonsky et al., 2011). Indeed, cognitive behavioural therapy (CBT) is the most widely used evidence-based practise for improving mental health generally and is guided by empirical research (Beck, 2011). Although Beck's short term, structured, present-orientated psychotherapy was originally designed to treat depression, it is now used for many mental health conditions. Based on the belief that psychological disorders are developed and maintained by

thought distortions and maladaptive behaviours (Field, Beeson, & Jones, 2015), CBT practitioners aim to challenge unhelpful cognitions such as thoughts and beliefs, and have the option of focusing on behaviours (Beck, 2011). Support for standard CBT in relation to NSSI has been documented (Crowe & Bunclark, 2000).

Problem-solving therapy (PST), which is considered to be under the CBT umbrella, is another psycho-social intervention which is aimed at enhancing an individual's ability to cope with minor and major stressors and, subsequently, to enhance mental and physical health (Nezu, Nezu, & D'Zurilla, 2013). The main treatment goals of PST include acquiring an adaptive orientation to problems, which may be achieved by acceptance, positive self-efficacy, optimism and effective implementation of specific problem-solving behaviours such as emotional regulation and management (Nezu et al., 2013). In a meta-analysis, Townsend et al. (2001) found that PST may reduce NSSI.

There is some evidence that psychodynamic treatments effectively reduce self-injury (Klonsky et al., 2011), while NSSI treatments appear to share particular aspects, such as understanding past and current relationships, emotional intelligence and a focus on developing self-image (Klonsky et al., 2007). Bateman and Fonagy (2001) and Korner, Gerull, Meares and Stevenson (2006) included NSSI as an outcome variable when using a psychodynamic treatment. Both studies reported significant reductions in NSSI that were maintained more than one-year posttreatment. Clarkin, Levy, Lenzenweger and Kernberg (2007) demonstrated the effectiveness of transference focussed therapy (TFP) for reducing self-injury (including NSSI) in women diagnosed with BPD. In another study about individuals with BPD (Martens, 2006), it was found that cognitive analytic therapy (CAT), which combines cognitive and dynamic therapies, was associated with a decrease in NSSI.

Interestingly, if one has been given a diagnosis of BPD with a focus on reducing self-harm, NICE guidelines (2009) state not to use brief psychological interventions of less than three months. Additionally, NICE recommends that for women with BPD and for whom reducing recurrent self-harm is a priority, comprehensive dialectical behaviour therapy (DBT) should be considered (NICE, 2009). Therefore, NICE suggests longer-term treatments for individuals presenting with NSSI and BPD than NSSI alone, albeit still with a focus on reducing self-harm.

Linehan's comprehensive, evidence based DBT (Linehan, 2015) evolved from efforts to create a treatment for women with complex presentations and a history of attempted suicide. The standard DBT treatment package consists of weekly individual therapy sessions, a weekly group skills training session, and a therapist consultation team meeting (Chapman, 2006). Skills training includes sessions on mindfulness, emotional regulation, interpersonal effectiveness and distress tolerance (Linehan,

1993). The use of randomised clinical trials (RCTs) has demonstrated that DBT is an efficacious and specific treatment for BPD (Chapman, 2006) which has promise for reducing NSSI (Linehan et al., 2006).

In addition to DBT, other long-term approaches to treatment have emerged. Mentalization-based therapy (MBT) is a long-term psychotherapy which is used with people diagnosed with BPD (Fonagy & Bateman, 2006). As with DBT, MBT treatment can last for a year or more. One of the criteria for the diagnosis of BPD is recurrent mutilating behaviour (DSM-5; American Psychiatric Association, 2013), therefore MBT could be recognised as a suitable treatment for NSSI. Mentalization is, in essence, the ability to think about thinking. By increasing the client's capacity for mentalization to stabilise their sense of self, emotions and relationships, it is hoped that the client will gain better behavioural control, increased affect regulation, more intimate and gratifying relationships and the ability to pursue life goals (Fonagy & Bateman, 2006). Rossouw and Fonagy (2012) reported that adolescents who self-harmed found MBT effective for reducing self-harm and depression compared to treatment as usual (TAU).

An emerging therapy, influenced by the work of Fonagy and Bateman (2006), is that of adaption-based process therapy (APT) (Fairfax & Gillies, 2012). This therapeutic approach is intended for work with complex client presentations and individuals who have been diagnosed with a personality disorder. APT is an alternative model of working, as psychological distress is understood as an understandable adaptation to traumatic life events rather than from the position of a diagnosis. The therapy is intended to enhance self-awareness of understanding our usual ways of being in the world, and our emotional life in the present. APT can be offered individually, but also in a 10-session group (Fairfax & Gillies, 2012). Although still being developed, early psychometric measures indicate clinically significant change, although at present this is too small to report on with any confidence.

Following on from this, another option is integrative therapy. This is a progressive form of psychotherapy that draws on and combines interventions from different therapeutic approaches to fit the needs of the client. Using various evidence-based treatments, an integrative therapist can gain a sense of what elements need to be combined to suit an individual client and presentation. In this sense, it is a flexible, inclusive approach (Zarbo, Tasca, Cattafi, & Compare, 2016).

In summary, the interventions NICE suggest for self-harm include CBT, psychodynamic or problem-solving elements, the suggestion therapists work collaboratively for a period of three to 12 sessions to identify the problems causing distress or leading to self-harm (NICE, 2011). For self-harm with a diagnosis of BPD, NICE Guidelines recommend a psychological intervention for longer than three

months. DBT was suggested but other interventions such as MBT (Fonagy & Bateman, 2006) and APT (Fairfax & Gillies, 2012) are also used with individuals living with BPD, NSSI and complex presentations.

Literature review

In this review, literature relating to individuals presenting with NSSI will be examined. There will be a focus on papers that report and explore feelings, attitudes and experiences experienced by individuals presenting with NSSI as well as societal perceptions and behaviour towards these individuals. Literature on stigma, shame, alienation and social isolation, prejudice, discrimination and oppression as well as self-concept will initially be presented. These are issues that have already been discussed in the literature relating to NSSI as well as becoming evident in the present study.

In the latter part of the chapter, interventions that have been applied to individuals presenting with NSSI will be reviewed. The first part will contain studies about closely related syndromes such as BPD which encompass NSSI, while the latter part will contain studies directly with participants who engage in NSSI.

Stigma

Stigma generally refers to negative prejudicial attitudes which lead to negative actions and discrimination (Penn & Wykes, 2003). Perceived stigma may influence whether people reach out for help (Cleary, 2017; Rowe et al., 2014), leading to a negative impact on treatment outcomes, isolation and rejection (Markowitz, Angell, & Greenberg, 2011).

Stigma towards people who engage in NSSI has been observed in attitudes from A&E staff (Mackay, 2005), healthcare students, non-healthcare students (Law, Rostill-Brookes, & Goodman, 2009) and nurses (Karman, Kool, Poslawsky, & Van Meijel, 2015). Indeed, the stigma surrounding NSSI (Adler & Adler, 2007; Hodgson, 2004; Lewis, Michal, Mahdy, & Arbuthnott, 2014) is one factor that most likely influences an individual's decision to discuss NSSI with others (Rosenrot & Lewis, 2018). Chaudoir and Quinn (2010) highlight that positive first disclosure experiences may have psychological benefits over time as they will increase the level of trust in others, although they were writing about revealing concealable stigmatized identities rather than specifically NSSI.

The attribution model of public discrimination was developed to understand the mechanisms underlying stigma and discrimination towards persons with mental illness (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). Lloyd, Blazely and Phillips (2018) aligned the attribution model of public discrimination with NSSI stigma, as perceptions of higher personal responsibility for NSSI behaviour as well as higher levels of danger and manipulation were positively associated with stigmatising attitudes and behaviours. Male university students reported significantly higher levels of stigmatising attitudes and behaviours than female students did. Rosenrot and Lewis (2018) emphasised the importance of initiatives to reduce NSSI stigma and foster supportive and

understanding responses to NSSI disclosures. They suggested endeavours to increase universal awareness and a prevention program to create social climates that are accepting of and prepared for self-injury disclosures. They discussed campaigns which encourage discourse around mental illness, working on the rationale that sharing one's distress with others will jumpstart a conversation and help to reduce stigma. Indeed, studies with nurses and hospital staff have indicated that stigma may be influenced by fear (O'Connor & Glover, 2017), lack of education and training as well as lack of confidence (Gibb, Beautrais, & Surgenor, 2010). Indeed, some authors found promise where education had indeed been employed (Karman et al., 2015).

Shame

Shame is also present when exploring the feelings of those who present with NSSI or have done so in the past (Duggan, Heath, & Hu, 2015). Indeed, scholars have supported a relationship between shame and NSSI severity, frequency and occurrence (Brown, Linehan, Comtois, Murray, & Chapman, 2009; Duggan et al., 2015; Rosenrot & Lewis, 2018; Schoenleber, Berenbaum, & Motl, 2014; VanDerhei, Rojahn, Stuewig, & McKnight, 2014).

Shame is an emotion characterised by feelings of being inferior, immoral and socially unacceptable (Blythin et al., 2018; Tangney & Dearing, 2002). It is a painful, complex emotion, which involves global self-devaluation, termed internal shame, as well as negative evaluations of the self by others, sometimes labelled external shame (Tangney & Dearing, 2002; Tangney, Stuewig, & Mashek, 2007). Therefore, shame can be seen as indicative of a negative self-concept (Taylor, McDonald, Smith, Nicholson, & Forrester, 2019). Indeed, in their study with a sample of adolescents, Xavier, Gouveia and Cunha (2016) found that external shame, hated self and fear of self-compassion indirectly predict NSSI, through their effects on depression and daily peer hassles.

As shame is an aversive emotional state, it may lead to NSSI as a means of regulating, avoiding or punishing oneself (Mahtani, Melvin, & Hasking, 2018; Taylor et al., 2018). Although comparisons were limited by a small sample size, Duggan et al. (2015) did not find any differences in feelings of shame between people with current and past experiences of NSSI. Taylor et al. (2019) also found that although shame continued to distinguish between participants with and without experiences of NSSI, it did not distinguish past and current NSSI. They suggested that shame remained elevated in individuals who engaged in NSSI, as well as those who had not engaged in NSSI for a duration of 12 months (Taylor et al., 2019). They speculated that whilst feelings of shame are relevant in the onset of NSSI, shame is less important its maintenance. They also thought it possible that the elevated shame observed in people with a history of NSSI represents a consequence of this behaviour, rather than a cause, which may be linked to the stigma and taboo surrounding NSSI (Taylor et al., 2019).

Given that they found that shame was also associated with the frequency of thoughts about NSSI in the past month, supporting the idea that feelings of shame could drive NSSI urges, they wondered if there may be other factors that contribute to the subsequent emergence of NSSI (Taylor et al., 2019).

McDermott, Roen, and Scourfield (2008) highlighted how shame encourages social withdrawal and secrecy, therefore possibly fostering NSSI over more adaptive means of coping such as seeking social support (Taylor et al., 2019). Rosenrot and Lewis (2018) identified shame as a barrier to NSSI disclosure. Participants spoke of shame as being either a difficult feeling that prevented them from sharing about their NSSI, or an accompanying feeling when speaking of it. Shame was also reported when considering NSSI in general. Participants' experiences of responses to their disclosure of NSSI were also discussed, with themes of silence and avoidance highlighted. Rosenrot and Lewis (2018) discussed how these common responses may increase NSSI-related shame. Indeed, shame has been found to hinder disclosure of wider emotional distress to friends, family and professionals (Hook & Andrews, 2005; Macdonald & Morley, 2001) and reduce the likelihood of accessing treatment for emotional and mental health problems (Corrigan, 2004; Hinshaw & Cicchetti, 2000). Additionally, shame-proneness was often reported as a reason for non-disclosure in therapy in a sample who had received treatment for depression (Hook & Andrews, 2005).

Alienation and social isolation

Following on from McDermott et al.'s (2008) finding that shame encourages social withdrawal and secrecy, feelings and experiences of alienation and social isolation have also been explored when considering NSSI (Castille et al., 2007). Alienation is the feeling that one is isolated from the rest of the world, is not part of any group or community, or/and is different from other people (Castille et al., 2007). It encompasses social isolation, which refers to the feeling of being segregated from one's community (Kalekin-Fishman, 1996). Although generally experienced as personal stress (Neal & Collas, 2000), alienation can lead to more serious mental health issues (York, Cornwell, & Waite, 2009). Neal and Collas (2000) stated that although it is experienced as personal stress, its sources are deeply embedded in the social organisation of the modern world. They feel that with increased isolation, our main interactions are with strangers rather than individuals with whom we have ongoing social relationships. Moreover, if the interactions of individuals who feel socially isolated are more negative and less subjectively satisfying (Hawkley, Preacher, & Cacioppo, 2007), this contributes to a vicious cycle in which a person becomes more and more isolated.

Cacioppo and Hawkley (2009) highlighted the issues that can arise from perceived social isolation and cognition. They found a heightened sensitivity to social threats and a confirmatory bias in social

cognition that is paradoxically both self-protective and self-defeating. They also observed heightened anthropomorphism and contagion, which they believe threaten social cohesion. They discuss whether loneliness is contagious, suggesting that driving away those who are lonely functions to keep the contagion in check, therefore leading people who feel socially isolated to becoming objectively more isolated. Cacioppo and Hawkley (2009) asked if the collective rejection of isolates observed in humans and other primates may therefore serve to protect the structural integrity of the social entities necessary for humans to survive and prosper.

Interestingly, Castille et al. (2007) found various schemas that differentiated repetitive NSSI from non-NSSI and from those who had engaged in only one episode of NSSI. These schemas are social isolation/alienation, defectiveness/shame. The social isolation/alienation schema was also found to be endorsed more strongly as the number of NSSI episodes increased.

Castille et al. (2007) discussed that individuals who frequently engage in NSSI report that they do so after experiencing rejection, separation or feelings of loneliness (Herpertz, 1995). These are feelings of individuals who endorse the social isolation/alienation schema; they feel isolated, not part of any group and different from others. Since feelings of loneliness often precede engaging in NSSI, it is not surprising that the more strongly one endorses this schema, the greater the number of times one will engage in NSSI (Castille et al., 2007).

Prejudice, discrimination and oppression

Prejudice, discrimination, and oppression must also be considered when discussing NSSI. These are three distinct realities and concepts, although the terms have at times been conflated and used interchangeably (Justice, 2018). Individuals are not born with prejudice; it is learnt via socialisation and becomes internalised through culture. Prejudices are feelings and attitudes based on limited knowledge and contact of other groups, and which rely on stereotypes. Discrimination, that is, making choices based on stereotypes and prejudgments, is the action that comes from prejudice. This can mean avoiding certain people and places, and although all humans can discriminate, it can be unlearned and not enacted (Justice, 2018).

Oppression is the combination of prejudice and discrimination plus institutional and historical power (Justice, 2018). It is the harmful and malicious pattern of control and unjust treatment which is practised by a societal group or regime. Oppression is determined by controlling discrimination and prejudice within the social, legal, ideological and day-to-day contexts that are rooted in structural, ideological, institutional and historical forms of power. Not all individuals can oppress; only those who profit from historical and institutional power (Justice, 2018).

Internalised oppression occurs when individuals from an oppressed group are socialised into accepting and therefore perpetuating their own oppression. This can be through beliefs, behaviours, attitudes and actions which support the oppressive system, making it seem like it is right and justified (Justice, 2018).

Staples, Neilson, Bryan and George (2018) researched the role of distal minority stress and internalised transnegativity in suicidal ideation and NSSI among transgender adults. They defined internalised prejudice as a phenomenon observed among various marginalised groups that refers to the internalisation of negative societal attitudes about one's group, leading to a devaluation of self and poor self-regard. They suggested that societal-level interventions may be more effective than individual-level interventions for reducing NSSI. Suggested interventions appeared to focus on NSSI indirectly, including policy changes and education about diversity in gender identity. Staples and colleagues (2018) felt that this may help reduce the generalised stigma present in the cultural milieu and therefore assist in protecting trans individuals against internalised transnegativity. Constructs representing forms of internalised prejudice have been widely studied among sexual minority individuals (Staples et al., 2018). In one such study, it was found that internalised homophobia was significantly related to reduced mental health, including NSSI, suicidal ideation and substance use, among individuals who identified as lesbian, gay, and bisexual (Meyer, 2003).

Self-concept

The self-concept has significance for people who engage in NSSI (Taylor et al., 2019). However, there has been little research on NSSI and self-concept integration (Taylor et al., 2019). Taylor et al. (2019) felt that the way a person felt about and perceived themselves (that is, self-concept) was central for understanding NSSI. They investigated three variables linked to self-concept, one of which was self-concept integration. They examined how well these variables differentiate adults who reported current NSSI, those who reported past NSSI and those who have never engaged in NSSI. They suggested that self-concept integration may fluctuate more dynamically in relation to the recency of NSSI. Self-concept integration was lowest for participants reporting current NSSI, distinguishing them from individuals without a history of NSSI. However, adjusting for other variables did not differentiate participants who reported past NSSI and those with no NSSI history. Hence, self-concept integration acted as a dynamic marker of NSSI which fluctuates in relation to the recency of NSSI (Taylor et al., 2019). This provides preliminary evidence that poorer self-concept integration is associated with current NSSI. Taylor et al. (2019) stated that although recent theoretical models of NSSI have emphasised the importance of self-concept in the occurrence of NSSI (Hasking, Whitlock, Voon, & Rose, 2017), arguably these processes are not developed sufficiently and do not recognise

the potential relational nature of NSSI. Indeed, Lear and Pepper (2016), in a paper focusing on self-concept clarity and emotional dysregulation in NSSI, found that NSSI frequency was not significantly predicted by emotion regulation, but that clarity of self-concept reached marginal significance in their sample of undergraduate students.

Claes, Houben, Vandereycken, Bijttebier and Muehlenkamp (2010) focussed on the association between NSSI, self-concept and acquaintance with self-injurious peers in a sample of adolescents. They found that negative self-concept was associated with NSSI. Adolescents who engaged in NSSI rated themselves lower on emotional stability, social skills, physical attractiveness and academic intelligence than their non-NSSI peers.

Building on the idea that self-concept has three components – namely self-esteem (self-worth), self-image and ideal self (Rogers, 1959) – Claes et al. (2010) found that the individuals who participated in NSSI had more friends who also engaged in NSSI, and that having more friends who engaged in NSSI was negatively related to self-esteem. The authors wondered if adolescents with low self-esteem were more likely to be attracted to peers who engaged in NSSI or if those with low self-esteem are more likely to copy NSSI as a way of managing feelings or to gain an identity in their peer group. Other authors have found self-harm to be associated with low self-esteem (De Leo & Heller, 2004; Hawton, Rodham, Evans, & Weatherall, 2002; Lundh, Karim, & Quilisch, 2007).

In Chaudoir and Quinn's (2010) paper about revealing concealable stigmatised identities, they comment that first disclosure experiences (although not necessarily those related to NSSI) are of great importance and can impact self-esteem. They found that individuals with positive first-disclosure experiences also had higher current self-esteem.

Forrester, Slater, Jomara, Mitzmanc and Taylor (2017) conducted a systematic review of research into self-esteem and NSSI in adulthood. They identified 17 studies and reported a significant negative relationship between self-esteem and NSSI. Lower self-esteem was indicated in those with experiences of NSSI versus those without. However, these authors felt that their results suggested that while low self-esteem and NSSI are related in both clinical and nonclinical populations, there are several other factors which also influenced this relationship.

Interventions and support

Consistent with the current study, this literature review includes interventions for the adult population. As various authors have explored self-harm which also includes suicidal intent, the review has been divided into two subheadings: research conducted with closely related syndromes and research conducted with NSSI or similar criteria.

The former subsection is focused on studies that include the term 'regardless of intent', which means self-harm with or without a suicidal intention. Participants in the first two studies had to have a diagnosis of a personality disorder (Davies, Bell, Irvine, & Tranter, 2011; Linehan et al., 2006), emphasising how NSSI was historically only thought of as a symptom of BPD. The following four papers are reviews of studies with patients in either a hospital or general practitioner (GP) setting who underwent interventions (Bennewith et al., 2002; Evans, Morgan, Hayward, & Gunnell, 1999; Kapur et al., 2013; Morgan, Jones, & Owen, 1993), leading onto three quantitative studies with patients, calling attention to the prevalence of patient studies. However, these studies differ from the second subsection, as the interventions use therapies based on evidence-based practice (Booth, Keogh, Doyle, & Owen, 2014; Tapolaa, Lappalainen, & Wahlström, 2010; Slee, Garnefski, Leeden, Arensman, & Spinhoven, 2008). In the penultimate study, Hawton and colleagues (1998) highlighted the complex nature of the term self-harm and the various definitions employed by different authors. The final, qualitative, study highlights the dominance of quantitative studies in the area of self-harm (Cooper et al., 2011).

A number of these studies, in which the focus is self-harm rather than NSSI, were conducted in the UK, illuminating the dominance of this approach in the UK. This trend is not observed when reviewing studies of interventions purely for NSSI. In the latter subsection on research conducted with NSSI or similar criteria, only three of the ten studies originated in the UK. The first two studies discussed (Gratz & Gunderson, 2006; Gratz, Tull, & Levy, 2014) are quantitative, and like two studies in the last subsection, have a focus on patients with a diagnosis of BPD. The third study is a quantitative UK study (Tyrer et al., 2003) about patients which does not include a clear definition of NSSI.

Following this, seven qualitative studies are discussed, only two of which came from the UK (Huband & Tantam, 2004; Long, Manktelow, & Tracey, 2015). Students were recruited for five of these studies (Buser et al., 2014; Gelinas & Wright, 2013; Long et al., 2015; Shaw, 2006; Whitlock, Prussien, & Pietrusza, 2015) albeit Long et al. (2015) also recruited from the community, and patients were recruited for the remaining two (Huband & Tantam, 2004; Kool, Meijel, & Bosman, 2009). None of the authors recruited purely from the community.

Research conducted with closely related syndromes

Both Davies et al. (2011) and Linehan et al. (2006) focussed on participants with a specific diagnosis, therefore excluding all individuals who may engage in self-injury but not meet the criteria for a diagnosis of emotionally unstable personality (ICD-10 F60.31) (World Health Organization, 1992) or BPD.

Davies et al. (2011) considered the feasibility of self-administered acupuncture as an alternative to deliberate self-harm (DSH). They did not clarify whether participants needed to be free of suicidal intent, but participants were required to fulfil the criteria for emotionally unstable personality (World Health Organization, 1992), meaning they were not looking at self-injury alone. Ten participants were taught to self-acupuncture over a period of six weeks. During this period, participants recorded their feelings, thoughts, emotional distress and coping behaviours. The authors concluded that the use of self-administered acupuncture may reduce emotional distress and the frequency of self-harm behaviour.

Similarly, Linehan's research team conducted a two-year RCT and follow-up of DBT versus therapy from experts on suicidal behaviours and BPD (Linehan et al., 2006). Clinically referred women with recent suicidal and self-injurious behaviours meeting the DSM-4 criteria for BPD were matched with controls. DBT was associated with better outcomes in the intent-to-treat analysis than community treatment by experts in most target areas during the two-year treatment and follow-up period. Participants receiving DBT were half as likely to make a suicide attempt, required less hospitalisation for suicidal ideation, and had a lower medical risk across all suicide attempts and self-injurious acts combined. Both sets of authors (Davies et al., 2011; Linehan et al., 2006) found support for their chosen intervention, but it is hard to ascertain how effective these interventions were specifically for NSSI, and if indeed all participants engaged in NSSI.

The following three studies (Bennewith et al., 2002; Evans et al., 1999; Morgan et al., 1993) are examples of early research in the UK which was intended to reduce self-harm by intervening when patients presented in a hospital or GP setting. All the studies included participants who had suicidal and non-suicidal intent. No statistically significant reduction in self-harm was found, and authors of a fourth study (Kapur et al., 2013) found an increase in self-harm behaviours.

Working in the UK, Morgan et al. (1993) focussed on individuals who presented at hospital for their first episode of DSH (including suicidal and non-suicidal intent). They were offered rapid, easy access to an on-call psychiatrist, as well as being encouraged to seek help at an early stage if the need arose. Analysis of follow up data one year later showed a reduction in the rate of DSH for the experimental group compared to the control group. However, the difference reported was not enough to reach statistical significance. Evans et al. (1999) followed on from Morgan et al. (1993) by including individuals who had self-harmed (regardless of intent) more than once. They followed participants up at six months and found that the intervention, in which the experimental group were offered access to an emergency telephone when needed, had no significant effect on the overall repetition rate in self-harm. Similarly, Bennewith et al. (2002) evaluated the impact of an

intervention on the incidence of repeat episodes of DSH in a UK sample. Self-harm in this study was defined regardless of intent and therefore integrated suicidal intent and non-suicidal intent. The intervention group members received a letter from a GP inviting them to a consultation, while the GPs were given guidelines on assessment and management of DSH to use in these sessions. The incidence of DSH did not differ significantly for those in the intervention group compared to the control group. Therefore, the intervention did not reduce the incidence of repeat self-harm.

Using a similar but slightly more proactive approach, authors of another UK study (Kapur et al., 2013) defined self-harm as an act of intentional self-injury or poisoning irrespective of the apparent purpose of the act. Their study was a pilot RCT, with 66 participants presenting with self-harm in two hospitals. They compared an intervention which included an information leaflet listing sources of help, two telephone calls soon after the participants presented at A&E and a series of letters over 12 months to TAU. These authors found that repeat self-harm was more common in those who received the intervention (Kapur et al., 2013).

It would seem that intervening with an NSSI patient population by offering them various forms of contact does not reduce self-harm by a statistically significant amount. As scholars rarely differentiate between suicidal and non-suicidal intent, it is hard to ascertain whether these interventions would be beneficial if focusing on NSSI alone. Using a different approach, authors of the following three studies have used CBT, DBT and ACT as interventions, respectively (Booth et al., 2014; Slee et al., 2008; Tapolaa et al., 2010), albeit with patient populations rather than with the general public within the community.

Influenced by an evidence-based intervention, Slee et al. (2008) reported that a time-limited, cognitive-behavioural intervention was effective for patients with recurrent and chronic self-harm (self-poisoning, with or without suicidal intent). Patients who received CBT in addition to TAU were found to have significantly greater reductions in self-harm, suicidal cognitions and symptoms of depression and anxiety, as well as significantly greater improvements in self-esteem and problem-solving ability when compared to the control group.

Similarly, Booth et al.'s (2014) UK study built on the previous study by implementing an intervention influenced by a third wave approach to address DSH, although self-harm was not clearly defined in the study. They used an adapted version of DBT, based on the group skills training component. The intervention was delivered to 114 patients in a psychiatric hospital. Significant reductions in participants' reports of DSH as well as significant increases in their distress tolerance levels (maintained at a three-month follow-up) were found. The authors concluded with a warning that

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this was not an RCT and results should therefore be treated with caution. Indeed, without a control group, one could argue about the quality of this quantitative study. The significant reductions in participants' reports of DSH could have been influenced by other factors such as meeting people at the group or from having a sense of belonging. It is questionable whether the reported reduction in self-harm can be attributed purely to the intervention.

Authors from Finland (Tapolaa et al., 2010) conducted an exploratory study of a brief intervention, also influenced by a third wave approach. The four-session intervention combined elements of acceptance and commitment therapy (ACT) with elements of solution-focussed brief therapy (SFBT) to prevent DSH in adults. The study was conducted with a sample of 16 patients who were invited to participate when accessing an emergency department for self-harming. In this study, DSH was defined as both deliberate self-poisoning (overdose) and self-injury with intent to harm the body, regardless of intent to die. Therefore, NSSI was not specifically addressed. The authors concluded that the intervention may have positive effects on mechanisms associated with a reduction of DSH, such as emotional regulation and positive future thinking. However, as there were only nine participants in the intervention group and seven in the control group, the validity of the results is questionable. For normality to be assumed, there is a requirement to have at least 30 people in each group. The researchers used non-parametric statistics (Chi-Square Tests and Mann-Whitney U tests) and acknowledged that such a small and homogenous sample limited both the generalisability and statistical validity of the results. Although positive outcomes were expressed in the last three studies, the quality of the latter two is questionable, especially the validity of Booth et al.'s (2014) study.

The complexity of the terminology used in studies as well as the all-encompassing nature of the term self-harm has been captured in a systematic review. Hawton et al. (1998) reviewed the efficacy of psychosocial and pharmacological treatments for preventing repetition of DSH. They identified and synthesised findings from all RCTs examining the effectiveness of the treatments of patients who have deliberately self-harmed. Twenty trials included reports of repetition of self-harm as an outcome variable, classified into 10 categories. It is important to note that although the authors referred to repetition of self-harm, eight of the studies were specifically about self-poisoning and five were about suicidal intent. Only seven studies specifically referred to self-harm, which generally includes suicidal intent and NSSI. Reduced repetition of NSSI following problem-solving therapy (all of these studies were about self-poisoning) and provision of an emergency contact card in addition to standard care was found. Significantly reduced rates of further self-harm (including suicidal acts) were observed in participants treated with depot flupenthixol versus placebo in multiple repeaters

as well as for DBT versus standard aftercare. It was concluded that further larger trials of treatments are needed due to considerable uncertainty about which forms of psychosocial and physical treatments are most effective for patients who self-harm.

Authors of one qualitative study about syndromes related to NSSI emphasised the limited number of qualitative studies in the area of self-harm. Cooper et al., 2011 explored the views of users and providers of care of contact-based interventions, such as telephone calls, letters and crisis cards, following an incidence of self-harm (including suicide attempts). Semi-structured interviews were conducted with 11 service users who had recently attended emergency services. It was found that participants' greatest time of need was directly after discharge from the hospital. Service users viewed contact-based intervention as a gesture of caring which counteracted feelings of loneliness. They also preferred delivery from mental health specialists, and although they considered the letter helpful at a later date, they felt phone calls should be made initially. Genuineness when delivering the intervention was also important. Two potential barriers of threats to privacy and means of accessing the service were also highlighted.

The majority of the quantitative studies indicated limited effectiveness of interventions designed to reduce self-harm, while it could be argued that the two studies with positive outcomes were flawed in their research methods. Slee et al. (2008), Davies et al., (2011) and Linehan et al. (2006) highlighted the benefits of their respective interventions, namely CBT, acupuncture and DBT, but again, it is impossible to ascertain their effectiveness for NSSI alone.

Although the above studies are about areas closely related to NSSI, it is hard to distinguish NSSI from suicidal intent, meaning there is limited information on what might be helpful for people who engage in NSSI. As can be seen, the majority of these papers were quantitative, therefore omitting the voices of participants and missing an opportunity for people with lived experience to share their experiences of the intervention or support.

Research conducted with NSSI or similar criteria

Various studies have been conducted with people who engage in NSSI. Other authors have used a different name but still distinguish NSSI from suicidal intent. The first three studies discussed (Gratz & Gunderson, 2006; Gratz et al., 2014; Tyrer et al., 2003) are quantitative, while the remaining seven are qualitative (Buser et al., 2014; Gelinas & Wright, 2013; Huband & Tantam, 2004; Kool et al., 2009; Long et al., 2015; Shaw, 2006; Whitlock et al., 2015). The first two studies (Gratz & Gunderson, 2006; Gratz et al., 2014) were with individuals who had a BPD diagnosis. This unfortunately excludes people who participate in NSSI without this diagnosis.

Gratz and Gunderson (2006) collected preliminary data on an acceptance-based emotion regulation group intervention for DSH (deliberate, direct destruction or alteration of body tissue without conscious suicidal intent but resulting in injury severe enough for tissue damage to occur) among women with BPD. It was found that the group intervention had positive effects on self-harm, emotion dysregulation, experiential avoidance and BPD-specific symptoms, as well as symptoms of stress, anxiety and depression. Given the sample sizes of the experimental and control groups were 12 and 10 respectively, the study would need to be replicated on a larger scale to confirm validity. Gratz and colleagues' (2014) conducted an RCT and uncontrolled nine-month follow-up of an adjunctive emotion regulation group therapy (ERGT) for DSH among women with BPD. The authors supported the efficacy of ERGT and the durability of treatment gains. It would have been interesting to see the results if the authors had not exclusively focussed on individuals who met the criteria for BPD (Gratz et al., 2014), allowing for a more general understanding of the effectiveness of an intervention for NSSI.

Tyrer et al. (2003) carried out an RCT on brief CBT versus TAU for people engaging in recurrent deliberate self-harm. A total of 480 UK-based patients were included. The authors did not define DSH; however, as there is a reference to para-suicidal self-harm, one could infer that the authors were interested in people who self-harmed without suicidal intent. No significant differences were found for those who repeatedly engaged in DSH during the 12 months of study whether they were in the brief CBT or TAU group. Tyrer et al. (2003) concluded that brief CBT is of limited efficacy for reducing self-harm.

Although Gratz and Gunderson (2006) found support for an acceptance-based emotional regulation group intervention, their sample size was not sufficient to confirm the quality of the study. As well as not clearly defining DSH, Tyrer et al. (2003) did not find evidence to support the use of a CBT-influenced intervention. This study is of interest given that other researchers have found support for a standard CBT in relation to NSSI (Crowe & Bunclark, 2000) and that NICE guidelines (2011) recommend CBT. Gratz et al. (2014), on the other hand, found support for an ERGT intervention, although they unfortunately only focused on those with a diagnosis of BPD. They omitted to include people with no formal diagnosis. Additionally, none of the quantitative studies gave participants with lived experience an opportunity to express their experiences. The following seven qualitative studies do give voice to those with lived experience, albeit focusing on student and patient populations, rather than the general population.

The first four studies originated from Canada and America and were with student samples (Buser et al., 2014; Gelinas & Wright, 2013; Shaw, 2006; Whitlock et al., 2015). Gelinas and Wright (2013)

collected data using a questionnaire to understand the cessation of DSH in a Canadian university sample. They looked at barriers, reasons and strategies. One of the reasons given for cessation was the receipt of help and support. Similarly, Whitlock and colleagues (2015) used a survey to identify differences between US students with current and past NSSI. Help-seeking, social support and psychosocial processes were recognised as important for stopping NSSI (Whitlock et al., 2015).

In addition to questionnaires and surveys, interviews have also been employed to explore NSSI. In an American study by Buser et al. (2014), interviews were utilised to collect data from students. These authors were interested in naturalistic recovery from NSSI. They found that natural recovery emanated from participants' realisation of the physical damage they were doing themselves, corrective interpersonal influences, and movement from unhealthy to healthy surroundings. Shaw (2006) used interviews to enquire into women's journeys to stop self-injuring. Canadian students were interviewed, and it was found that the process involved multiple factors beyond whether or not the women wanted to stop, such as subjective meanings of behaviour, professional treatment, disclosure experiences, relational ties, a decrease in psychological catalysts, self-initiative, life engagements, and momentum. Particular interventions were found to influence women's attitudes towards stopping. The authors of these four studies have illuminated what participants found helpful, as well as highlighting various factors that contributed to helping them cease their NSSI.

Similarly, qualitative studies have been conducted in the UK and Holland respectively (Huband & Tantam, 2004; Kool et al., 2009), although with patient populations. Kool et al. (2009) looked at self-injurious behaviour (SIB) (self-harm without suicidal intent). Their Dutch participants were patients in a psychiatric intensive treatment centre who had ceased self-harming or only rarely did so. The researchers used semi-structured interviews and identified connection as key to all phases of the process of stopping self-injury. They suggested that nursing interventions should be focussed on forging a connection, encouraging people who self-injure to learn alternative behaviours and developing a positive self-image.

Huband and Tantam (2004) focussed on UK patients. They used semi-structured interviews to speak to 10 women who recalled their experiences of cutting and how helpful they found specific interventions. Using self-wounding as a description, these authors stipulated that the participants, who were patients within a department of general psychiatry, must have had self-injury recorded as without suicidal intent. Patients reported that having a long-term relationship with a key worker and being encouraged to express feelings were the most helpful strategies, whereas relaxation was the least helpful and reportedly made self-injurious behaviour worse. It appears that the self-control perceived necessary to resist the urge to self-harm would be compromised and weakened if patients

were to practice relaxation. Therefore, we can see that patients valued connection, long term relationships and the opportunity to express feelings. It would be interesting to know if these comments translate to adults who engage in NSSI within the community as well as students and patients.

Long et al. (2015) highlighted how few qualitative studies have been conducted in non-medical, community settings. However, these authors recruited their participants from counselling settings in the community and third-level education, therefore also focusing on a student population. The study was conducted in Northern Ireland (Long et al., 2015), and authors defined the term self-injury as the intentional and direct injuring of one's body tissue without suicidal intent and for purposes not socially sanctioned. Long et al. (2015) investigated clients' perspectives on counselling for self-injury using semi-structured interviews. Four intervention categories that participants believed to be helpful and unhelpful were highlighted, namely: building up trust, seeing beyond the cutting, human contact and integrating experiences. Participants perceived counselling to be helpful when counsellors were willing to work with underlying issues rather than primarily focusing on the cessation of NSSI.

The majority of the aforementioned studies have either been with participants from a student population or medical setting. Although Long et al. (2015) identified the lack of studies in a non-medical, community setting, they eventually advertised and recruited within a university setting due to recruitment issues. Therefore, in this literature review, the lack of studies purely accessing a community adult sample who reside within the UK is highlighted.

Rationale

A review of the available literature demonstrates that there is a paucity of UK-based research with adults that is focused on interventions and support for NSSI (Klonsky et al., 2014). This is particularly the case for qualitative studies which give voice to individuals with lived experience, who are from the community and who have ceased their NSSI.

NSSI is often a private affair (Hagell, 2013), meaning that few people who engage in NSSI present at hospital. Therefore, studies within the community vary in their estimates of the prevalence of NSSI. It is estimated that approximately 13%-45% of adolescents (Lloyd-Richardson et al., 2007; Plener et al., 2009) and 4% of adults (Briere & Gil, 1998) within the community have engaged in NSSI. On the basis that accurate figures are unknown, and some individuals do not reach services, these adults must be reached and given a voice. There is also a possibility that adults in the community may not

have the same support afforded to youth, for example, teachers and parents, meaning they have fewer resources to hand.

Giving voice to those with lived experience is important, as these people have had periods of healing and wellness and can provide their insight into strategies for recovery. Huband and Tantam (2004) interviewed 10 UK female patients about their experiences of cutting and how helpful they found interventions. Long et al. (2015) spoke to students from Northern Ireland as well as people from the community and asked about perspectives on counselling.

The current qualitative study is designed to build on these studies and contribute to UK research in this area, using semi-structured interviews to gain an in-depth knowledge of individuals' experiences of interventions and support on their journey to ceasing NSSI. Many of the studies to date have been quantitative (e.g. Gratz & Gunderson, 2006; Gratz et al., 2014; Tyrer et al., 2003), and so did not capture participants' in-depth experiences. This study will include a distinct inclusion criterion that differentiates NSSI from suicidal intent and will involve a community sample, unlike the majority of studies, which are with psychiatric patients and students. This study will be conducted in the UK, differentiating it from the majority of qualitative studies into interventions for NSSI, which have been conducted overseas. In addition, the sole focus of this study is the adult population, whereas other authors have focussed on youth and young adolescents. Therefore, by having a distinct criterion for NSSI and giving voice to a UK-based, adult community sample, this study will fill a gap in the literature.

Hence, this study has the potential to provide critical information regarding the kinds of treatment, intervention, and support that individuals who have ceased their NSSI found helpful. It may also illuminate what they did not find helpful and in some cases may have found detrimental to the process of ceasing. Such research is imperative for assisting counselling psychologists and other mental health practitioners to work effectively with this client group, as well as to reduce suffering and the serious implications attached to NSSI.

Research aims

The aim of this study is to gain an in-depth knowledge of individuals' lived experiences of interventions and support on their journey to ceasing NSSI. Following on from qualitative studies focusing on interventions and support for NSSI with psychiatric patients and students, another aim is to gain further knowledge by including a UK-based, adult community sample, and through the use of semi-structured interviews. The research is firmly situated in a therapeutic context, with a further

aim of educating and providing knowledge on interventions and support that are reported to help

cease NSSI.

Methodology

This is a qualitative study in which the aim is to gather rich data on people's experiences of interventions on their journey to ceasing NSSI. Qualitative research lends itself to a critical, questioning approach to life and knowledge (Braun & Clarke, 2013). An element of the qualitative paradigm includes the use of naturally occurring data collection methods that more closely resemble real life, rather than other forms such as experiments (Silverman, 2000), enabling us to improve our understanding of psychological conditions. This fits with the approach and philosophy of counselling psychologists, who endeavour to work collaboratively with the individual's unique subjective psychological experience to make sense of those experiences and alleviate distress (BPS, 2019).

Recruitment strategy

By recruiting adults who have engaged in NSSI in the past but who no longer do so, the hope was to gain a retrospective insight into what assisted them in ceasing such behaviour, and what resources they used to replace the behaviour.

Related organisations that support individuals who engage in NSSI, such as Harmless (a national voluntary organisation for people who self-injure, their friends, families and professionals) and SISH (a Bristol-based self-injury community organisation) were asked to assist with recruitment. It was also hoped that this strategy would create a snowball sampling effect, as knowledge of the study was shared amongst these organisations. These agencies agreed to advertise and to explain that individuals who expressed an interest would be able to contact the researcher for the information sheet. SASH (a self-injury interest group) sent out an email to their members, who are professionals within the field, while SING (a self-injury network group) sent an e-bulletin to their members asking for support with recruitment. I attended SASH and SING meetings, which allowed me to network and discuss recruitment. I also attended the HARMLESS conference in 2016. In addition to the organisations mentioned, another supportive organisation suggested by a SISH member was NSUN (National Survivor User Network). They kindly placed an advert in their newsletter on three occasions, as well as on their Facebook page.

Inclusion criteria

Participants needed to identify as having engaged in NSSI in the past and to have now ceased this engagement. Duration of abstinence was not specified, as it was felt that it was important for each participant to identify their understanding of ceasing NSSI, rather than for that criteria to be imposed upon them.

Ethical considerations

Ceasing NSSI possibly infers that a person no longer feels the need to injure themselves, perhaps due to personal circumstances or because they have developed other strategies to replace NSSI. Either way, it was felt that these individuals may be less vulnerable and have more resources at hand than those who still actively participate in NSSI.

It was not felt that there were any particular risks to participating in the study. However, it had to be recognised that there is always the potential for research participation to raise uncomfortable and distressing issues for participants, especially in studies such as this, where the discussion involves periods of participants' lives that are likely to have included difficulties. Therefore, throughout the study, the British Psychological Society's (BPS) (2009) Code of Ethics and Conduct was followed in terms of confidentiality, informed consent and the right to withdraw (Willig, 2008). Ethical approval was granted by the university's research ethics committee (Appendix D).

Before the semi-structured interviews began, participants were sent an information sheet (Appendix B) explaining the study and a consent form (Appendix C). The information sheet explained who the researchers are, what the research is about, what participation would mean and the need for participants to be 18 years or over. The sheet also detailed how the data would be anonymised, stored, used and eventually destroyed to ensure complete confidentiality, including storing personally identifiable details separately. Finally, it was explained that participants have the right to withdraw their data at any point after the interview until August 2018, when the thesis would be submitted. The sheet also included contact details of the counselling service Bristol Mind, the self-injury support group SISH (Self Injury Self Harm) Bristol, and of the researcher and research supervisor in case the participants wished to make contact or raise any queries.

Participants were also informed that prior to the interview that they would be asked some demographic questions. Demographics can be helpful as they allow researchers the opportunity to reflect on the relationship between results and samples (Braun & Clarke, 2013).

Participants' individual informed consent was expressly sought. It was explained that once they gave consent, the researcher would audiotape their interview, and the resulting data may be used within any publications or presentations arising from the study. Participants were also asked whether they wished to review their interview transcript for accuracy before their data was used when they would be given an opportunity to withdraw any comments they did not wish to appear in the public domain.

In addition to the details provided on the information sheet, the consent form also included the researcher and research supervisor's contact details as well as pointing out that participation was voluntary and that participants had the right to refuse to answer any question. It also reminded the participants that they were the 'experts', and that there were no right, or wrong answers and that the researcher would be interested in everything they had to say. This information was important to help empower participants and to emphasise the importance of each individual story, as well as to challenge the possibility of researcher-participant hierarchy (Braun & Clarke, 2013).

Participants were reminded at the beginning of the interviews that they only needed to answer questions they felt comfortable in answering. At the end of each interview, the researcher checked that the participant had contact details for an individual or organisation they felt could offer them support if needed.

All data was stored in a password protected encrypted folder and only the researcher and research supervisors had access to this information. Interview data was anonymised; each participant was allocated a pseudonym. At the end of the project, all data will be deleted and/or destroyed.

Participants

Since semi-structured interviews are considered excellent for generating rich, detailed data, it is suggested that 10-20 interviews are sufficient to generate the necessary data for a medium-sized research project (Braun & Clarke, 2013). A size of 12 participants were recruited, which was considered sufficient due to the rich and detailed content of the data gathered.

Participants ranged from 25 to 55 years old, with a mean of 41 years (see Table 1). These ages are consistent with the literature indicating that NSSI decreases in maturity (Walsh & Rosen, 1988).

Ten of the 12 participants identified as female, and two as male (see Table 1). This reflects the evidence that women self-injure more than men (Whitlock et al., 2006), although some researchers have suggested a similar overall rate of NSSI for men and women (Briere & Gil, 1998).

One of the participants identified as Somali, and one as Greek Cypriot. The remaining 10 identified as Caucasian (see Table 1). Remaining mindful that this research was conducted in the UK, Gratz (2006) indicated higher rates of self-injury have been reported higher in Caucasians than non-Caucasians, although other authors have found a very modest significant effect for ethnicity (Whitlock et al., 2006).

Seven of the 12 participants did not identify with any social class, and one did not relate to the categorisation. The remaining four stated that they were working class (see Table 1).

Eight participants were heterosexual, one participant identified as fluid, and two participants were bisexual. One participant could not relate to the categorisation and felt unable to answer (see Table 1).

	Participant pseudonym	Age	Gender	Racial ethnic background	Social class	Sexuality	Data collection method
1	Matt	54	M	White Christian	N/A	Heterosexual	Skype
2	Claire	49	F	White British	Working class	Fluid	Skype
3	Sharon	46	F	White British	No class	Heterosexual	Telephone
4	Alison	49	F	White British	No class	Heterosexual	Skype
5	Leslie	47	F	White British	No class	Heterosexual	Telephone
6	Maureen	55	F	White British	No class	Heterosexual	Telephone
7	Amburo	25	F	Somali	Working class	Heterosexual	Telephone
8	Annita	53	F	Greek Cypriot	Working class	Bisexual	Telephone
9	Derek	27	M	White Jewish	No class	Heterosexual	Skype
10	Vanessa	32	F	White British	No class	Heterosexual	Telephone
11	Maddy	27	F	White British	Working class	N/A	Face to face
12	Tamara	27	F	White British	No class	Bisexual	Skype

NB: "N/A" indicates that participants did not relate to this categorisation.

Table 1: Demographics of research participants

Data collection

The data was collected via semi-structured interviews (Appendix A), resulting in rich and detailed data about individual perspectives and experiences. The use of semi-structured interviews has many advantages such as the flexibility to probe and ask additional questions. Additionally, only small numbers of interviews are needed to generate sufficient data. They are also ideally suited to sensitive topics such as NSSI (Braun & Clarke, 2013).

The interview guide included questions aimed at gaining an in-depth knowledge of individuals' experiences of the interventions and support they experienced prior to ceasing their NSSI. The initial question asked participants about their understanding of NSSI, with the intention of being less probing and more sensitive than later questions (Braun & Clarke, 2013). The purpose of this strategy was to build rapport with the participants, in the hope that they would feel comfortable disclosing personal information further into the interview (Braun & Clarke, 2013). Reinharz (1993) stated that rapport is imperative in interactive data collection, as it generates rich and detailed accounts pertinent to the research question. To challenge the possibility of researcher-participant hierarchy, and to empower participants, the process of empathetic interviewing was employed (Braun & Clarke, 2013).

The next section of the interview guide included questions relating to the onset of NSSI, how often it took place and how much time had passed since ceasing, before moving onto specific questions around interventions. The latter part of the schedule focussed on more general questions, inviting the participant to offer any thoughts that had been missed, including a question about what support they may have desired but had not received at the time. These 'clean-up' questions can sometimes initiate rich, unexpected data (Braun & Clarke, 2013). See Appendix A for interview guide.

Interviews were carried out at a time that suited participants and could be either face to face or via telephone or Skype, depending on participants' preferences (Braun & Clarke, 2013). The aim of providing flexibility in contact methods was to encourage individuals to share, as self-injury is often reported as being private (Hagell, 2013). As these are interactive data collection methods which enable the use of semi-structured interviews, they are all suited to the selected qualitative analytic method of thematic analysis, which is used to identify themes within the data set (Braun & Clarke, 2013).

Face-to-face interviews can generate rich, detailed data about individual perspectives and experiences, meaning fewer interviews are needed to collect sufficient data (Braun & Clarke, 2013). They are also flexible, enabling the researcher to ask unplanned questions and to have control of the data produced, thus generating useful data (Braun & Clarke, 2013). Face-to-face interviews are also suitable for sensitive issues such as NSSI (Braun & Clarke, 2013). One participant opted for a face-to-face interview, which led to the collection of rich data.

However, face-to-face interviews can also be seen by some participants as unsuitable for discussing sensitive issues due to the lack of anonymity (Braun & Clarke, 2013). Therefore, telephone and Skype interviews were offered as alternatives.

Semi-structured telephone interviews may help facilitate more participation from groups under-represented in research (Miller, 1995). This is relevant to this study because, as previously mentioned, NSSI is thought to be a private affair (Hagell, 2013). Therefore, it may be easier for participants to speak about their history via telephone. This proved to be the case, as half the participants chose to have telephone interviews. Miller (2001) found participants were more willing to set up interview times via the phone compared to methods such as email.

Skype was offered as a third option, allowing researcher and participant to see each other, enabling both to view body language and cues (Hay-Gibson, 2009). Five participants opted for Skype interviews. Hanna (2012) suggests that Skype interviews retain elements of a face-to-face interview while maintaining the flexibility and personal space offered by a telephone interview.

Analysis and theoretical framework

Data were transcribed verbatim with a focus was on spoken words, sounds and paralinguistic features (Braun & Clarke, 2013) such as pauses and non-verbal utterances. The notation system for producing an orthographic transcription was adapted from Jefferson (2004), as noted in Table 2.

?	Indicates a question
[pause]	Indicates a pause in speech
Erm or Hmm	Phonetically and consistently common non-verbal utterances
[over speaking]	Overlapping speech
[sigh] [laugh]	Signals a speaker laughing or sighing and so on during a turn of speech
[unclear 0.04.31]	Inaudible speech followed by time on recording
I and P	Identity of speaker. Turn-taking in talk
[…]	Edited material

Table 2: Transcription notation system

As it was decided that this focus would be on identifying themes from individuals' self-reports, thematic analysis was chosen as the most appropriate method of analysis, since this is a method for identifying, analysing and reporting patterns (themes) within data (Braun & Clarke, 2013). Thematic analysis is a widely used qualitative analytic method within psychology (Roulston, 2001) and, due to

its flexibility, is a useful research tool for providing complex, rich and detailed data (Braun & Clarke, 2013).

Thematic analysis followed the six phases outlined by Braun and Clarke (2013). These are as follows:

- Phase 1: Familiarising yourself with the data. This involved reading and re-reading the data and noting down any initial thoughts and reflections.
- Phase 2: Generating codes. This stage involved a process of systematic data coding.
- Phase 3: Identifying key features of the data. This involved searching for themes and then examining the data for broader patterns of meaning or 'candidate themes'.
- Phases 4 and 5: Defining and naming themes. This called for a process of review and refinement.
- Phase 6: Producing the report. This involved selecting illustrative data extracts and presenting the themes to connect logically and meaningfully.

As thematic analysis is not constrained by inbuilt theoretical assumptions, researchers need to clearly specify the theoretical framework that underpins data (Braun & Clarke, 2013). Therefore, it is important to note that this research was influenced by a critical realist framework (Fletcher, 2017). This is an ontological framework that calls on a real, knowable world that sits behind a subjective, socially located knowledge that is accessible to the researcher (Madill, Jordan, & Shirley, 2000). This knowledge is thought to be socially influenced, reflecting a separate reality we can only partially access (Braun & Clarke, 2013).

Rationale for using thematic analysis

Other qualitative forms of analysis, namely interpretative phenomenological analysis (IPA) and grounded analysis, were considered. IPA has origins in psychology and a theoretical orientation based on phenomenology, interpretation and idiography (Smith, Flowers, & Larkin, 2009). Although TA and IPA have similar characteristics (Braun & Clarke, 2013) in that they both lead to rich and detailed accounts of human meaning and experiences, they also have differences.

IPA researchers make a commitment to focus on the idiographic experiences of their participants (Smith et al., 2009). TA researchers do not tend have this aim (Braun & Clarke, 2006). IPA is also more time consuming and involved than TA, meaning it is not necessarily suitable for those with time restrictions or novice qualitative researchers. Both of these restrictions apply to me.

Grounded theory was also considered as an alternative method of data analysis. Specifically, constructivist grounded theory, since a relativist position forms the basis of this approach and is demonstrated by the assumption that, through the interpretation of the participants' narratives, the researcher constructs a theory (Charmaz, 2001). Although it has similar features to grounded theory, TA is focussed on encapsulating the data into themes, which will then be expressed, rather than creating hypotheses and theories in connection to the data (Ryan & Bernard, 2000).

Critical realism

Critical realism's foundations as a post-positivist ontological perspective are based on the works of Bhaskar (1975). The theory is thought to integrate ontological realism, epistemological relativism and judgemental rationality (Archer, 1995). Critical realists are concerned with the complex networks of observable and theoretical elements that go further than the surface of social phenomena (Danermark, Ekstrom, Jakobsen, & Karlsson, 2002). Society would not exist without individuals' reproductions and transformations of relationships, practices and structures (Alvesson & Skoldberg, 2009).

An alternative perspective to critical realism is social constructionism (Willig, 2012). A major focus of social constructionists is to uncover how individuals or groups participate in the construction of their perceived reality. Therefore, if something can be socially constructed, then it can be constructed differently, resulting in change (Elder-Vass, 2012). Although the critical realist position has much in common with the social constructionist position (Madill et al., 2000), the interests of critical realists lie with the positive development and application of knowledge, whereas social constructionists claim that knowledge is uncertain and consists of constructions of reality that are permeated with power (Cruikshank, 2011). Critical realists conclude there is a real world out there, working on the supposition that such an assumption can neither be proved or disproved.

As the primary concern of critical realists is the relationships between people and structures (Archer, 2010), the approach is thought to be an appropriate framework for exploring mental health (Pilgrim, 2013). Therefore, a critical realist position was adopted for this study about peoples' representation of their experiences, views and meanings concerning their experiences of interventions and support in relation to NSSI, while bearing in mind the influences of wider socio-economic factors in the formation of peoples' reality. Therefore, participants are seen as experiencing their own reality, which is influenced by their perception of events and the context in which they were experienced. From a critical realist position, there appears to be a gap in the literature concerning subjective experiences of interventions and support in relation to NSSI. It is not assumed that data reflects reality, as it needs to be explicated, enabling the researcher to gain access to underlying motivations

and effects (Willig, 2008). Therefore, by observing and analysing, it is possible to access participants' reality and gain an understanding of their experiences, which in turn offers the possibility of improving knowledge. With this knowledge comes an understanding of what change might occur if different interactions were to take place (Zachariadis, Scott, & Barrett, 2010).

A critical realist approach supports the view held by counselling psychologists that participants will have a bias and recall their experiences as remembered, from their perspective, which may be different from others' remembering of that event. Therefore, it is accepted that the researcher is active in the research process. As a researcher who at times identified with aspects of the participants' narratives, I was aware that my experiences may influence the process of analysis. As discussed, I would only see the data through the eyes of my reality, which could lead to the emphasis being placed on certain aspects of the data that resonate with my story. Equally subconsciously, less emphasis may be placed on aspects that did not resonate with my story. The use of a research diary allowed me to reflect on these points.

Reflexivity

I am a final year trainee counselling psychologist. Throughout my career working as a support worker and counsellor in the field of alcohol and drugs, I have met numerous individuals who have participated in NSSI. I developed an interest in the topic, and during a psychology undergraduate degree, I produced a critical review of the area, focussing on a potential mechanism of NSSI. During my second year on the professional doctorate in counselling psychology, I conducted an online survey with students who had participated in NSSI, asking them about those experiences. I have now chosen to pursue this interest further as the focus of my thesis.

Critical realists emphasise the importance of recognising how research is influenced by its context, including the impact of the researcher through a process of personal reflexivity. The context for this research includes the aim of extending knowledge in the field of counselling psychology. This situates the research firmly in a therapeutic context, with a further aim of educating and providing knowledge on interventions and support that are reported to help cease NSSI.

My initial attraction to the topic of NSSI came about after witnessing a young lady burning her arm with a lighter.

While conducting the current study, I have come to realise that my increased interest in the topic of NSSI is influenced by the nature of the behaviour, which is connected to a way of coping with difficult feelings, rather than desiring to take one's life. As one of the participants stated, she was trying to live, not kill herself. I suspect the sense of struggling with emotions but, at that moment,

still choosing a behaviour that maintains life, provokes in me a sense of hope and resourcefulness. Due to this difference in intent, I feel challenged by the research (predominately from the UK), which places suicidal self-harm and non-suicidal self-injury together, and generally states an interest in DSH 'regardless of intent'.

At conferences I feel frustrated when I only hear about suicide or self-harm (regardless of intent) if I have been under the impression NSSI would be addressed. I understand the rationale given by academics (Kapur et al., 2013; Linehan, 2000; Stanley, Winchel, Molcho, Simeon, & Stanley, 1992) as to why they feel they must research 'regardless of intent', since Klonsky, May and Glenn (2013) found NSSI to be more strongly associated with a history of suicide attempts than other factors. Nevertheless, I feel that for purposes of responding to an individual and providing effective interventions, NSSI and attempted suicide must be viewed separately.

Subsequently, for this research, I have opted to use the term NSSI, which is influenced by American and Canadian studies from academics such as Gratz, Klonsky, Lewis, Muehlenkamp, and Nock.

Reflections of the interviews

I felt a lot of empathy for the participants during the interviews and when reviewing the transcripts. I really had a sense of their journey and had to constantly remind myself I was acting as a researcher and not a therapist. On the occasions when a participant seemed distressed, I could not help placing my therapist's 'hat' on top of my researcher 'hat', albeit remaining mindful of my objective. In a timely fashion, I gently brought them back, reminding them of the nature of the interaction. I feel the role of researcher and therapist are interwoven; to only view the participant through a researcher's lens is something I do not feel able to do or believe is conducive to building a trusting relationship.

I identified with many aspects of the interviews and felt I needed to be mindful of this when reading through transcripts and analysing the data. I reflected on these aspects throughout my analysis and discussion, being aware of the similarities which may have heightened my reaction to participants' responses. I kept a note of these points as they emerged, and on reflection, considered my contradictory experiences when working as a healthcare assistant on mental health wards, where I have witnessed staff spending time with service users. I reflected on my critical realist stance, being aware that I bring all these experiences to the analysis. However, taking this into consideration, there still seemed to be a strong sense of participants reporting unhelpful types of support.

Analysis and Discussion

This research was undertaken to gain an in-depth knowledge of individual experiences of interventions and support on participants' journeys to ceasing NSSI. The results of the research are retrospective and consist of the experiences that participants chose to share.

The data obtained from interviews with participants were systematically coded, and key features were identified together with broader patterns of meaning. Four main themes became apparent across the entire data set, as follows:
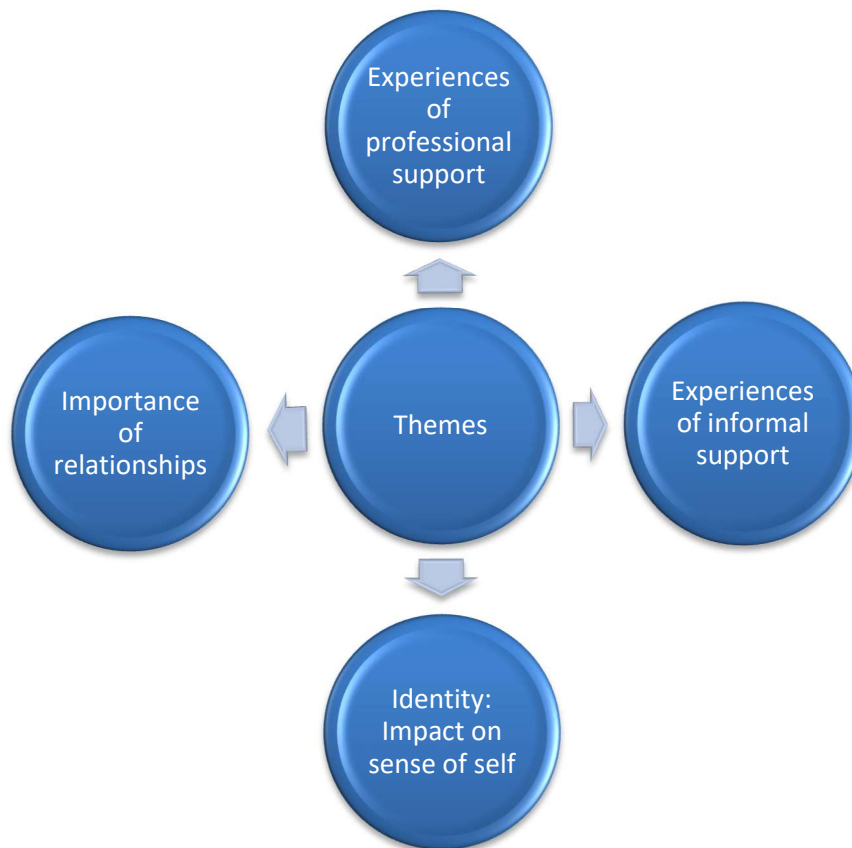
Extracts from each of these themes were considered, leading to sub-themes for each theme.

Each theme expressed a separate element that contributed to the participants' experiences of interventions and support. Theme 1, experiences of professional support, is about the quality of support participants received during interventions, including the impact that absent or unhelpful professional support had on their sense of wellbeing, and the positive impact of helpful professional support. Theme 2, experiences of informal support, includes sub-themes on self-help, psychosocial support, family and friends. Theme 3, identity: impact on sense of self, covers self-worth, judgements and labels, and how having a voice can be influenced during interventions. Theme 4, importance of relationships, covers the importance of consistency and connection in relationships.

Theme 1: Experiences of professional support

Participants spoke about their experiences of professional support. The three sub-themes identified were lack of professional support, unhelpful professional support and helpful professional support:

Lack of professional support

A high percentage of the participants spoke about a lack of professional support. This varied from not being able to find support to support being taken away. Participants also spoke about the lack of support when presenting at A&E and during stays on mental health wards. A sense of frustration was evident, as illustrated by Matt.

> Matt*: Well we were living in a little seaside town [pause] it was beautiful but there were very few facilities for any help, and me and my partner we begged for help, but I was going out my mind, the doctor kept saying there wasn't anything, you know for psychological help, counselling.*

Matt knew the importance of professional support as he had worked in a caring profession, but he and his partner were unable to access any support until his distress and NSSI had taken a toll on his relationship, career and lifestyle. He lost his job due to his mental health and could no longer pay his mortgage, meaning his partner felt she could not cope anymore and left him, so he had to sell the house.

Matt's quote provokes a sense of isolation. Castille et al. (2007) discuss how individuals who participate in NSSI frequently report that they do so after experiencing rejection or separation and due to feelings of loneliness. If Matt already had a schema of social isolation/alienation, this might

precede engaging in NSSI, which could, in turn, reinforce the schema, leading to an increase in NSSI (Castille et al., 2007). If Matt had not felt so alone and had felt the support of those around him, this may have reduced his need to self-harm.

This was the same for Leslie:

> Leslie: *I didn't get any support to begin with [pause] so I had nothing, I had three years of nothing. So understanding, empathy, you know, er, knowledge, information, erm, self-help, support for families. I mean, the effect of all of this on my family is hideous and my husband.*

The impact of both Matt and Leslie's distress and NSSI placed pressure on their relationships, as their partners did not know how to offer support. Leslie reached out to her GP to be told that she was 'over-sensitive'. Leslie explained that it was only at the point of crisis that she finally managed to reach out and receive the support she needed:

> Leslie*: [...] and to have the guts to go to the health visitor and tell her I was smacking my head on the wall, I was in such a state I had to reach a crisis point before anybody would do anything. Whereas, if the GP in the first instance had taken a little bit more time and consideration into finding out more about my background as well [pause] and, and, and reassuring me that it was safe to say exactly what was going on inside my head, it was safe. And that, "Your child won't be taken away".*

Leslie felt that if her family doctor had spent a little more time with her when she was constantly presenting at surgery after the birth of her child, he may have been able to intervene and offer support and reassurance. Leslie spent three years in distress and the fear of what the consequences might be, stopped her from being open about her NSSI.

Leslie hints at a sense of shame, fearing that what she is doing is wrong. Shame is related to NSSI severity, frequency and occurrence (Brown et al., 2009; Duggan et al., 2015; Rosenrot & Lewis, 2018; Schoenleber et., 2014; VanDerhei et al., 2014). Leslie later discussed experiences of abuse and difficulties, so there is a possibility that these feelings of shame already existed for Leslie and were then triggered by the sense she was not coping and was doing something wrong. These pre-existing feelings of shame in addition to possible feelings of low self-worth from Leslie's past and current situation are likely to have impacted on her need to NSSI.

As well as Leslie's feelings of internal shame, her doctor labelling her as 'over-sensitive' when she presented at the surgery could have been an unhelpful response regarding Leslie's need to disclose. The importance of first disclosure experiences has been discussed (Chaudoir & Quinn, 2010). This

incident could have affected Leslie's concern about negative evaluations of the self by others, also known as external shame (Tangney & Dearing, 2002; Tangney, Stuewig, & Mashek, 2007). The doctor's response could be perceived as an act of avoidance, which may increase NSSI-related shame (Rosenrot & Lewis, 2018). Shame has been found to hinder disclosure of emotional distress, although not directly NSSI, to friends, family and professionals (Hook & Andrews, 2005; Macdonald & Morley, 2001).

Many participants spoke about not knowing where to turn for appropriate support. Claire summarised this point:

> Claire: *I see [pause] what I see as bad is the lack of support I have. That's the thing. I didn't know, who do I go to? Who do I contact?*

Claire's uncertainty about who to approach was compounded by her fear of the consequences if she did reach out. She wished to be understood and supported but not taken to a mental health unit. Claire explains:

> Claire: *Who do I tell? And then another thing that also always plays is what they can do with you if you tell. Will they take me to a unit? Erm, all these things go through your mind. So, it's a bit of, a, I don't know where to go to, someone who truly understands and supports me.*

It had been difficult for Claire as she had reached out at work, which led to the police arriving at her house. Claire presumed her colleagues had shared their concerns, confusing NSSI with suicidal ideation, and the police had responded to their concerns. Claire believed that the police were there to assess her under section 135 of the mental health act, where an individual can be removed from a dwelling if it is considered that they have a mental disorder and may need care. She was glad that she was able to explain and to the police that her injuries were NSSI and that she was not suicidal. After this incident, Claire had concerns about who she could trust.

Authors of a study conducted with students (Muehlenkamp, Brausch, Quigley, & Whitlock, 2013) identified that individuals who engaged in repetitive NSSI reported significantly lower perceived social support from family members and that fewer of these participants sought advice compared to those who had engaged in single acts and the control participants. It would be interesting to find how much this perception was influenced by the fear of consequences. Fortune, Sinclair and Hawton (2008) found that amongst school pupils who self-harmed, the decision to seek help was at times hampered by not knowing whom to ask for help. Maybe these pupils are similar to Leslie and Claire, where it is not just about whom to reach out to, but that the act of reaching out is compounded by the fear of how it will be received. Rosenrot and Lewis (2018) explored barriers and responses to the

disclosure of NSSI. They emphasised that shame influenced the probability of disclosure. Shame, fear and not knowing who to speak to are likely to increasingly hinder a person's ability to reach out.

At times, participants felt that support was lacking even after they had accessed it. Matt experienced support being taken away, whereas Maureen felt she had not been supported after disclosing abuse. Others did not feel they received the support and interventions they needed when staying on mental health wards or visiting A&E. Matt eventually accessed a therapist, but this support ended unexpectedly:

> Matt: *[Therapist] […] she went out on sabbatical. Paid leave obviously, doing nothing for a long time so I was, you know, deemed, I wasn't deemed sufficiently at risk to warrant somebody else stepping in. So, I was just left out on my own.*

Matt felt alone again, expressing a sense of abandonment and betrayal by both his therapist and the system. This time it was worse as he had lost his partner, career and home. These were important to him, so we could assume these were his protective factors. Therefore, Matt no longer had some of the protective factors he had once had when he first started to engage in NSSI and seek support.

This would again feed into Matt's feelings of rejection and isolation, possibly increasing his need to engage in NSSI. He had also experienced separation, due to the break-down of his relationship (Castille et al., 2007).

Maureen experienced something similar after disclosing her childhood sexual abuse. Due to a lack of appropriate professional support, Maureen continued to engage in NSSI to manage her trauma.

> Maureen*: I think having, having, I suppose at that time at school, anything like that wasn't talked about anyway [pause] and obviously with the grooming and that that went on and he really did make me believe it was all my fault [pause] and I really did, I really believed it was all my fault. So, but I think once, when I find [pause] and I finally disclosed about the sexual abuse when I was sectioned [pause] but nothing was sort of put in place, was put in place then, so rather than being able to start working through that [pause] it was just, it was left.*

This lack of appropriate support reinforced Maureen's belief that the abuse was her fault, and she was not going to be believed. She went on to say:

> Maureen: *Yeah, and it was just almost like 'well you said that, that's it' and then you are left hang [pause] you know, you are left there with what, what do I do with this? Finally, after all these years [pause] actually told, come out and told somebody. Erm, but you are still left with all the, you know, all of the feelings [pause] and what he told me and what he did and*

[pause] and that. I mean I did [pause] And I do think if I'd have had that support then things would have been very different [pause] It reinforces that you are not, you are not going to be believed. You are going to be ignored. And it just reinforces so actually that then pushes it even further down.

Maureen continued to engage in NSSI until years later when, through self-help, she sought support for her abuse. Her honesty about the abuse followed by the subsequent lack of support were detrimental as she was left with the feelings that the disclosure provoked but had no one to support her with those feelings.

Although Shaw (2006) focusses on disclosure of NSSI rather than underlying issues, she still highlights the importance of disclosure experiences, as does Maureen's quote. How professionals respond to people sharing their traumatic experiences undoubtedly makes a difference. Rosenrot and Lewis (2018) identified shame as a potential consequence of receiving avoidant responses to disclosure. Although Maureen does not say the word shame, there is a likelihood that her feelings would be similar.

As Chaudoir and Quinn (2010) highlight in their paper about revealing concealable stigmatised identities, first disclosure experiences are of great importance and can impact self-esteem. They found that individuals with positive first-disclosure experiences had higher self-esteem. They suggest that one reason first-disclosure experiences are related to current well-being may be because they reduce the fear of disclosure and therefore have psychological benefits over time as this increases trust in others.

Rosenrot and Lewis' (2018) emphasise the importance of initiatives to reduce NSSI stigma as well as to foster supportive and understanding responses to NSSI disclosures. This could be an increase in education on the topic; Claire's colleagues may have responded differently if they understood that her NSSI was a response to distress rather than a declaration of suicidal intent. All Claire appeared to desire is someone who would respond kindly to her disclosure and offer her support, without fear of being sectioned.

Amburo also felt a lack of support as an inpatient on mental health wards. She thought it would have been beneficial to speak to a therapist during her stay.

Amburo: *I guess I didn't get much time with the nurses and I guess that that would have been probably helpful [pause] also maybe it would have been nice for someone to, oh let's see, [pause] erm [pause], yeah anyway I guess I just didn't have much chance to talk to any,*

it would have been nice to talk to a therapist actually, I think. I don't think I saw; I have never
seen a therapist while I have been an inpatient.

Amburo's reflection resonates with a study conducted by Lindgren, Svedin, and Werkö (2018), where adults who self-harmed described the importance of quality in the caring relationship and tailored care. They concluded that a radical improvement in the attitudes of healthcare personnel is a major priority for patients' outcomes. Amburo was on a mental health ward where one might expect that health care professionals would provide an appropriate quality of care, yet she gives the impression that she felt alone, with no one to talk things over.

Some participants felt that A&E departments provided a lack of support due to incorrect assessments and lack of knowledge. Maddy felt her needs were not met when she presented at A&E with NSSI.

Maddy: *[…] they would ask you about five questions, each one scored, like, zero to 10 or*
something. Erm, but you didn't get to choose a number, it was just basically yes or no and
they [pause] scored it. Erm, if ever I answered the question, "Did you do this to end your
life?" if I said no, that would score me a zero. That meant that I didn't score highly enough to
see someone from the crisis team. So obviously my self-harming isn't seen as a crisis to them
unless I want to end my life I'm not a crisis, but that's wrong because I was at risk of losing
my life from self-harm [pause] even though that wasn't my intention.

Maddy described her level of NSSI as quite serious, as she would cut deeply. She believed the seriousness of her NSSI warranted further support. She presented with a high level of distress, yet when she answered 'no' to the question around whether her self-harm had a suicidal intent, she was discharged with no further support or intervention.

There is a real sense of Maddy being dehumanised and treated as a number. The number then determined whether she became a crisis. However, in Maddy's case her number was not high enough and she was dismissed instead. Due to an unhelpful scoring system Maddy did not receive crucial support. The power imbalance (Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995) seemed to be creating a sense of oppression which in time would lead on to internalised oppression (Justice, 2018) where Maddy would not feel she was deserving of basic human rights.

Vanessa said there was a tendency for a lack of support from A&E staff, which she believed was due to a lack of knowledge and training.

> Vanessa: *I think when you present in A&E with, er, like self-injury versus when you present in A&E as someone who's attempted suicide. I don't think they know the difference and it can be a bit [pause] depending on which nurse comes by the [pause] way that they treat that as either something really trivial or, you know, whether or not you're just a complete basket case. It's [pause] you're very hit and miss and [pause] I get the sense that they would like better training on, you know, what the differences are [pause] and what the remit is [pause] a huge difference between, er, wanting to end your life and doing something as a survival strategy.*

Vanessa felt there was confusion amongst A&E nursing staff and that NSSI was not understood. Her feelings were consistent with those reported by Taylor, Hawton, Fortune and Kapur (2009). These authors reviewed the attitudes of participants who self-harmed (including those with suicidal intent) to clinical services. They identified poor communication between patients and staff as well as a perceived lack of staff knowledge concerning self-harm. Many participants suggested that psychosocial assessments and access to after-care needed to be improved.

Many participants did not feel they had the support they needed, although their feelings about this lack of support varied. The lack of support is important when considering the research of Gelinas and Wright (2013), who identified the receipt of help and support as a reason for the cessation of NSSI.

One could argue that whilst participants in this study eventually found the support they needed, which may have been due to their ability to ask for support (identified as an important factor for positive outcomes by Whitlock et al., 2015), concern remains for the patients who feel they cannot reach out due to, for example, feelings of shame or fear, as well as for how inappropriate responses to a person's distress may exacerbate such feelings.

Leslie summarises this:

> Leslie: *I don't care now, I just go with my turmoil, but I've learned that, that's taken me 20 years to learn that. If I'm in turmoil I just go to my GP now [pause] I just say, "I'm in turmoil," [laughs] that's it [pause] but you [pause] unless you know and you've got the confidence you can't do it, can you?*

It would be ideal if access to support and understanding were readily available for individuals who engage in NSSI. One area that offers holistic understanding is community psychology. Community psychologists seek social justice for all individuals in a community, empowering marginalised individuals and communities, as well as embracing and promoting diversity. Community psychologists understand that an individual's behaviour is not just the result of their own thinking.

They place human behaviour in the context of social groups and communities. Community psychologists aim to improve the quality of life of an individual in a group, rather than treating the individual as the problem for exhibiting certain behaviour (Dalton, Elias, & Wandersman, 2001; Kagan, Burton, Duckett, Lawthom, & Siddiquee, 2011; Maloney, 2016). Using this approach, nurses and other staff would be encouraged to interact with people who engage in NSSI in a positive manner, understanding and embracing them. More education in the community would allow individuals to respond more productively. Additionally, by offering community support, it is hoped that the need to NSSI would be reduced.

Unhelpful professional support

Many participants also shared experiences of support that they found to be detrimental or damaging. Many had experienced unhelpful interactions, which is of concern when such individuals already present with increased vulnerability (Andover et al., 2005; Gratz, 2006; Herpertz et al., 1997; Klonsky et al., 2003; Soloff et al., 1994) and often limited protective factors (Muehlenkamp et al., 2013).

Matt spoke about his experience of being on a mental health ward and described how the staff confiscated any object that could be used to engage in NSSI, which caused him to want to do it more. He did not find this intervention helpful.

> Matt: *Erm [pause] but what happens when you stop someone doing something, you want to do it. In a hospital they would take away all the sharp objects, which doesn't really help. I understand why they do it, it's to maintain a safe environment. But all that makes people do is search out more.*

One could argue that this was due to Matt's sense of agency being removed as well as the power imbalance that exists on mental health wards, where control is often disguised as care (Maloney, 2016). Matt's choice to engage in NSSI was taken away, with no other coping strategy given to replace the behaviour.

Annita felt that the response to her NSSI was punitive and that the hospital was criminalising her behaviour.

> Annita: *I think on the ward erm, they, kind of, tend to punish you. For self-harming they either put you on closer obs. They don't want to talk to you about it and it's, like, they just use it as, as a method of controlling you and saying, "Right, okay, you're not allowed out," or*

they'll have to put you on close observation. So they put someone, usually a man, to sit outside your door, which is really scary and very [pause] er, for me it would be unsafe erm, and it's more, kind of, controlling and overwhelming, the wards were [pause] that are the most provoking actually. They just made me feel so bad that I was actually erm, wanting to harm myself even more 'cause they'd made me feel like a very badly behaved erm, er, woman, but also a, a criminal. It was almost like they were criminalising your behaviour.

Annita's experience of feeling she had done something wrong, in addition to her increasingly limited freedom, caused her to feel vulnerable and scared, increasing her desire to engage in NSSI. If time had been taken to ascertain Annita's history or at least hear what she wished to express, the staff may have realised a male on her door made her scared and may have triggered old trauma. Like Matt, Annita felt that the strategies employed were controlling and detrimental.

Annita began to feel 'badly behaved' and like 'a criminal'. One wonders if these interventions triggered old feelings and created internalised oppression (Justice, 2018). The NHS could be perceived as an institutional and historical form of power (Justice, 2018). Although NHS employees would argue against exhibiting prejudice and discrimination, they may have become so socialised to their interventions, thinking and behaviour that they no longer recognise their power or the detrimental effect it has on the people receiving interventions. Theories and practices today seem to rely on popular representations of what is 'normal' and what seems to have gone awry when people do not act 'normally' (Parker et al., 1995). Miller and Rose (1986) argue that psychiatric institutions operate as power structures regardless of the individual intentions of the power holders. Parker et al. (1995) point out that the originating cause of this is not psychiatry itself, but rather an effect of power regimes. Albeit this constant treatment of an individual with mental health issues is likely to create an internalised oppression for those on the receiving end. Parker et al. (1995) elaborate by saying that society is caught up in an historical process that places mental health professionals in positions of power over service users, allowing some people the right to speak and taking it away from others. Therefore, certain categories of people are given power while others are disempowered.

Meyer (2003) found that internalised homophobia was significantly related to reduced mental health, including NSSI, suicidal ideation and substance use among individuals who identify as lesbian, gay or bisexual. It may be the case that internalised stigma for NSSI could also cause difficulties, especially if interventions are experienced as punishing and as reducing individuals' locus of control and freedom. It is understandable that Annita felt the desire to increase her NSSI, especially considering what she had experienced in the past. Annita seems to have a sense of an injustice, as if

something wrong is being done to her, yet her wording that she felt 'very badly behaved' and a 'criminal' indicate that the process of internalised oppression had begun. It must also be considered that due to Annita's earlier experiences of trauma, these interventions may have triggered or amplified old trauma and feelings of powerlessness.

Annita's use of the words 'punish', 'method of control', 'not allowed' and 'scary' are reminiscent of a prison rather than a place of care. Annita appears on one level to realise that there is an injustice occurring, as you would if an innocent person had been incarcerated. On another level she has begun to believe the feelings and thoughts this experience has provoked.

Maureen had several spells on mental health wards but pointed out that no staff ever asked her why she engaged in NSSI.

> Maureen: *If it's [pause] don't [pause] I can't remember but anybody ever asked me 'why are you doing this?' Rather than the actual self-injury. What is this doing? You know, what... why are you doing this? What is it helping? Is it helping?*

Maureen felt her treatment focussed on placing a 'band-aid' on the wound, rather than on the function of the NSSI or the opportunity to explore this using a trauma-informed approach (Sweeney & Taggart, 2018). This resonates with Long et al.'s (2015) study, where it was highlighted that counsellors working with people who engage in NSSI must see beyond the cutting and have a willingness to work with underlying issues, rather than focussing on cessation of NSSI. It seems that participants desired a form of human contact and treatment which is fundamentally different from the manner it is delivered on mental health wards.

Alison had a similar experience when she attended a day hospital, where she felt she was placed in an impossible position. To gain support, she needed to completely cease NSSI, a strategy that had been allowing her to cope.

> Alison: *So, I was in a day hospital for eight months every day, 9 till 4. Erm, and they had a no self-harm policy, if you like. So [pause] and I hope this is out of date now, but I had to sign a contract to say whilst I was at the day hospital I wouldn't self-harm. And if I did self-harm, erm, the first time I would be suspended from therapy for a day. The second time, a week and then the third time I would be discharged from all therapy from then on ever, you know. [Sharp intake of breath]. So having [pause] being in the early stages really of having quite a serious problem with self-harm, you know, bad cutting and things [pause] there wasn't any alternative, you know, I [pause] you know, just [pause] to get [pause] to have therapy you*

have to stop self-harming and there's no negotiation and there's no [pause] talking about
self-harm, there's no nothing.

Alison reported that after a suicide attempt, which has been highlighted as a great time of need (Cooper et al., 2011), the day hospital withdrew their support for a week. Alison eventually managed to replace her NSSI with food purging for remaining time at the hospital. She hid this replacement coping strategy and could therefore access support. Alison's story highlights the difficulty of ceasing NSSI without another strategy in place or at least the opportunity to speak about the NSSI.

Annita experienced a similar guideline when accessing DBT:

Annita: *And erm, I, I just found it absolutely horrible. I couldn't get, I couldn't get my head round it erm, and I didn't like the fact that they had these, kind of, rules and regulations about self-harm. The fact that they didn't want to speak after you'd self-harmed. I found that really cruel.*

She explained further:

Annita: *[…] I think that's awful; I don't agree with that at all. 'Cause I'm still feeling bad and I've got to deal with the after feelings [pause] of having self-harmed and I think self-harm, you know, even though sometimes it brings relief to people, it sometimes brings guilt and shame and all that stuff [pause], not what I was looking for, I wanted more of a humane approach.*

Both Alison and Annita expressed a sense of being abandoned; left alone to deal with difficult feelings. Cawley, Pontin, Touhey, Sheehy, and Taylor (2019) conducted a systematic review of the relationship between rejection and self-harm or suicidality in adulthood. They concluded that perceived rejection may leave individuals at risk of self-harm (including suicidal intent), which may account for the increased risk in marginalised societal groups. Alison and Annita were already dealing with difficult feelings which may have been exacerbated by their sense of rejection.

As well as a sense of rejection, Annita also mentioned feelings of shame after NSSI. Taylor et al. (2019) felt that the elevated shame observed in people with a history of NSSI represents a consequence of this behaviour, rather than a cause, linked to the stigma and taboo surrounding NSSI. This could be true in Annita's case after her experience of the DBT intervention. The rationale of DBT is to shape the patient into calling the therapist at earlier stages of a crisis, thus replacing destructive behaviour with asking for help appropriately, with the understanding that a phone call is no longer useful after a patient has engaged in NSSI. These therapists suggest that, by that point, the

patient has already solved the problem (Linehan, 1993). However, this approach seemed to provoke feelings of shame and a sense that she had done something wrong for Annita. A sense of being stigmatised may have arisen, even if this was not the intention. Perceived stigma may influence whether people reach out for help (Cleary, 2017; Rowe et al., 2014), and reportedly leads to a negative impact on treatment outcomes, isolation and rejection (Markowitz et al., 2011). We can see how the lack of support when Annita felt she needed it may have affected whether she reached out for support (Cleary, 2017) and thus her treatments outcomes (Markowitz et al., 2011), reinforcing a cycle of isolation and rejection (Markowitz et al., 2011). All these factors will feed into each other, maintaining an unhelpful cycle and potentially increasing Annita's feelings of internalised oppression and her need to NSSI. These feelings would be amplified if Annita already had a fragile sense of self (Taylor et al., 2019).

Taylor et al. 2019 also found that although shame continued to distinguish between participants with and without experiences of NSSI, it did not distinguish past and current NSSI. They indicated that shame remained elevated in individuals who participated in NSSI, as well as those who have not done so for a duration of 12 months. They speculated that whilst feelings of shame are relevant at the onset of NSSI, they are less important in its maintenance. They also thought it possible that the elevated shame observed in people with a history of NSSI represents a consequence of this behaviour, rather than a cause, linked to the stigma and taboo surrounding NSSI. Shame was also associated with the frequency of thoughts about NSSI in the past month, supporting the idea that feelings of shame could drive NSSI urges. Therefore, Taylor et al. (2019) wondered if other factors may contribute to the subsequent emergence of NSSI acts.

Cooper et al. (2011) highlight the need to support patients after discharge from hospital, although one could argue that this could also apply to individuals after they have engaged in NSSI. Authors of a recent international comparison of recovery from NSSI among young people (Kelada, Hasking, Melvin, Whitlock, & Baetens, 2018) highlighted that treatment for NSSI must position recovery as a process that involves relapse, therefore alleviating the pressure individuals place on themselves to cease the behaviour immediately. It could be argued that staff at the day hospital and DBT intervention need to reconsider their approach in light of current research, including research with those with lived experience. Alternatively, perhaps a different approach specifically for NSSI could be developed.

Although the interventions described so far were perceived as detrimental and punishing by the participants, the professionals from the mental health wards may be able to supply their rationale

and a copy of procedures and care plans, hence supporting their actions. However, this seems less likely in the case of the following reports from Sharon, Amburo and Maddy.

> Sharon: *I found that just that in A&E Departments, and I don't know whether it still happens, but I find them not very understanding at all. Always treat [pause] well, treating me as though I was, because I'd done it myself that I was wasting their time. Well, just being made to wait a long time, and just in [pause] well, yes, being rude and just being very offhand and not appearing very bothered or very concerned or not seeming very compassionate, just the way, just the whole manner really.*

It is difficult to ascertain whether this behaviour is due to the general manner of staff or if it is exclusive to individuals who present with NSSI. Karman et al. (2015) conducted a systematic review and found that negative attitudes to NSSI are common amongst nurses. Education had a positive influence on attitudes, especially when it included reflective and interactive components. Interestingly, O'Connor and Glover (2017) explored hospital staff's experiences of relationships with adults who self-harm (including suicidal intent) and found that a fear-based relationship occurred across mental and physical health settings, despite differences in training. Gibb et al. (2010) reported that staff did not feel confident working with patients who engage in NSSI and that their training in this area was inadequate. Additionally, negative attitudes were significantly associated with higher levels of staff burnout. These studies seem to validate Sharon's experience.

In addition, as expressed by Turner (1987), within the medical approaches, individuals are assumed to be responsible for aiding the process of cure as well as accepting diagnosis and medication. In this context, nurses may perceive that people who engage in NSSI are doing something to themselves. In a culture where so much emphasis is on individual responsibility, it is possibly hard for untrained nurses to understand NSSI, especially as the focus of treatment is generally on the individual rather than the social context (Parker et al., 1995).

Foucault argued that the humanisation of treatments in the eighteenth century encouraged the internalisation of the difficulty's individuals exhibited (Parker et al., 1995). The conscience of individuals with mental health issues would act as self-discipline, which would be more efficient than treatment. This would lead to a modern psychiatry in which individuals struggling with mental health would no longer be seen as outsiders but as problems within society (Parker et al., 1995). Therefore, nurses who have been socialised to this way of thinking, where the abnormal is internal to the person (Parker et al., 1995), would struggle with individuals if they do not understand their actions, as well as having a lack of understanding how to manage NSSI. The rudeness Sharon described could

be prejudice and discrimination (Justice, 2018), but it could also be that Sharon's feelings of shame had been triggered (Taylor et al., 2018), evidenced by 'because I'd done it myself that I was wasting their time'. Even if this was the general attitude of the professionals, it would be understandable that it felt personal and triggering for Sharon. Again, as with Annita these feelings would be amplified if Sharon had an existing fragile sense of self (Taylor et al., 2019).

Amburo shared a similar story, although she felt her experience was due to her diagnosis of BPD.

> Amburo: *No, I prefer the Samaritans to A&E. Because I feel like once the professionals see that person has got a label, I was actually treated in a way that I wouldn't be if I was like schizophrenic or something, erm, I have been to A&E many times and most of the time it has just been me like, you know, telling the charge nurse and [pause] really disinterested and like I had one nurse she was sort of looking around the room and you can't do that to someone who's, who has mental health issues and is there to get help.*

Amburo suggests a feeling a sense of injustice. She clearly realises that she deserves better treatment. Perhaps the unhelpful professional support Amburo reported was due to her presenting with NSSI or/and a diagnosed personality disorder. It could be argued that NSSI is viewed differently from other cases presented at A&E. Maddy explained:

> Maddy: *so… Erm, well, I know now because I'm better that they were actually neglectful and maybe breaking the NICE guidelines that they follow, I was refused local anaesthetic when I needed stitches because I was told that if I could do that to myself in the first place then a few stitches wouldn't really matter, they wouldn't hurt. I was told that [pause] this one nurse told me that she comes to help sick people to put food on their table for her kids, not to come and mess about with me who puts myself in hospital deliberately. I would be spoken to with no respect, but then I would hear them go and speak to another patient in the next cubical behind the curtain, that hadn't self-harmed, that was there for an accident, really nicely. Yet I'd just been disrespected [pause] and it was [pause] nine times out of 10 it was a bad experience so I would just let myself lie at home instead of telling someone I needed help [pause] So A&E was the worst out of all the different experience that I've had with self-harm…*

It is difficult to see these reports as historic when Maddy's last such experience at A&E was less than a year ago. Maddy, who described her NSSI as severe, avoided seeking support for fear of such a dehumanising, barbaric and cruel experience. She knew such a horrific experience would increase her need to NSSI on returning home after discharge. It appears that clinical staffs' attitudes and

knowledge regarding people who self-harm (including NSSI) have not altered since a 2012 systematic review by Saunders, Hawton, Fortune and Farrell, where it was concluded that attitudes of general hospital staff are largely negative. This was found to be more so in relation to individuals who repeatedly self-harm, as Maddy did. According to this study (Saunders et al., 2012), it would seem that self-harm patients are viewed more negatively than other patients, except those abusing alcohol or drugs.

Maddy was correct to identify a possible breach of NICE guidelines, which emphasise the importance of health and social care professionals using a non-judgemental approach to develop a trusting, supportive and engaging relationship as well being aware of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service (NICE, 2011).

Maddy's experience also echoes those of Amburo's and Sharon's when considering prejudice, discrimination and oppression (Justice, 2018). Maddy's experience of not receiving local anaesthetic highlights not only where the power lies (Parker et al., 1995), but also an abuse of that power. This could also be the case when the nurse made prejudicial comments to Maddy, which feel like evidence of discrimination, although the nurse may not have been aware of this. The nurses' behaviour may have triggered old feelings of shame connected to trauma (Lee, 2012) for Sharon, Amburo and Maddy, as well as feelings about the stigma around NSSI and/or shame. If such treatment is repeated over time, it may lead to internalised oppression.

It seems that people who wish to seek emergency support for their NSSI are placed in a difficult position. When considering individuals' expressions of fear at what asking for help may lead to, it is concerning to hear that when they did reach out, they experienced unhelpful interventions. As many people who participate in NSSI express it as a way of managing difficult feelings (Klonsky, 2009; Nock et al., 2009), it could be argued that this becomes a vicious cycle if those feelings are compounded by unhelpful support and interventions. Cooper et al. (2011) highlighted that the time which has the greatest need for support for individuals who self-injure (including those who attempt suicide), is directly after discharge. Therefore, it would be hoped that interventions leading up to discharge are as gentle and supportive as possible. Genuineness of intervention delivery was also mentioned as important in this paper, which does not seem to reflect the experience expressed by participants. When it has been highlighted that help-seeking ability has been a factor in ceasing NSSI (Whitlock et al., 2015), it is of concern if individuals experience hostility when they do reach out for support. It is clear that more education and support are needed for staff working within these health settings.

Although many participants reported a lack of and unhelpful professional support, many also reported helpful experiences of professional support.

Helpful professional support

Many participants felt they had benefitted from psychological interventions. Some discussed alternative coping strategies they had learnt in skill-based interventions, while others spoke about the value of discussing underlying issues and the benefits of being able to speak to someone. A few had the opportunity to experience both.

Sharon, Vanessa and Alison spoke about the benefits of DBT. Sharon explained how DBT allowed her to deal with her difficulties in a different way. She felt that it had enabled her to cease NSSI, and the skills DBT taught are something she now uses continuously.

> Sharon: *The most helpful thing was doing the DBT, in learning how to deal with the issues differently, so that I no longer had to self-harm or felt the need to. It's very successful, yeah. And with the DBT it was over time employing distress tolerance skills and putting things into my life that I enjoyed. And just using the skills of DBT, the mindfulness and the relational effectiveness and emotional regulation and distress tolerance. Using them skills. I just don't have those feelings [pause] now because I have been using DBT skills so long that I'm able to use them without going that bad again.*

Vanessa also felt that DBT had given her alternatives. She approached her NSSI as if it was a battle she needed to overcome. DBT gave her the tools to do this.

> Vanessa: *[…] I'd done the DBT and the DBT was extremely helpful and it had helped me cut back on some of the, sort of, self-destructive behaviour, but I had so many things going on in my life that tackling them all was becoming very difficult. But erm, another relationship ended, and I had to move back in with my mum [pause] I put a lot of my DBT focus into, you know, tackling. So, I, sort of, it was at that point then I thought right I'll use the skills in the battles I can win, and the self-harming was one of them. And then obviously learning the DBT skills as I've gone have given me alternatives.*

The DBT practitioner's acceptance of Alison's NSSI was important to her, as was the fact that she could speak about her NSSI, which proponents of previous interventions such as the day hospital (mentioned earlier) staff had not allowed her to do so. Alison explained:

Alison: *[…] what helped is just that thing [pause] well, it's in DBT, isn't it, thing of acceptance… almost not making it a big deal, erm, but understanding that that, you know, in one way it is just a coping mechanism [pause] and focussing much more on what that's about rather than the fact that you've done that.*

Since Alison's NSSI was all-consuming, one could argue that the opportunity to speak about it allowed for some of the power to be taken out of the 'impulse' as she was able to make sense of the build-up to the incident. As previously discussed, many felt that forbidding NSSI meant it was something they should be ashamed of and for which they were being punished, whereas being able to speak about it possibly reduces the intensity of those thoughts, as people who engage in NSSI would sense more acceptance. Alison continued:

Alison: *DBT was so helpful because it became a point where the self-harm was everything really, you know, I couldn't… you know, the days, the years when it was really bad, you know, I certainly wouldn't get through a week and quite often not get through a day. [That's] why DBT was really helpful because it focused on self-harm as well as the issue [pause] so doing the, you know, the chain analysis and erm, the diaries and things. You know, as much as I hated it, it was, kind of, quite aversive, to be honest, 'cause I was exposing the self-harm every week and, you know, and [pause] not literally [laughs] er, exposing the fact that, you know, this week I'd self-harmed three times. And these were the events leading up to it. These are the emotions. You know, I probably needed to do that to be able to understand why I did it and help me find other ways really [pause] It's the first opportunity for [pause] to be allowed to talk about self-harm. And because, you know, it was all-consuming and, you know, I needed to talk about it, not to indulge myself, you know, but to, you know, to try and find a different way of coping. And afterwards I think, kind of, became part of, you know, how I am really, if that makes sense, almost unconscious thought processes that, you know, that I use, particularly in something like the interpersonal skills, I'm much more aware of what's going on.*

Alison spoke about how DBT became part of how she was; she used her new skills without consciously thinking about doing so. Authors of RCTs have demonstrated that DBT is an efficacious and specific treatment for BPD (Chapman, 2006) and has shown promise for reducing NSSI (Linehan et al., 2006). As mentioned previously, NICE guidelines suggest DBT for clients who present with BPD, but not for NSSI alone. It would be helpful if more research was conducted to explore the efficacy of DBT for NSSI, subsequently allowing an opportunity for long-term treatment regardless of a diagnosis.

With these new skills, Alison was able to concentrate on the underlying issues.

> Alison: […]erm, I think since that time it was a gradual, you know, getting stable in terms of not self-harming all the time and then having more psychological therapy to help me understand the issues underlying it really.

Leslie spoke about how engagement with mindfulness-based cognitive therapy (MBCT) taught her to be aware of her bodily sensations:

> Leslie: Yeah definitely because the thing is that with the, with the mindfulness-based cognitive therapy, when you're thinking about how's your body feeling and when you are identifying how is your body feeling, what are you feeling now when you're feeling this distressed emotion [pause] that's something that you, you [pause] that stays with you. You know, that's quite a massive thing and so that was, that was amazing that he helped me to look into that and to see how it was affecting my body. And also then it gave me the clues to know that in the [pause] following on from that therapy I can identify issues through feelings and sensations in my body [pause] which I wasn't aware of before.

Leslie felt this was useful as she was more aware of the sensations in her body and could now identify when she was feeling emotional and so when there was an issue, that previously she would not have noticed. Treatment for NSSI is currently under-researched (Klonsky et al., 2011) and, to the best of the author's knowledge, there are no current studies about effects of MBCT for people who engage in NSSI. Even so, as mentioned previously, authors of RCTs have demonstrated that DBT is an efficacious and specific treatment for BPD (Chapman, 2006), and has shown promise for reducing NSSI (Linehan et al., 2006). Therefore, given that DBT includes a module on mindfulness, it aligns with current researched informed interventions that MBCT may be beneficial. More research is needed in this specific area.

Engagement with MBT allowed Amburo to gain more insight into others' experiences. Before the therapy, she felt she tended to 'mind read', which she reported caused problems in her relationships and subsequently contributed to her need to NSSI. Amburo explained:

> Amburo: […] I think the most helpful intervention I have had is MBT… initially when I get involved with a man I'd become unwell and unstable and erm, I'd end up presenting to A&E a lot and using the emergency services and, you know, like self-harming and stuff.

> Amburo: I guess it is what mentalisation is so this, I was taught that, you know, like not to jump to conclusions and to be curious and I was able to sort of get back and see that other

people have their own views and they have their own thought processes and that, that and that and know that they behave in a certain way, etc. [pause] It has just taught me that erm, you know, there is a lot of things I don't know and it is better to ask like just the importance of communication and healthy communication, so not communicating by a like self-harming or whatever because that's not a really healthy way to communicate [pause] I now like have, erm, a better, better relationships with people in general but especially men.

Amburo explained that her NSSI had a function of letting others know she was in distress, so her new ability to not assume she knew what others were thinking but to check if what she was thinking was correct allowed her to have healthier relationships. Amburo was able to access this treatment as she had persisted until she was given a diagnosis of BPD. As mentioned in the introduction, Rossouw and Fonagy (2012) found MBT effective for reducing adolescents' self-harm (regardless of intent) and depression compared to TAU. The study itself did not require a diagnosis of BPD to be eligible for the study but it measured self-harm regardless of intent, therefore encompassing both suicidal intent and NSSI. It would be interesting to see more research addressing MBT and NSSI alone.

Leslie also felt she benefitted from one of the 'third wave' CBT approaches. Schema therapy enabled her to gain insight into her attachment style and issues around childhood abandonment.

Leslie: […] *Schema therapy is very helpful as well because that gave me some understanding as to why I have particular, you know, problems with attachment or, you know, different things, abandonment.*

It follows that more research in the area of NSSI and schema therapy would be helpful. Crowe and Bunclark (2000) have shown support for standard CBT in relation to NSSI, while NICE guidelines (2011) recommend CBT. However, further exploration of 'third wave' approaches would be beneficial.

Matt, Claire, Annita and Maddy all spoke about time with their therapists. Matt had lost much in his life which he felt was due to his distress and NSSI. Therapy allowed him to speak about this loss and the guilt he felt towards his ex-partner.

Matt: *So she [therapist] really helped massively to get over what was going on in '96, you know, everything was still really fresh, after [location] and the loss and the guilt, so yeah I mean that really helped as well.*

Claire's focus was on how kind, understanding and non-judgemental her therapist had been. This came at a time when Clare reported feeling alone and misunderstood.

> Claire: *[…] she [therapist] was amazing, she was amazing [pause] but it was everything was so natural, and she was so lovely and so [pause] kind and so [pause] understanding and non-judgemental.*

Annita seemed to benefit from the opportunity for exploration, sense-making and acceptance.

> Annita: *My therapist, yeah she's obviously given me a lot of time and, and we discuss, we explore things and we work things out erm, erm, yeah it's, it's therapy, you know, you, kind of, talk about your experiences and try and understand them more and erm, try and accept what's happened, but also, like, build up a resilience as well at the same time.*

There is a clear sense here that Matt, Claire and Annita benefited from having someone listening to them. Their therapists seem to have created spaces which contained the three core conditions of empathy, congruence and unconditional positive regard (Rogers, 1957). Huband and Tantam (2004) reported the importance of being encouraged to express feelings when considering a reduction in NSSI. As NICE guidelines (2011) suggest, regardless of approach, therapists should be able to work collaboratively with clients to identify the problems causing distress or leading to self-harm.

Annita benefited from contact from her therapist between sessions. Although the use of some therapies, such as DBT, allows contact with a therapist as an alternative to NSSI, many therapists are concerned about boundaries. Even so, this highlights the importance of available human contact, even if that contact comes in the briefest of manners.

> Annita: *[…] sometimes my therapist has rang me outside of session times just to touch base and diffuse a situation when she knows I've been in a crisis and I haven't been in the crisis house, has prevented an admission and prevented me from harming myself even more. So that kind of intervention erm, a really brief intervention has helped me. And even sometimes she'll send me a text. You know, just to, sort of like, give me a bit of erm [pause] well, just a bit of an uplifting thing really, a bit of hope just to, kind of, try and hold on until we meet and things like that.*

A key factor of community psychology is the ability to give and receive emotional and practical support in the form of friendship, as the clear boundary between expert and lay knowledge dissolves (Maloney, 2016). This means that support is constantly available rather than just within the boundaries of the therapy room.

Maddy spent more than three years in therapy as an inpatient. Maddy described her NSSI as often quite serious and needing hospital attention. During her time with two therapists, a clinical

psychologist and an art psychotherapist, she was able to form trusting relationships and explore her issues, which she explained allowed her to eventually live in the community without the need to NSSI.

> Maddy: *[…] my clinical psychologist and art psychotherapist are the most amazing people I've ever met. Erm, I tried to push them away at first, told them bad things about myself to try and get them to hate me so that they would give up on me. Erm, but they didn't give up, they didn't quit and let me push them away and then they kept firm boundaries in place erm, 'cause I was always trying to push the boundaries.*

There is a sense here that Maddy dislikes herself and, rather than waiting for the rejection she has felt from family and friends in the past, she attempted to sabotage herself. This may have allowed her to feel some control over the situation. Maddy may have internalised oppression from the years she spent in the mental health system, many of which were her formative years. She now feels she deserves to be treated as she has been, which includes the sexual abuse she endured as a child. As many people who have been abused blame themselves, it may be that shame accompanied Maddy's difficult feelings. However, her therapists were consistent, respectfully hearing Maddy's request to stay away but still returning the next week, possibly modelling to Maddy an experience she had never encountered before. Even with her mother, Maddy had felt the need to NSSI to get her needs met. Here, the therapists were showing Maddy another way of being. Although Maddy was possibly experiencing shame and low self-worth, her therapists did not make this situation worse. Indeed, they appeared to act in a manner which meant Maddy felt safe exploring her difficult feelings. They also gave her the tools to manage these feelings.

Importantly, Maddy's therapist utilised her creative thinking to create a safe place to explore issues which could then be contained until she wished to explore them further.

> Maddy: *Erm, but because my psychologist got to know me that she figured out that I'm really good at visualising things, my imagination is really good. So she started to [pause] we drew out on paper what I could visualise in my mind to lock certain memories away just for a short period of time, like, we would draw a box with padlocks on it. Erm, my safe things are dogs. So, then we would draw dogs or paw prints on there [pause]'cause they were guarding that box and keeping it safe. And they were things that I could [pause] 'cause I could [pause] I'd seen them on paper once I could then [pause] visualise them so if I had a bad memory come in or erm, I didn't feel safe to deal with it [pause] I could visualise those things in my mind. So*

> *[pause] Yeah [pause] They're in a box until my next therapy session [pause] where it was safe to open that box and deal with the memories.*

Although it is hard to ascertain what intervention participants' therapists were practising, there is evidence that psychodynamic treatments effectively reduce NSSI (Klonsky et al., 2011). Additionally, the treatments considered for NSSI appear to share particular aspects, such as understanding past and current relationships, emotional intelligence and focus on developing self-image (Klonsky et al., 2007). Bateman and Fonagy (2001) as well as Korner, Gerull, Meares and Stevenson (2006) included NSSI as an outcome variable when using a psychodynamic treatment, and both reported a reduction that was maintained beyond 12 months post-treatment.

For Maddy, who had no family in her life, reaching out was something she had done from an early age:

> Maddy: *[…] but perhaps from the age of 18 I would ring the Samaritans or try calling on friends. I started to open up more to [pause] I got used to talking about my problem, so I would open up more to therapists. Erm, even though I hadn't known them long I would ask them for help and coping mechanisms.*

Other participants also found it helpful to speak to the Samaritans. Amburo reached out to them when she had been feeling suicidal and accessed them regularly when engaging in NSSI.

> Amburo: *Samaritans are people who are like, you know, they all had years of training or whatever, it was really helpful… Like after I talk to them, just to have a chat when I just sort of like need a person and I have also talked to them when, you know, like I am standing next to, on like a platform waiting for a high-speed train to pass by, erm, but I definitely had like overall a more positive experience of them, so yeah I do use them quite a lot.*

Again, this highlights the possible benefits of having someone available when people are feeling in distress and in need of human contact.

Maureen found the crisis team helpful, as she felt they were there not just there in times of crisis but also when she wished to explore and reflect on different aspects of her life.

> Maureen: *I still have the number for the crisis team. And, erm, there was one, one lady there, [name] who I, I [pause] we could talk for ages, erm, and that was often about exploring different things and why I, you know, why I felt like that. There was a lot of reflection and exploration of why these things were affecting me in this way.*

Annita also received this kind of support from the crisis house. She felt accepted and safe to explore her emotions in this environment.

> Annita: *[...] In the crisis house it's, like, more about, "What's happened to you?" So, you're able to explore things and it's in a safe environment for women [pause] I learnt how to talk about things [pause] rather than just go for the razor blade all the time. And they gave me the time to do that as well. But sometimes there were times that I didn't know why I [pause] I didn't know, I just did it and that was okay too. They would say that that's okay, but it's the fact that they, kind of, validate your feelings and they want to spend time with you and, you know, it's supporting and help you ground yourself with other methods. You know, it doesn't always work, but it's [pause] I think it's the way that [pause] It's like the therapeutic approach that they used.*

Annita wished to understand her distress but still needed to use NSSI and not be judged for doing so until she had found other ways to manage her emotions. She found this form of unconditional support at the crisis house, where a trauma-informed approach was seemingly used, collaboratively exploring 'what happened to you', rather than 'what is wrong with you' (Sweeney & Taggart, 2018). It seems that a policy which allows for NSSI creates an important space for exploring alternative coping strategies. As discussed earlier this can reduce the feelings of shame that such a restriction can exacerbate. Annita also explained that once she had visited the crisis house, she could self-refer at any time. Participants appeared to benefit from knowing that someone is there for them.

Maddy also appreciated brief conversations with the community mental health team (CMHT).

> Maddy: *Erm, checking with my community mental health team even if they were just to call me, a 10-minute phone call, just to check in with me 'cause I felt even though I didn't want to talk about self-harm I felt quite isolated. I just wanted someone to call to make sure I was okay and even just [pause] for a general chitchat.*

Maddy did not necessarily wish, at that point, to speak about her NSSI or deeper issues (which she later explored as an inpatient), but it was helpful to know she was not alone.

The need for human contact expressed by Annita, Maddy, Amburo and Maureen resonates with Long et al.'s (2015) study, where the importance of contact was also highlighted. It may also be worth considering whether there are advantages to having such support available at any time, eliminating the problem of individuals being unable to find or ask for support (Whitlock et al., 2015). As Maddy pointed out, this also eliminated feelings of alienation and social isolation. This is important because feelings of loneliness often precede engaging in NSSI (Castille et al., 2007).

Other participants spoke about the usefulness of being able to explore underlying issues which, as Matt explained, helped to reduce NSSI:

> Matt: *We wouldn't have talked directly about the self-harm, we'd have talked about the things, about the things that are around it. So, I think the way we used to work, was to talk about what was going on, and by doing so, you would reduce the chances of self-harming.*

Vanessa felt that making sense of what was causing her distress helped much more than interventions which were focused on reducing her NSSI.

> Vanessa: *I honestly think that it wasn't for a few years of seeing the therapist when it finally came out that there was like abuse going on at home and they kind of got to what was behind a lot of the reasoning for it [pause] and the impact it was having and, you know, getting to the bottom of what was causing it, that had far more of an impact than any strategies around not harming.*

As noted above, Long and colleagues (2015) identified the need for counsellors' willingness to see beyond NSSI and discuss underlying issues that are important to clients. They advised counsellors against purely focusing on NSSI cessation.

Completing this sub-theme of helpful professional support is a reference to a professional intervention that was not necessarily intended to have the effect it did. Maureen had been on a high level of antipsychotics and painkillers for many years. Due to a suicide attempt, the hospital stopped all her medication.

> Maureen: *The biggest thing was that I took the overdose, they had to wipe me off all the medication. Erm, because just the state I was [pause] you know, just my body couldn't take it anymore. Erm, and that actually [pause] that cleared my mind. I was going to say I wasn't I was… I was on a that huge amount of medication that that [pause] just made [pause] even thinking difficult, erm, I mean I would sleep most of the time anyway [pause] I can remember that when I started to regain consciousness, and that was a slow process [pause] But actually feeling, feeling different about life. And knowing that I wanted a different life to the one that I had [pause] So they actually sort of got me into a shower and I was sitting down, but I was laughing. I can remember the nurse saying, 'what are you laughing at?' I said, 'but I can feel it, I can feel the water'. And it was the most amazing feeling ever. To suddenly sense, to have your senses back.*

After her medication ceased, Maureen could feel sensations and process thoughts in a way she had not done for many years. What is of particular interest is her new ability to make sense of the some of the courses and interventions she had been introduced to when she was taking medication. It was as if she had heard and retained the information but been unable to process it until the medication ceased.

> Maureen: *Yeah, it was sort of sitting back there and these books just sort of brought it forward and [pause] cos there were things that I thought 'grief that makes sense now!'*

Participants shared a need for human contact, which enabled them to start making sense of their experiences and learn new coping strategies. Similarly, Kool and colleagues (2009) suggested that nursing interventions should encourage people who engage in NSSI to learn alternative behaviours. Participants also appeared to value being able to access support when they felt the need, rather than waiting until their next appointment, highlighting the need for more support to be offered in the community. Although not explicit, these interventions seemed to help the participants manage their difficult feelings, such as those of shame and low self-worth.

Theme 2: Experiences of informal support

Participants spoke about their experiences of informal support. The three sub-themes identified were self-help, psychosocial support, and family and friends, as illustrated below:
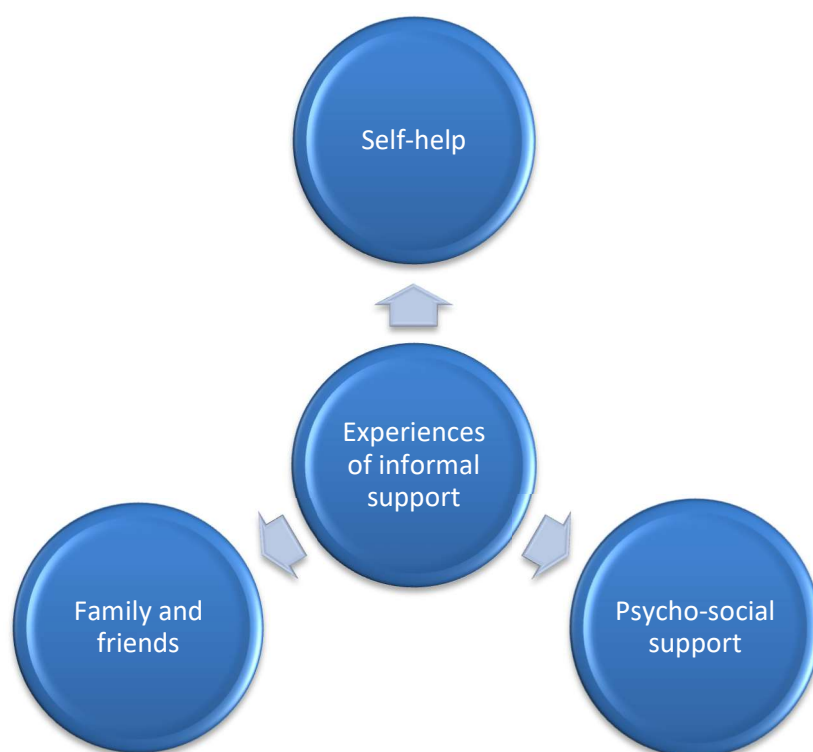
Self-help

Participants spoke about their experiences of self-help, although these varied in nature. Matt spoke about the benefits of choosing to cease his medication, whereas Amburo researched a diagnosis that made sense to her and then approached her doctor for a referral. Vanessa benefitted from exercise, while Tamara found a helpful strategy of highlighting her current scars and eventually covering them with tattoos. Maureen spoke about the use of various self-help strategies such as self-help books, writing, walks, reflexology and reflection.

Matt felt his NSSI was connected to his use of medication as it started after his doctor prescribed him anti-depressants and ceased when he chose to stop his medication:

> Matt: *And really, I think all my self-harm ended when I took the massive step of deciding just to come off all my medication.*

To the author's knowledge, there does not appear to be any research exploring medication as a possible trigger for NSSI, however there is limited research supporting the efficacy of various pharmacological treatments. To date, it seems no scholars have focussed on the effect of such treatments on NSSI alone, and others, as suggested by Turner, Austin, and Chapman (2014) are limited due to small or uncontrolled reports (Klonsky et al., 2011). It would be interesting to know if

others had the same experience as Matt. Maureen also ceased NSSI after ceasing medication, but this was a conscious decision for her.

Amburo's self-help strategy was to research until she found a diagnosis that she felt explained her experiences, and then to ask her doctor for a referral. She hoped that by confirming a diagnosis, she could make sense of her experiences, and subsequently access support.

> Amburo: *[…] I went to the GP when I was like 23 or something and I was like, you know, I am really having problems in my relationships, I think I have a personality disorder so can you refer me?*

Due to her diagnosis, Amburo was able to access an intervention. However, she also reported that the diagnosis could be a hindrance, such as when attending A&E, as mentioned earlier. Although Amburo was referring specifically to her BPD diagnosis, it is interesting to note that similar feelings were expressed in a study conducted by Lewis, Bryant, Schaefer and Grunberg (2017) about the possibility of NSSI becoming a formal diagnosis. Participants in that study spoke about how this would increase understanding of NSSI and validate their NSSI experience. They believed a diagnosis would reduce stigma, encourage NSSI help-seeking and improve NSSI treatment. However, disadvantages voiced were increased stigmatisation and diminishment of underlying concerns.

Ideally, it would be beneficial if interventions were available regardless of a diagnosis as general understanding is increased. Despite the prevailing circumstances, Amburo was resourceful in her ability to get her needs met and unfortunate that the same 'label' also caused her distress when attending A&E. It is also interesting that Amburo found an understanding of herself through ideas that have fed from the medical model back into popular culture (Parker et al., 1995), rather than being able to gain the support she needed prior to her self-diagnosis. Perhaps she internalised her oppression from the treatment at A&E (Justice, 2018) to the point that she needed to find a 'label' to would explain what was 'wrong' with her rather than learning/being supported to understand it as a formulation, and being treated as an individual (Johnstone, 2014).

Vanessa found running an important distraction in her early attempts to cease NSSI.

> Vanessa: *Erm, er, having distractions, to busy me self, you know, going running, that was always a good one if [pause] I got really tempted in the early days, you know, going out for a run and, sort of, those feelings of release from a good sweat. I know it sounds silly but at the time when I was trying to, sort of, really stop and not do that, that was a big thing that really helped.*

Vanessa found it important to participate in an activity which avoided any attention being placed on her arms. Also, since exercise has also been linked to pleasant activated feelings (Hyde, Conroy, Pincus, & Ram, 2011), it may have helped with difficult feelings associated with the desire to NSSI. Jarvi, Hearon, Batejan, Gironde and Bjorgvinsson (2017) found that participants with a recent history of NSSI engaged in significantly less physical activity than those without a history of NSSI.

In contrast, Tamara found that highlighting her current scars as a reminder that she did not wish to add more helped her reduce her NSSI. She appeared to utilise consequential thinking.

> Tamara: *[…] getting a red pen and highlighting all the scars that I already had. So, it was kind of like don't add to it, but it was a process of marking my body but not in a [pause] not adding to anything that was already in existence. Um, I've since got tattoos to cover up much of my scarring. So, I[pause] that helps me not want to affect that area of skin because it's got tattoos that I like on it.*

Although Tamara does not explicitly explain this, possibly due to it not being in her awareness, there is a possibility that feelings of shame and the stigma attached to NSSI (Taylor et al., 2019) led her to find a more socially acceptable way of covering her scars. This, in turn, may reduce the uncomfortable feelings the scars may provoke, avoiding the need to work through to scar acceptance, which feelings of shame may have hindered (Lewis & Mehrabkhani, 2015). Either way, this was a creative way of dealing with her scars.

Maureen had various self-help strategies she found helpful. As mentioned earlier, as soon as she ceased her medication, she began to read, recalling and building on information she had received in the past. Maureen also benefitted from writing, walking, reflexology and reflection.

> Maureen: *[…] start to look at self-help books… you know changing attitudes and how to progress. I know one of the first books I read was Susan Jeffers 'Feel the Fear and Do it Anyway' [pause] when I was able to get out I would literally just take myself off for a walk [pause] I would do something, you know, try and use a different coping mechanism and reading was what really helped. Was reading about it and thinking about it. Writing, writing was oh just amazing [pause] just to get it down [pause] I had reflexology every week [pause] and that was just the most amazing thing [pause] so if I was feeling very anxious and erm, uptight, and things like that, if I thought about that and when [name] was giving me reflexology, it literally did, it would take me [pause] to when she was doing that and then the calmness. I do use reflection [pause] what was going on for me at that time? Could I have done something different?*

Reading, writing, walking and reflexology combined with Maureen's ability to self-reflect enabled her to move forward. Much of Maureen's journey to ceasing NSSI was due to her ability to incorporate self-help into her daily routine. This allowed her to develop different coping strategies and respond to her feelings in a more helpful manner.

Support from others in the community also seems to be of importance.

Psycho-social support

Claire spoke about pushing herself to leave the house and visit a park, where she eventually began to speak to others. Derek sought such contact through volunteering, open mic nights, support groups and people who expressed kindness.

Claire also started searched online for other people experiencing NSSI, allowing her to start making sense of her experiences, connect with others and not feel so alone:

> Claire: *Well, I started doing that and sometimes I didn't even want to get out of bed. And I pushed myself little by little by little, I mean, I started meeting people [pause] I just did the whole reading about it things. And trying to speak [pause] to see if other people's experiences [pause] online to see if there were anyone that [pause] why they did it. Was how many people do this? Why do they do it?*

Derek reported the importance of contact with others. This was important for both Derek and Claire, as they feared reaching out for help in case they were taken to a mental health unit. Derek also feared being forced to take medication.

> Derek: *[…] when people saw that I was a bit screwed up in certain places I used to go to erm, er, there was a garden centre that I did [pause] that I worked at, volunteered there and the workplace that I'm still at now I volunteer there. Erm, and erm, there was a music, an open mic place that I erm, used to go to and they had other, like, community things going on there and some people in the street I would, like, talk to and some people would be very nice. And erm, the police sometimes would be very nice erm, and I would accept, like, talking to them and stuff to the point of referring me on to the mental place. If anybody did that then I wouldn't go but, I mean, I would accept their, their erm, warm and generosity otherwise, yeah.*

Derek: *[…] Yeah, I mean, it would be better […] some of it is in person, but erm, but there's er, erm, that […] but yeah most of its online, yeah.*

Claire shared that an advantage of talking to people online was that she did not need to worry about the consequences of reaching out for support, as her identity could remain a secret (Rodham, Gavin, Lewis, Bandalli, & St. Denis, 2016). Online presence has been researched and although concern about the nature of some online advice and content has been expressed (Lewis et al., 2012), it seems that exposure to hopeful online messages can enhance a positive attitude toward recovery (Lewis et al., 2018). Additionally, due to the public nature of online presence, authors of another study posited that this served a purpose of 'bearing witness', as well as being able to allow users to seek and offer support to like-minded individuals (Rodham et al., 2013).

Derek and Claire both also reported benefiting from human contact. It would be ideal if the fear of the consequences of reaching out could be eliminated, thus enabling individuals to reach out without fear of having their liberty removed. This was something Derek was able to find through a support group and as discussed previously, is something that community psychologists encourage.

Derek: *[…] a lot of these events are quite few and far between now so it's not as erm… they're not very all large or established. And [name] there's a charity called [name] I went to erm, to meet with them and write an article for them once which was, which was nice, and I didn't feel under any threat. And [pause] And there is some, there's some survivors around some of those communities that I've met in person […]*

It would be advantageous if more support groups were available so individuals could seek support and understanding whilst reducing the fear of ramifications. Buser et al (2014) revealed that one possible aspect of natural recovery from NSSI was moving from unhealthy to healthy surroundings. These groups could offer individuals a space to experience a healthy environment with the support of their peers. Whitlock et al. (2015) expressed students' desire for social support, which was also expressed by the participants in this study, therefore appearing to be a need of students and adults in the community alike. Social support could help combat feelings of social isolation and alienation (Castille et al., 2007). If people were participating as part of a group it is feasible that they may gain a sense of identification and a sense of belonging, counteracting feelings of social isolation and alienation. The need for belonging is innate in all of us (Yalom & Leszcz, 2005). Many individuals may not have previously felt part of a group, so the success of feeling part of a group may in itself prove to be curative, in addition to increasing self-esteem (Yalom & Leszcz, 2005). In time, such positive

interaction may help Derek with his unhelpful internalised oppressed (Justice, 2018) thoughts that others saw him as 'a bit screwed up'.

Family and friends

Support from family and friends was also crucial. Maureen appreciated contact with her friends and Leslie realised the importance of family too. Having Derek's family back in his life was of huge importance, while Tamara's support came from her mother.

Maureen had stopped calling friends but realised the advantages of reconnecting to them.

> Maureen: *[…] do something that I had stopped doing, which was calling friends but actually for, er, for 'do you want to come up for a coffee?' Something that was light and, erm, very different. Erm, a girlie, you know, like a girlie chat?*

Maureen also took the opportunity to share her feelings when it arose.

> Maureen: *Talking, that's it, talking. Telling people how you feel.*

Leslie felt that support from family and friends had helped her cease NSSI.

> Leslie: *Yes, I think, yes, I think kind of, erm, support from family and friends…*

Derek felt he had lost his parents' support for a period, but at the time he reached out to support groups, his family came back into his life. The support offered by his family helped him to cease his NSSI.

> Derek: *[…] since I've started talking out about it they've started, like, believing me and supporting me again. So, I've, kind of, got my parents back when I lost them from that. They were turned against me by the mental health system [pause] so much more helpful and peaceful and I don't [pause] that's a contributing factor to me not having to resort to things like fasting and stuff, yeah and trying dangerous desperate things. I'm very lucky yeah, very lucky.*

In light of feelings associated with NSSI such as social isolation and alienation (Castille et al., 2007, stigma (Adler & Adler, 2007; Hodgson, 2004; Lewis, Michal, Mahdy, & Arbuthnott, 2014) and shame (Brown, Linehan, Comtois, Murray, & Chapman, 2009; Duggan et al., 2015; Rosenrot & Lewis, 2018; Schoenleber, Berenbaum, & Motl, 2014; VanDerhei, Rojahn, Stuewig, & McKnight, 2014), perhaps it is understandable that Derek's parents love and support would help alleviate these feelings, thus

reducing his NSSI. It feels sad that Derek perceived this support as being 'lucky', rather than a human right which again suggests he has internalised his oppression. In time with further support he may begin to feel he is worthy of this care.

Tamara had a close relationship with her mother. Being able to speak to her mum about her NSSI helped enormously. Luckily for Tamara, this was a positive disclosure experience. Although Chaudoir and Quinn (2010) were writing about revealing concealable stigmatized identities rather than specifically NSSI, they highlight that positive first disclosure experiences may have psychological benefits over time as they will increase the level of trust in others.

> Tamara: *I've got a very supportive relationship with my mum and, um, yeah. I think to be honest since that, um, since that disclosure it, it opened up just much more frank conversations and, um, yeah, she's very supportive.*

Relationships and support from family and friends are important. Vanessa highlighted the difficulties which can arise when family relationships come to an end.

> Vanessa: *...so every time there has been any upheaval there's been children involved and there's been quite intense [...] they've been quite intense relationships as well, and it's been, sort of, difficult to, sort of, move on from those and let those go. So it has resulted in, sort of, slipping back in terms of, you know, going back to some old coping strategies...*

Derek and Vanessa both highlighted that what was of great support can become difficult when there has been a breakdown in the relationship.

It is understandable that individuals who engage in NSSI value the support of their friends and family. As noted earlier, authors of a study conducted with students (Muehlenkamp et al., 2013) found that individuals who repeatedly engaged in NSSI reported significantly lower perceived social support from family members and fewer individuals to seek advice from than those who engaged in single acts and control participants (Castille et al., 2007). NSSI was also associated with perceived isolation and alienation (Castille et al., 2007). Feeling the support of family and friends is likely to be a relief when also taking into account difficulties with maladaptive attributions in stressful social experiences (Guerry & Prinstein, 2009), and fewer resources for adaptive solutions in social situations, as well reduced self-efficacy to utilise these adaptive solutions (Nock & Mendes, 2008). Therefore, the relationships participants spoke about are important, especially if their social networks were limited. As relationships with friends and families develop, it is likely to be easier for an individual to develop confidence and take risks in forming new friendships, which itself offers a potential route to more support.

Elements that were helpful and unhelpful for participants in ceasing their NSSI have been detailed in Themes 1 and 2. Participants did not like having their sense of agency removed or being placed in situations where they could not access support unless they ceased their NSSI. They also spoke about the fear of reaching out. In contrast to some unhelpful experiences on mental health wards and at A&E, participants valued therapeutic and healthy human contact, enabling them to learn new ways of coping and exploring their underlying issues. They expressed a desire to have support readily available which was not just exclusive to therapy. Participants recognised the benefits of self-help and reaching out to others as well as the support of family and friends.

Individuals presenting with NSSI tend to self-derogate (Herpertz et al., 1997; Klonsky et al., 2003; Soloff et al., 1994), so it is understandable that the quality of interactions with professionals and the community could influence their sense of self, as discussed in Theme 3.

Theme 3: Identity: Impact on sense of self

Participants spoke about factors that impacted their sense of self. Three sub-themes were apparent, namely self-worth, feeling judged and having labels attached, and the importance of having a voice. These are illustrated below:
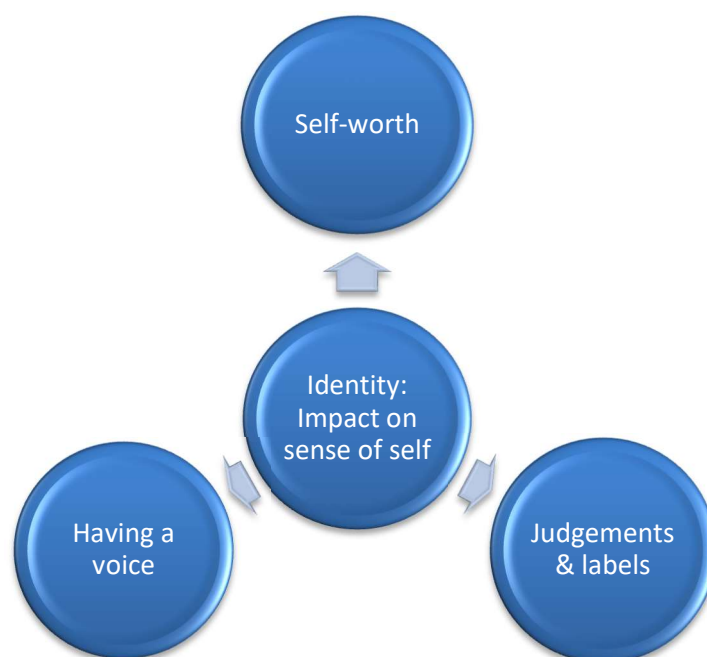
Self-worth

When an individual has a fragile 'sense of self', interactions can feel amplified and can, in turn, impact an individual's feeling of self-worth. Alison had an experience at A&E that reinforced a negative belief she already had about herself:

> Alison: *[…] not asking for help as well was, was I deserving of it really, I think. 'Cause, sort of, you know, some of the treatment I had in A&E [pause] erm, the way I was treated was that I didn't deserve help really because, you know, and other things that were said to me at A&E, you know, "You're wasting our time. There are people here that are really ill" [pause] I always remember being [pause] in A&E overnight 'cause my self-harm had been really bad [pause] and I was in an overnight ward with two other people, both of who had fallen over, one had cut their head, I don't know what the other person had done, but they were both drunk, they'd both been drinking. So all through the night the nurse was talking to these two other people. And they were, sort of, saying, "Oh, yeah, you know, when we go out on Friday nights we get pissed," and all this kind of stuff. Chatting, there was quite a lot of bravado. I do remember that night when I was completely ignored the whole time, that it's almost they've caused their injuries [slightly laughs], you know [pause] they've [pause] drunk to excess, fallen over in the road and cut their head. So [pause] why am I [pause] you know, the one to be ignored? I felt terrible, I mean, when [pause] you know, when they [pause] I genuinely did feel terrible. When they would say to me, you know, "There are people that are really ill here [pause] and, you know, you've done this to yourself" [pause] I felt incredibly guilty, you know [pause] I really did feel bad [pause] yeah I felt wretched, you know. And when I was, you know, chucked out in the middle of the night in the winter to go home [pause] and, kind of, you know, two-mile walk, you know, thought that's what I deserved really.*

Alison struggled with feelings of low self-worth and tended to self-derogate, which has been linked to individuals who engaged in NSSI (Herpertz et al., 1997; Klonsky et al., 2003; Soloff et al., 1994). Her experiences with nurses at A&E reinforced her negative beliefs and feelings, going against the recommendation from Kool and colleagues (2009) that nursing interventions should focus on forging a connection, encouraging people who self-injure to learn alternative behaviours and develop a positive self-image.

As well as the unhelpful experience of feeling ignored, which may have felt amplified due to Alison's childhood experiences, subsequently triggering feelings of shame, Alison also alluded to a sense of internalised oppression. This may not be in Alison's awareness, but sharing that she felt she

deserved such poor care and consideration could be indicative of a pre-existing belief, potentially from childhood, that in all likelihood was re-enforced and subsequently internalised by attending A&E.

Developing a positive self-image was not easy for some. Vanessa explained:

> Vanessa: *Er, I suppose it's me own attitude, you know, you've got to keep positive, you've got to want to change and that's really hard and you've got to feel you deserve it and that's really hard.*

Although not specifically for NSSI, as the authors of these studies also included people who had suicidal intent, low self-esteem has been documented to have links to self-harm. Lundh et al. (2007) found that high rates of deliberate self-harm are associated with low self-esteem while De Leo and Heller (2004) found that one of the factors significantly associated with increased deliberate self-harm is low self-esteem. Hawton et al. (2002) found self-esteem to be a factor associated with self-harm. It is perhaps understandable that individuals such as Vanessa, who have low self-esteem, find it difficult to challenge negative thoughts and feelings and feel worthy of care. It is also of concern to hear that rather than being given care that may help to tackle their already low perceptions of self, participants were often subjected to unhelpful interventions masquerading as care (Maloney, 2016), serving to reinforce their existing unhelpful self-beliefs. Participants may have benefitted from a positive intervention where empathy is exhibited, potentially leading to an increase in self-worth, as previously highlighted by Chaudoir and Quinn (2010), who reference positive disclosure experiences leading to higher current self-esteem.

It must also be considered that when interacting with people presenting at hospital, nurses are in a relative position of power (Maloney, 2016). An individual presents at hospital seeking the knowledge and support of a professional, whom they assume will have a certain level of qualification. The individual entrusts themselves into their care. Therefore, when someone like Alison experiences an unhelpful intervention with a nurse, this may have a greater negative impact on her than if the intervention came from an individual she perceived to be her equal.

Participants also reported experiences of external validation that allowed them to start feeling better about themselves.

> Claire: *[…] it [pause] and people were saying, "Yeah, you're amazing," and I was looking at them and thinking, "Are they joking? [pause] Saying, "You can be so helpful to us and you can do this and you speak all these languages and would you be interested in teaching*

mental health for the Latin/American community and? [pause] that appreciated me for who I was.

It was new for Claire to hear praise like this, and although she found these words hard to believe, they allowed her to start feeling better about herself. These words drew on Claire's strengths and what she had to offer to others, which allowed Claire to feel of value, as well as giving her purpose. A crucial part of feeling secure is the validation we receive from others (Parker et al., 1995).

Maddy also received external validation, although this came from her dog:

Maddy: *The worse feeling in the world for me would be to feel lonely again erm and with a dog or any pet I suppose that could never happen because they like me, all animals just seem to like me. And they want me and they rely on me so they need me, but I know that if a dog gives me a cuddle and a kiss, dogs can sense things, they haven't got an ulterior motive. So if a dog likes me it's because I'm a nice person else the dog [pause] would know. So they validate [pause] it's like, you're [pause] yeah, you're okay. You're doing alright, you're a nice person. Else the dog wouldn't like you [laughs].*

Maddy had struggled with her self-worth, but she began to work on this during her time in long-term therapy. The validation and unconditional love she received from her dog allowed her to build on her belief that she was worthy.

Alison's self-worth improved if she was spoken to as a human being. Sadly, this was rare during her experiences in hospital wards.

Alison: *[…] this is my best conversation with a nurse on the ward as well. He talked to me like a normal human being [pause] who has brains, who had potential, whose [pause] life wasn't necessarily going to be mental health [pause] he was just really nice [pause] saw me as an intelligent human being that, you know, could have hope really, I suppose.*

Alison also found this support in therapy:

Alison: *The clinical psychologist, erm, helped improve my self-esteem massively [pause] he helped me feel better within myself [pause] he helped me cope through the situation and then to coming out of it.*

This contrasts with Alison's previously reported experiences of attending A&E. Those interactions meant that Alison was able to potentially challenge her old beliefs about feeling unworthy.

Leslie's therapy allowed her to come to a place where her increase in self-worth decreased her desire to NSSI.

> Leslie: *[...] I think the therapy helped because it made me feel better about myself [pause] It gave me more self-esteem and helped me understand why I was doing things as well. It gave me the insight that made me think, "Well, yeah, well, the reason why I'm doing that is because that," [pause] to be able to realise that you're worth more than that action or that you, you [pause] you're worth more [pause] like, the situation that I was in, I put myself er, like bottom of the pile really and allowed other people to, kind of trample all over me. And then once I [pause] when I've got to the stage where I can think, "Actually, I'm really worth something and [pause] and I'm worth more than doing that to myself," that helps as well.*

When Leslie was given space to make sense of her actions and explore her beliefs, she could see she was worth more than she had previously thought. This would not have been possible in a detrimental interaction, as discussed earlier, as one could argue that to be able to explore these raw feelings there needs to be a feeling of safety and containment.

Amburo increased her feelings of self-worth by doing voluntary work with homeless people and contributing to the community.

> Amburo: *[…] well I used to volunteer when I did, volunteering has been helpful for my own health generally. Yeah, so that's just generally been helpful so that includes, it would have been helpful for the non-suicidal self-injury as well [pause] the most helpful for my mental health is probably I have done like homelessness volunteering [pause] it just makes me feel a lot better about myself so it helps with like confidence and erm, I feel like I am sort of giving back, I feel like I am doing something worthwhile.*

> When Annita started work she began to feel more worthwhile:

> Annita: *[…] my home circumstances massively changed in that time and, you know, I met my partner and, you know, I went back to work and, you know, it's like sort of, er, a bit of a snowball, you know, when you start picking yourself up the things that you're capable of doing and going back to. You know, and that makes you feel more positive and you've got more to, sort of, distract you and more to, sort of, make yourself feel worthwhile.*

Amburo and Annita highlighted that an increase in self-worth can be achieved within the community setting. Amburo felt more worthwhile as she had purpose by giving to those less fortunate than herself, while Annita's self-worth increased due to the value she felt from work. As Annita pointed

out, the addition of good things in her life created a snowball effect that subsequently fed into her increased sense of self-worth, which presumably would give her increased confidence to invest even further in those positive aspects.

How participants increased their self-esteem varied, but what seemed to be of key importance was the quality of their interactions. This also is interwoven with the next subtheme, in which the impact of judgements and labels on sense of self is considered.

Judgements and labels

Participants reported that their sense of self was impacted by how they felt they were judged and labelled by others. Sharon explained that she felt judged by people in the community and professionals, while Matt explained that he felt he was never accepted for who he was.

> Sharon: *I think people, people were judgemental. Yes, yeah, I mean, people being judgemental and not understanding (pause) why I was doing it. A mixture, a mixture. People in the community, but also doctors.*

> Matt: *[…] it would have really helped if I had been accepted as who I am, not accepted as Matt the self-harmer or Matt the lunatic but as Matt, and I was always nothing other than a piece of meat really.*

Sharon did not feel understood. People were not only judging, but they were also perhaps not sensing Sharon's distress. Matt felt like he was being treated as an object rather than a person. His reference to 'a piece of meat' provokes connotations of not being seen for the person within, but rather being defined by his behaviour. Sharon and Matt knew that others were using their NSSI to define them, rather than looking beyond it.

Alison struggled when she heard herself being referred to as 'the DSH' (deliberate self-harm) and 'a silly girl'.

> Alison: *[…] you're seen as a time-waster and all those kind of things, but some of the treatment was just quite awful really, you know, being left for hours and hours, just to be seen. The first time I heard someone say, "What are we going to do with the DSH?" and I didn't really know what that meant and I didn't [pause] really understand, you know, that they were referring to me [pause] hearing people talk about me in [pause] you know, ways I didn't understand or a bit derogatory [pause] I've been called, "A silly girl," erm, quite a few*

times, erm, er, people have said, you know, "Why have you done this?" but quite often the more common experience in A&E was to be treated in silence really.

There is a possibility due to demands placed on A & E that others without a presentation of NSSI may also need to wait long periods of time but the language directed at Alison *"What are we going to do with the DSH?", "A silly girl"* is dehumanising and infantilising. It could be thought of as another method of oppression when the individual is not treated as an adult, which in time will lead to internalised oppression (Justice, 2018).

Annita explained how a label was used to her disadvantage.

> Annita: *[…] it's just this derogatory, kind of, label that goes round 'cause more, more, more erm, well, more people are diagnosed with personality disorder if you self-harm. And there is an institutional stigma er, around in the system and it's horrible and it's, it's damaging and it's actually caused more problems […] for, for a lot of us. Erm, but er […] and I think on the wards especially, you know, you're seen as, like, badly behaved if you self-harmed […] rather than someone who's actually not well […] can actually pathologize you even more so erm, and it's like, if you challenge it then you're seen as a bad one as opposed to, "Actually, hang on a minute," I might have a point in challenging their attitude and they don't like it […] And so by challenging them they're reinforcing that label on you and then they're using it as […] well, they're using it against you, they're saying that, "Oh, yeah, well, you're being challenging because you've got this er, a, a label of PD". And, I mean, that infuriates me and so if you get angry it's, like, for them it's more evidence that you've got it. [Laughs] It's just ridiculous. Sorry, it's so stupid. It is a catch 22.*

Both Alison and Annita felt they were treated in a derogatory manner, which is unfortunate given that people who engage in NSSI tend to self-derogate (Herpertz et al., 1997; Klonsky et al., 2003; Soloff et al., 1994). As discussed in previous themes, these unhelpful interactions have the potential to reinforce negative feelings and beliefs of an already fragile sense of self, where feelings of shame (Rosenrot & Lewis, 2018), low self-worth (Lundh et al., 2007; De Leo and Heller, 2004; Hawton et al., 2002) and fear are prevalent.

Annita raised an important point about diagnosis. As discussed earlier, individuals with lived experience have expressed mixed feelings about a formal NSSI diagnosis (Lewis et al., 2017), with a potential disadvantage being increased stigmatisation. Formal diagnosis could also become an additional obstacle as it can create a circular situation where staff no longer see beyond the diagnosis.

Johnstone (2014) explained that a psychiatric diagnosis can be seen as an explanation, but in fact is a series of circular arguments, as Annita articulated. An example of this would be asking, "Why am I struggling to regulate my emotions?", to which the answer would be "Because you have BPD". However, asking "How do you know I have BPD?" could lead to the answer ''Because you struggle to regulate your emotions". Johnstone explains that in other branches of medicine, there is an exit from this circle as tests such as scans can be run that may highlight a brain tumour. Individuals might like a diagnosis while they endeavour to make sense of their current situation, but as Johnstone (2014) argues, formulation is a better way of doing this. As well as the reliability and validity of psychiatric diagnosis being open to question, diagnosis can also create many problems (Johnstone, 2014).

Many individuals who are given a psychiatric diagnosis may have feelings of shame, worthlessness, failure and hopelessness. Therefore, a diagnosis can be viewed as a confirmation that they are fundamentally flawed, thus reinforcing their beliefs about self. It can also create a situation where it is harder to challenge an expert verdict (Johnstone, 2014). Annita reported an incident in which she was completely disempowered and became her diagnosis. Diagnosis can also become a self-fulfilling prophecy if a person is told that they cannot be reliable and accountable because of their illness; the person concerned is more likely to believe this, and less likely to extricate themselves from the vicious cycle (Johnstone, 2014).

Johnstone (2014) argues for a better approach, where so-called symptoms are seen as survival strategies that have outlived their usefulness. Even if the cause of distress is not always initially apparent, creating a narrative of one's own story can facilitate a helpful healing process.

Participants appeared to be creating their own narratives when reporting positive experiences with their therapists. Although some had experienced specific trauma, others came from backgrounds of neglect, criticism and hostility, where their feeling of self-worth has constantly been attacked or others have normalised their experience, not realising the damage that was being caused (Johnstone, 2014). Being able to make sense of these experiences and how they adapted to cope could be argued to be more beneficial than a diagnosis, especially if others are unable to see beyond the diagnostic labels.

Participants' experiences of feeling labelled were not restricted to mental health wards and A&E. Maddy shared that she had felt labelled by family.

Maddy: *My family were so used to me self-harming that it had almost become old news, like, didn't seem to matter to them anymore. And my identity was Maddy who hurts herself and is self-destructive and [pause] so it didn't really matter to them what I did anymore.*

Maddy said she no longer had her family in her life, but one senses the pain she feels when using words like 'old news' and repeating 'didn't really matter'. To her family she had become her NSSI and her identity is invisible to them because of this label. Maddy's comments feel absolute as she expresses that her family perceive her in such a manner, rather than trying to understand what was behind her behaviour. The importance of unconditional love and support offered by family is explored in theme 2. If this support and understanding do not exist, this is understandably a potential blow to an individual's sense of self.

Maddy found this lack of understanding frustrating and described how unhelpful it was to be labelled as an attention seeker when she was trying to manage feelings of distress and ask for help. Maddy's comments highlight that her frustration could also lead to a feeling of apathy, emanating from the perceived lack of help and understanding.

Maddy: *There's also that a stigma with erm, say you've deliberately hurt yourself; you've done that and then you're asking for help people don't understand that. There's [pause] that attention-seeking stigma [pause] even if you're not labelled as attention-seeking the sheer [pause] the lack of understanding is frustrating anyway. So, it's just, "What's the point?"*

Maddy also mentioned the stigma attached to NSSI (Adler & Adler, 2007; Hodgson, 2004; Lewis, Michal, Mahdy, & Arbuthnott, 2014). Her comment supports the existing literature, in that stigma is likely to influence an individual's decision to discuss NSSI with others (Rosenrot & Lewis, 2018).

Claire, Vanessa and Maddy also shared how peoples' caring responses had been helpful. Claire appreciated peoples' discretion when she visited the park:

Claire: *And I used to take the t-shirt and you could see the cuts and there were other people there [pause] And they would talk a little bit with me and I knew they could see, but they didn't ask any questions and I started feeling gradually better.*

Claire highlighted an important point, as research indicates that scarring represents a potentially significant challenge for those who engage in NSSI, and it would be useful if therapists held this in mind (Lewis, 2016). Hodgson (2004) reported that individuals who engage in NSSI have concerns about others seeing their scars and take measures to hide them or make stories to socially normalise them. Claire took a risk when she left her scars exposed, as a helpful response was not guaranteed.

In a study by Lewis and Mehrabkhani (2015), participants with lived experiences spoke of feelings of shame that created a barrier to their scar acceptance. Therefore, how others react to NSSI scars may reinforce feelings of shame or, in the case of Claire's interaction, allow the person to feel better and potentially to work towards scar acceptance. This also demonstrates the importance of helpful responses to scarring whether from a therapist or the wider community.

Vanessa felt that her partner did not judge her but instead had faith in her. This allowed her to feel empowered:

> Vanessa: *[…] I think because he makes me more self-sufficient generally with his attitude towards me in that, you know, he puts a lot of faith in me to sort things but I know that if I'm getting really stuck he's going to be there and he's not going to shout at me, he's not going to judge me. Really empowering I think is probably the best word for it, he's very good at making me feel empowered.*

Vanessa's feelings of empowerment contrast with the feelings participants reported on the mental health wards and when presenting at A&E. Vanessa felt her husband allowed her to have a choice in her decisions, but she also knew he was there for her if it became too difficult.

Maddy's therapist's non-judgemental stance created a safe space for her, allowing her to analyse her own work:

> Maddy: *Er, it was definitively the work as well. My [pause] I've always been a really creative person. And my art psychotherapist allowed me to get that across on paper and just without being judged then we would analyse our work [pause] my work together.*

Maddy appreciated a collaborative approach where the power imbalance was taken out of the relationship. Her therapist tapped into Maddy's strengths and worked with her creativity.

Participants preferred a non-judgemental approach where they were seen as individuals rather than being defined by a label. It is clear that pathologising individuals is not helpful. A community psychologist would aim to improve the quality of life of individuals in a group. Rather than treating the individual as the problem for exhibiting certain behaviour, the focus would be on the individual in the context of the social environment (Dalton, Elias, & Wandersman, 2001; Kagan, Burton, Duckett, Lawthom, & Siddiquee, 2011). This setting would potentially afford individuals a voice, which was also valuable to participants.

Having a voice

Participants expressed feelings of not being heard or having a voice. Matt expressed frustration at not being valued for his opinion, especially when discussing his care. He felt a lost his sense of identity in the patient role and felt he was not given a voice.

> Matt: *I'd worked years at university and worked to achieve went in an instant with you know the people that were treating me. I wasn't given any credence for my own insight because I've got a deep insight into [pause] because I did psychology for four years, undergraduate, postgraduate. I'd worked with people [pause] victims of severe, horrific abuse. I counselled those, and it was like everything that I had done didn't matter. Anything that I, any ideas I had were who are you? You can't have ideas you're a patient.*

Claire felt the same when she was seeing a therapist. She felt desperate to speak about her experiences of abuse, but the therapist did not feel this was appropriate.

> Claire: *But I have a lot of stuff from my childhood and abuse and stuff that I need to talk, and she used to say, "No, no we can't talk about that." Erm, "I'm actually an expert in trauma and I think you are too traumatised to talk about it," and I said, "Well, to be fair, I'm not too traumatised to talk about it".*

Participants were frustrated by the responses of mental health ward staff to NSSI as they felt they were not been spoken to when they felt that they needed to be heard. This seemed to create a feeling of disempowerment, reminiscent to when their choices had been removed. Matt felt he was not seen as a valuable member of society who had views and knowledge on mental health as well as insight into how he would like his care to proceed. Matt knew what it felt to be respected as he had been a professional for many years, yet when he began to struggle, Matt felt his voice and opinions were no longer valid. Claire also did not feel valued for what she had to say. How people who engage in NSSI are responded to by professionals or members of the community will either help challenge unhelpful beliefs of low self-worth (Lundh et al., 2007; De Leo and Heller, 2004; Hawton et al., 2002) and potential feelings of shame (Rosenrot & Lewis, 2018; Lewis & Mehrabkhani, 2015) or detrimentally may reinforce those unhelpful beliefs and feelings.

Similarly, Alison felt she had no voice when it came to discussing her care:

> Alison: *And the patients say what they would like is for someone to speak to them for five minutes a day. I mean, you know, I thought, well, if that's, you know, that's all we're asking for. That's probably what I would have been happy with… what I would have liked would be,*

erm, to ask what I think, erm… I remember quite often with the not so good psychiatrist having, you know, a five-minute appointment, which gave me no opportunity to speak.

While Annita felt she could not speak when she felt she needed to explore her NSSI:

Annita: *For self-harming they either put you on closer obs. They don't want to talk to you about it and it's, like, they just use it as, as a method of controlling you and saying, "Right, okay, you're not allowed out," or they'll have to put you on close observation.*

Annita's feelings again highlight the difficulties experienced by participants on mental health wards. What staff perceive as care (Maloney, 2016) may feel controlling and punitive to patients. Not allowing someone their voice is a form of power and oppression which may lead to internalised oppression (Justice, 2018).

Amburo felt she was not heard when she asked not to be discharged from hospital. She felt it was too soon and that nobody cared.

Amburo: *[…] one time I felt like I was getting discharged too early and didn't feel like they cared and they were very interested and erm, so I felt a bit like I was wasting my time and a lot of the time I would just end up feeling worse [pause] I didn't matter, that I wasn't being heard.*

Amburo's feelings resonate with a point raised earlier; that the greatest time of need for individuals who self-harm is the period directly after discharge (Cooper et al., 2011). Amburo not feeling was being heard at this time would likely reinforce unhelpful feelings and beliefs.

Finally, Derek highlighted the power of having his voice heard.

Derek: *I stopped about two years ago. Since I started talking about erm… and do… talking about the erm, damages that the psychiatric drugs cause, I've stopped since then.*

Once Derek felt he was being heard and not mocked, as well as gaining a sense of belonging at the support groups he attended, he no longer felt the need to NSSI.

Participants expressed which interactions helped promote their sense of self and which they found frustrating and upsetting. Interacting with others who believed in them, allowed them a voice and saw them as a person was more helpful than feeling disempowered by having their voice taken away or being labelled or treated in such a way that fed into an already fragile sense of self.

Amongst the descriptions of various interventions/support, it was evident that relationships are of importance. Theme 4 explores what it is about relationships that mean so much to participants.

Theme 4: Importance of relationships

Relationships were clearly of importance to participants. Two sub-themes were found and are illustrated below: consistency and connection.

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      │  Consistency │
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      │ Importance   │
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Consistency

Sharon spoke about the importance of regular contact with others. The people varied, but she knew she had someone to turn to.

Sharon: *So, the whole of the DBT was the most helpful, but before then it was, I was seeing the counsellor or seeing the care coordinator and be able to talk about the things, that seeing somebody regularly.*

Alison spoke about people in her life who had always been there for her. She described difficult counselling sessions with a therapist, whose style was to remain silent. Her NSSI generally increased after these counselling sessions, so she reached out for support and her pastor travelled to meet her, just to sit with her and support her. Whatever happened, her friends were there unconditionally, as expressed by the three core conditions empathy, congruence and unconditional positive regard (Rogers, 1957). Alison explained:

Alison: *[..] had two friends from church, so I've been to church all my life and that's really important to me. So, one was the pastor at the church and then the other person was a lady who were like parents to me, they were like parents [pause] that I never had. And I think, you know, having those consistent people in my life for a number of years [pause] never gave up [pause] did so much to support me so it was almost like someone was, kind of, holding on to me all that time [pause] I felt a lot of the time I didn't have anything to live [pause] So having someone, that was, you know, two people that were consistent.*

At this time these two people were all Alison felt she had, and she became emotional as she spoke about their support. Whatever happened, they were a consistent support, possibly helping to challenge unhelpful thoughts and feelings of low self-worth (Lundh et al., 2007; De Leo and Heller, 2004; Hawton et al., 2002), shame (Rosenrot & Lewis, 2018; Lewis & Mehrabkhani, 2015) and fear. Many participants, including Alison, had lives which had been filled with chaos and inconsistencies. Therefore, having someone reliable, caring and consistent would be important, and it is understandable that they should wish to keep these people in their lives.

Annita highlighted the need for consistency to build up a trusting relationship, which for her took time.

Annita: *I think for me I've just learnt to reduce my self-harm by having my therapy [pause] consistently having that relationship with my therapist, that I can just say anything to her and I know it's not going to, like, spin out into, like, a bigger thing [pause]. It's the consistency. So time and continuity in that relationship, you're not bouncing from one person to the other and not having enough time to build up a trusting relationship because with the consistency you need to feel you've got the time to build that relationship. And so you gain*

trust. I do not trust people easily erm, it takes a long time for me to trust people. Erm,
especially when I'm dealing with a lot of personal stuff.

Annita explained that trust allowed her to feel safe. She could then begin to explore and gain insight.

> Annita: *[…] the crisis house again it's, like, yeah, I know who the staff are, they know me,*
> *they've seen me really bad and so I can open up to them. It's that continuity again and trust*
> *that you can build and, and that gives you safety. So it's you can't feel [pause] I can say*
> *safety to you, but that doesn't come initially, it [pause] it's the therapeutic relationship that*
> *you need to build up on [pause] before you get the safety. So, then the safety becomes a time*
> *that, you know, you can then explore stuff. And try and work things out and get a better*
> *understanding of yourself.*

Many individuals who engage in NSSI have trust issues, especially if they have been exposed to unhelpful interactions and interventions. People need time to build caring, trusting relationships, so if an individual's trust has been abused through adverse childhood events and unhelpful interactions or interventions, they are going to need more time to feel safe. Long et al. (2015) highlighted participants' desire to build a trusting relationship, and although Chaudoir and Quinn's (2010) paper was in relation to revealing concealable stigmatized identities, they highlight that positive experiences may have psychological benefits over time as it will increase level of trust in others.

The importance of this consistency was also discussed by Hawkey et al. (2007), who identified that isolated individuals would experience greater interactions with strangers rather than individuals who have ongoing social relationships. Moreover, if the social interactions of individuals who feel socially isolated are more negative and less subjectively satisfying (Hawkley et al., 2007) this contributes to a vicious cycle in which the person becomes more and more isolated.

Maddy engaged with her therapists for three years, ensuring consistency. Initially, she tried to 'push them away' and tell them things so they would not like her, but their consistency and presence allowed Maddy to begin to trust.

> Maddy: *[…] and once we got through that period after about a year that was when I really*
> *started opening up and I wouldn't be where I am today without them, so [pause]. As I said,*
> *never giving up, their [pause] consistency. Push them away, they wouldn't go. If I told them*
> *that I didn't want to see them they would respect that, but they would still turn up for the*
> *next appointment, they never got [pause] they never wavered once.*

This was not easy for Maddy as she had been a victim of childhood abuse, as well as experiencing unhelpful and at times detrimental support in professional settings. Her therapists were aware of childhood experiences, meaning they understood when Maddy pushed them away. Maddy disliked herself so much, she feared that if they knew her, they would reject her. However, her therapists helped her to challenge these beliefs and gave her the support, care and understanding she needed. A consistent period was required for Maddy's trust to develop, so she was able to finally understand that these people were not going to let her down, which had been her experience in the past.

Maddy's desire for consistency echoes a study by Huband and Tantam (2004), where patients reported that having a long-term relationship with a key worker and being encouraged to express feelings were helpful strategies. This is in line with NICE guidelines on the long-term management of self-injury, where the importance of health and social care professionals using a non-judgemental approach to develop a trusting, supportive and engaging relationship is emphasised, as well as an awareness of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service (NICE, 2011).

Consistency seems to be of importance, although participants also spoke about the importance of connection. As many of the participants spoke about feelings of isolation a sense of connection seems to be vital.

Connection

Claire had felt alone for a while:

> Claire: *[…] it was almost, like, oh [sounds exasperated] I don't know, I just felt really, really, really isolated.*

She began to make a conscious effort to visit a local park. At first, the thought of speaking to someone seemed excruciating, but then she realised she quite liked it.

> Claire: *[…] you know, it just happened one day, this gentleman with his dog that I used to see he stopped and just started talking to me and I remember thinking inside, "Oh God, go away, go away, go away." But then started talking and it was actually quite nice.*

This led Claire to appreciate her surroundings and develop a connection with nature in a way that might be encouraged when practising mindfulness.

> Claire: *And then the dog [pause] animals are a big thing for me and then [pause] well, I used to go to the park and I used to just lie there on the grass listening to the birds and nature [pause] and there were these crows that always used to come, the same crow. I used to take food and then they used to come. And I thought, "This is lovely."*

Claire had felt alone, and although it had taken great effort for her to go to the park, she felt the benefits of doing so, connecting with other humans and nature. Researchers have supported the potential health benefits of nature contact (Frumkin et al., 2017), highlighting an association among measures of nature connectedness, wellbeing and mindfulness (Howell, Dopko, Passmore, & Buro, 2011). This aligns with the study by Buser et al. (2014), where the benefits of healthy surroundings for naturalistic recovery from NSSI were highlighted.

Alison and Derek also felt alone before they found the support and connection they needed:

> Alison: *Erm, I can honestly say that in the early days I really honestly thought I was the only person in the world that did what I did.*

Alison had found this to be a lonely place, thinking she was the only person who engaged in NSSI. She found comfort and relief knowing there were others like her.

> Derek: *Yeah I was considering actually dying before erm, before I did get in contact with them 'cause I didn't [pause] through the mental health system a lot of the time you think you erm, you [pause] they don't encourage patients mixing with each other. So, I thought I was the only one that [pause] Yeah, completely isolated with it, yeah. Yeah, exactly, I was really at a turning point at that time [pause] where I thought [pause] where I was considering erm, erm, I was considering dying at that point if… yeah. Yeah and then so I was glad to not be isolated at that point.*

Finding support through survivor groups allowed Derek to realise he was no longer alone, and that others had experiences such as his and were willing to listen and support. Derek's quote demonstrates a sense of loneliness prior to this connection which not only impacted his NSSI but had also led to thoughts of suicide. His new group seemed to help alleviate these feelings and experiences of alienation and social isolation, which have been identified in connection to NSSI (Castille et al., 2007).

Sharon found this connection with friends from church while Amburo reported a connection with God.

Sharon: *[…] it's being able to talk to them on the phone or at church or I suppose go out for coffee with them, things like that really. Spending time with people, yes, yes.*

Amburo: *I clean myself [religious ritual] and then afterwards I pray for five minutes and I take time out away from work and stress and, you know [pause]. Erm and stay connected to like God and just your faith [pause] he is also like, just like a hand, like I feel like I am not alone when I think of God. It is like, you know, at least I have got God like, I might be feeling lonely and down or whatever, but I realise that there is some sort of like supreme being or creator that I can't see, who is out there looking out for me.*

Knowing her God was there gave Amburo a feeling of connection and reassurance. She did not feel alone when she thought of God. Amburo also found a connection through people who had shared similar experiences.

Amburo: *I mean I have got most of that from MBT therapy because there was a group, there was a group element, but even just online communities and anywhere where I could find people who understood the views that I had, had similar experiences and, you know, weren't going to judge me and, erm, so like I have had, I have got, I have had a few friends who actually had the same personality disorder diagnosis. We could just be sort of open with each other, or we could get each other [pause]. So that's really helpful knowing that, you know, I am not alone and there is other people that are, you know, sort of fighting this same battle.*

There appeared to be a sense of camaraderie amongst Amburo's friends through a shared understanding of their difficulties. As relationships had been difficult for Amburo this may have been of particular importance to her. In Amburo's case, an online presence seemed helpful, but in their thematic analysis of online autobiographical accounts of NSSI, Breen, Lewis, and Sutherland (2013) highlight that self and identity processes which are particularly relevant in early adulthood may contribute to vulnerability to engaging in NSSI. This self-identification with NSSI, which also provides a community of others to identify with, may become enmeshed when developing a sense of self.

Claire also sounded relieved to know she was not alone:

Claire: *Knowing there are others like me.*

The author of a study utilising a resilience research approach highlighted the importance of connections to parents, non-parental adults, friends and school (Masten, 2009). Taliaferro and Muehlenkamp (2017) explored protective connectedness factors amongst LGBTQ youth and reported that feeling safe at school and connected to non-parental adults were relevant factors for

reducing the risk of repetitive NSSI. Taliaferro, McMorris and Eisenberg (2018) found that transgender and gender non-conforming youths suggested that feeling safe at school, being connected to non-parental adults and parent connectedness are robust protective factors.

Many individuals who engage in NSSI in the community will not have parents and teachers who can provide a sense of connectedness. This highlights the importance of educating the community and health services to the needs of this vulnerable population. Kool et al. (2009) identified connection as important for all phases of the process. They suggest that nursing interventions should focus on forging a connection.

Annita felt this connection was imperative when it came to her therapeutic relationships and explained if she did not feel connected, she could not spend time speaking with her therapists.

> Annita*: It's definitely the relationship. The relationship is crucial. If you haven't got that relationship you haven't got the, the time for exploration or anything else. You know, you can forget it, like, I close up, I don't even bother to talk to people when I can't connect to them or I haven't, you know, I haven't got the time to talk to people.*

Both consistency and connection were identified by participants as important. This included consistency of knowing someone was there, consistency of the same therapist, connection to nature and/or connection to others.

Arguably, NICE guidelines for working with people presenting with self-injury do not adequately address consistency and connection. The guidelines recommend three to 12 sessions of a psychological intervention and the ability for the therapist to work collaboratively with the person to identify the problems causing distress or leading to self-harm (NICE, 2011). They also suggest that health and social care professionals working with people who self-harm should aim to develop a trusting, supportive and engaging relationship with them (NICE, 2011), which could be thought of as encouraging connection (although this is not expressly mentioned in the section for psychological interventions). Even so, in light of the current findings, one could question whether three to 12 sessions are a sufficient duration to develop a trusting, supportive and engaging relationship with the consistency that participants explicitly stated they desire.

In contrast, NICE guidelines for individuals diagnosed with BPD, with a focus on reducing their self-harm, recommend not using brief psychological interventions (of less than three months' duration) either for BPD or for the individual symptoms of the disorder (which may include self-harm). In addition, NICE recommends that for women with BPD for whom reducing recurrent self-harm is a

priority, a comprehensive DBT programme should be considered (NICE, 2009). It appears that, to procure consistency and the time to build a connection, one needs to have a diagnosis of BPD.

Conclusion

The aim of this qualitative study was to gain an in-depth knowledge of adults' lived experiences of interventions and support on their journey to ceasing NSSI. Individuals who volunteered from the community shared their experiences, and it became clear over the course of the analysis which support and interventions participants considered helpful and unhelpful. Participants did not like having their sense of agency removed or being placed in situations where they could not access support unless they ceased NSSI. Some did not know where to go for helpful support, which seemed to be exacerbated by a fear of the consequences of reaching out. Unhelpful interactions may create or exacerbate feelings of shame, stigma, internalised oppression, low self-worth, alienation and social isolation. These unhelpful feelings not only increase the likelihood of NSSI but may also interact, thus creating further distress.

On the whole participants, found therapy to be beneficial aside from those aspects of interventions where support was withdrawn following NSSI. This highlights the need for further research into interventions that may be specifically helpful for NSSI. Current research has been conducted around self-harm, including that carried out with suicidal intent, as well as in conjunction with BPD. Therefore, more work needs to be done to explore psychological interventions in relation to NSSI, with the hope that these interventions will readily become available to individuals presenting with such difficulties.

Participants valued human contact which they considered therapeutic and healthy and which enabled them to learn new ways to cope with and explore their underlying issues, contrasting with the reported unhelpful encounters on mental health wards and at A&E. This desire for an environment that is conducive to personal growth builds on Buser et al.'s (2014) study with students, where the importance of a healthy surrounding was highlighted. Participants also expressed a desire for support or human contact whenever needed, rather than having to wait for a formal appointment. Consistency and connection were important in participants' relationships, as these factors enabled them to build trust and feelings of safety. This desire for connection resonates and builds on the study Kool and colleagues' (2009) study with patients, emphasising the same need in the adult community.

Participants also reported the benefits of utilising self-help and reaching out to others as well as using the support of their family and friends. Although the studies in the literature review were generally about formal interventions, the resourceful nature of participants and their desire to reach out to others informally through volunteering, support groups or simply speaking to someone in the

park have been highlighted in this study. These interactions were reportedly beneficial and appeared to reduce the fear present when considering reaching out for formal support.

The quality of participants' professional and informal interactions had a marked effect on their sense of self, as discussed in theme 3. Unhelpful interactions, such as feeling labelled and judged, were considered to have a detrimental impact on sense of self, with the likelihood of reinforcing unhelpful beliefs about self, as well as having the possibility of exacerbating NSSI. In contrast, helpful and supportive interactions, where individuals felt they had a voice and felt valued, appeared to positively influence participants' sense of self. Therefore, it could be particularly important to keep this in mind when considering adolescents accessing services and support for NSSI. If these formal and informal interactions are deemed to be beneficial, this could have a positive effect at an early age, subsequently possibly reducing risk for this client group. They may still have feelings of shame, stigma, low self-worth and a sense of alienation and social isolation that have originated from childhood experiences, but positive interactions will help to counteract these feelings and hopefully give individuals the space to build positive feelings about self, rather than triggering and adding to already unhelpful thoughts/feelings, as those unhelpful interactions appeared to do.

The desires expressed by participants could be achieved with more support offered by the community. For this to come to fruition, there seems to be a need for further education and support for individuals within the community, enabling them to gain an understanding of the nature of NSSI, and insight into what would be a helpful response towards people who currently feel the need to NSSI or/and bear the scars of doing so.

This need for training also stretches to frontline services. More needs to be done to assist nurses and staff to respond to people who engage in NSSI in a more helpful, caring manner. As discussed, scholars have shown that nurses struggle with people presenting with NSSI (Taylor et al., 2009; Karman et al., 2015), which has been echoed by the experiences shared in this current study, illuminating the need for more training and supervision. This extends to mental health wards where, in light of the current study, responses to NSSI may need to be re-evaluated. Utilising individuals with lived experience could assist this cause, as they can discuss their experiences, enabling helpful and educational conversations around NSSI.

The findings of this study are unique, given that it involved an adult, UK-based, community sample of people who engage in NSSI. Voice was given to those with lived experience, therefore starting to fill a gap in the literature that currently exists. The findings around the desire for connection and healthy surroundings builds on previous research conducted with students and patients (Buser et al.,

2014; Kool et al., 2009), extending to adults living within the community. The expression of experiences of attending mental health wards and A&E confirm pre-existing literature, albeit from the perspective of the person accessing the service, highlighting the prevalence of the ongoing challenge these settings present and the need for further training and supervision. The benefits of therapy were similar to those found in studies conducted for closely related presentations, namely BPD and self-harm. This highlights the need for more research into interventions specifically for NSSI and for the same consistency of care applied to NSSI as these other presentations. This would support the needs expressed by those in the current study, as well as those of patients in a previous study (Huband & Tantam, 2004).

A novel finding of this study is the sense of fear participants expressed at the thought of reaching out as well as the ramifications of doing so. Interestingly, participants reduced this fear by utilising self-help and informal supports. The distinction between the benefits of healthy interactions accessed within the community and detrimental, unhealthy interactions in some formal settings was clearly expressed, therefore warranting the need for further support within the community. By educating and increasing awareness about NSSI within the community, such support could exist in voluntary positions, support groups, buddy systems or a café or venue to attend when in need of non-judgemental support and understanding. Through these settings, individuals can learn new ways of being, whether by discussing alternative coping strategies with others, or inadvertently obtaining these skills through positive interactions in safe, nurturing environments, subsequently increasing self-worth and confidence. These settings could also hold vetted resources if individuals wished to access formal support such as psychological interventions based on a holistic knowledge and understanding of NSSI, which may address such difficulties as trauma and grief, or to simply pursue psychological exploration. There could also be group sessions and talks with those who have lived experience, allowing those still struggling to feel hope and a sense of belonging.

It was also highlighted how detrimental unhelpful interactions can be. Such interventions not only feed into pre-existing feelings of low self-worth, internalised oppression, shame, stigma, isolation and alienation but may also potentially create these issues. The importance of healthy interactions to counteract these presenting issues was evident.

Limitations

As all participants resided in the UK, the findings in this study may not be assumed to be applicable for interventions and support outside of the UK. In addition, the study is qualitative, hence will have

limited generalisability (Braun & Clarke, 2013) and may not reflect the experiences and views of all individuals who have ceased NSSI within the UK. Additionally, regardless of efforts to practice reflexivity throughout the study (Braun & Clarke, 2013), the researcher recognises their active role and undoubtedly influenced the research through their life experiences and points of view.

The study was advertised through services that support people who engage in NSSI and/or have challenges with their mental health. This could lead to only recruiting individuals who are already linked up to these supports, therefore not reaching those who do not have such supports or links in place. There was also a gender difference as only two males compared to 10 females participated in the study. This reflects the finding that females self-injure more than men (Whitlock et al., 2006), but contrasts with a finding suggesting similar overall rates of NSSI for men and women (Briere & Gil, 1998). Various reasons could explain this discrepancy such as not as many males being connected to the support services or possibly a reticence in sharing their experiences.

Finally, as there is still limited research which focuses purely on NSSI, and even more so in the UK, some of the research drawn upon included participants who self-harmed with suicidal intent as well as NSSI. Although the authors of many self-harm papers do include NSSI, it is impossible to ascertain the percentages present, and it is an assumption that the results and conclusions capture opinions expressed by individuals who NSSI. Additionally, although relevant, more NSSI studies conducted with adolescents were drawn upon due to the paucity of research focussing on NSSI exclusively with adults.

Implications for counselling psychology and the wider therapeutic community

The ways in which people who NSSI would like counselling psychologists and professionals in the wider therapeutic community to respond to their distress have been highlighted in this study. Although many reported a need for therapy which went beyond the NSSI, others were relieved to be able to speak about it. This emphasises the need for assessment and formulation (Johnstone, 2014), allowing each person to be treated as an individual. An ability to collaboratively make sense of and hypothesise about a person's difficulties while drawing on psychological research would enable a clinician and client to explore which intervention/s are helpful at any time (Johnstone & Dallos, 2014). This recursive process allows for fluidity in the therapeutic process, as if a person initially wishes to explore alternative coping strategies, for example, they may in time wish to explore their

predisposing, precipitating and maintaining influences, allowing them to gain more insight into their current presentation.

Participants spoke about the need for consistency and connection, allowing time to build up a therapeutic relationship, building trust and the space to explore alternative coping strategies and underlying issues. These needs go beyond the guidelines suggested by NICE (NICE, 2011) for individuals presenting with self-harm. Therapists may wish to bear this in mind if in a position to offer extended therapy.

In addition to consistency and connection, the need to know that someone is there when individuals feel the need to reach out was also highlighted. This could be addressed by focussing on community psychology and building on services and knowledge within the community. Services such as the Samaritans partially fulfil this role, but more needs to be done so individuals know where to go for support and no longer feel alone. Interventions such as DBT which include the temporary withdrawal of support once NSSI has occurred may need to be readdressed to avoid exacerbating feelings of loneliness, rejection and low self-worth.

Counselling psychologists and the wider therapeutic community also need to be mindful of what this study has highlighted regarding participants' limited knowledge of where to gain helpful support, which at times is compounded by the fear of reaching out. Availability of services and how people access these services needs to be advertised within the community, incorporating messages of reassurance outside and within the therapeutic space.

Due to previous experiences and/or fear of consequences, individuals who engage in NSSI may need to be reassured when disclosing this behaviour. It is imperative that the therapeutic community respond helpfully, and that if professionals feel a lack of proficiency in this area, they actively gain further training and supervision enabling them to respond in a conducive manner.

Counselling psychologists and the wider therapeutic community can also assist Community Psychologists in providing a supportive environment, taking the approach that how society responds to individuals who NSSI can either have a positive influence, providing a sense of belonging, or a detrimental effect which feeds into pre-existing unhelpful beliefs about self. Therefore, the focus should be on the community rather the individual themselves.

It would also be helpful if counselling psychologists bear in mind some of the feeling's individuals may experience in relation to shame, stigma, self-worth, internalised oppression, isolation and alienation. It would also be worth bearing in mind that they may have had prior life experiences or interactions with professionals that have created or exacerbated these unhelpful feelings. Subsequently, it may take time and patience for a trusting, helpful therapeutic relationship to form,

noting that this may a different interaction to any experienced in the past and as such may be a huge milestone for many.

Directions for further study

It has become apparent that fear plays a central role as a barrier when reaching out for help. Further research around this topic may help to ascertain what can be done to eliminate this obstacle. Although constructs representing forms of internalised oppression have been widely studied among the LBGTQ community (Staples et al., 2018), more could be done with NSSI in mind and the wider community. Further research on the efficacy of specific NSSI interventions would be of value, potentially reinforcing the need for consistent long-term care. Participants highlighted the benefits of MBCT and ceasing medication. This insight could provide a 'spring- board' into further studies. Further research is also needed around perceptions of NSSI within the community to increase public awareness and subsequently eliciting helpful community responses.

References

Adler, A. (1927). *Understanding human nature*. New York: Greenburg.

Adler, P. A., & Adler, P. (2007). The demedicalization of self-injury: From psychopathology to sociological deviance. *Journal of Contemporary Ethnography, 36*, 537–570.

Alvesson, M. & Sköldberg, K. (2009). *Reflexive Methodology: New Vistas for Qualitative Research, 2nd ed*. London: SAGE

Am. Psychiatr. Assoc. (2013). *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,* Washington, DC: Am. Psychiatr. Assoc.

Andover, M.S., Pepper, C.M., Ryabchenko, K.A., Orrico, E.G., & Gibb, B.E. (2005). Self-mutilation and symptoms of depression, anxiety, and borderline personality disorder. *Suicide and Life-Threatening Behavior, 35*, 581-591.

Andrews, T., Martin, G., Hasking, P., & Page, A. (2013). Predictors of Continuation and Cessation of Nonsuicidal Self-Injury. *Journal of Adolescent Health, 53*, 40-46.

Archer, M. (1995). *Realist Social Theory: the morphogenetic approach*. Cambridge: Cambridge University Press.

Archer, M. (2010). Critical Realism and Relational Sociology, *Journal of Critical Realism, 9,* 199-207.

Barrocas, A. L., Hankin, B. L., Young, J. L., & Abela, J. R. (2012). Rates of nonsuicidal self- injury in youth: age, sex, and behavioural methods in a community sample. *Pediatrics, 130*, 39–45.

Bhaskar, R. (1975). *A Realist Theory of Science*. Leeds: Leeds Books.

Bhaskar, R. (1998). Philosophy and Scientific Realism. In: M. Archer, R. Bhaskar, A. Collier, T. Lawson, and A. Norrie, *Critical realism: essential readings*. London: Routledge.

Bateman, A., & Fonagy, P. (2001). Treatment of Borderline Personality Disorder with Psychoanalytically Oriented Partial Hospitalization: An 18-Month Follow-Up. *American Journal of Psychiatry,158,* 36-42.

Bennewith, O., Stocks, N., Gunnell, D., Peters, T.J., Evans, M.O., & Sharp, D.J (2002). General practice-based intervention to prevent repeat episodes of deliberate self-harm: cluster randomised controlled trial. *BMJ, 324*, 1254-1257.

Beck, J.S. (2011). *Cognitive behavior therapy: Basics and beyond* (2nd ed.). New York: Guilford Press.

Bhugra, D., Desai, M., & Baldwin, D. (1999). Attempted suicide in West London 1: Rates across ethnic communities. *Psychological Medicine, 29*, 1125-1130.

Black, E.B., & Kisely, S. (2018). A Systematic Review: Non-Suicidal Self-injury in Australia and New Zealand's Indigenous Populations. *Australian Psychologist, 53*, 3-12.

Blythin, S.P.M., Nicholson, H.L., Macintyre, V., Dickson, J.M., Fox, J.R.E., & Taylor, P.J. (2018). *Experiences of shame and guilt in anorexia and bulimia nervosa: a systematic review.* Psychology & Psychotherapy: Theory Research & Practice.

Booth, R., Keogh, K., Doyle, J., & Owens, T. (2014). Living Through Distress: A Skills Training Group for Reducing Deliberate Self-Harm. *Behavioural and Cognitive Psychotherapy,42*, 156–165.

BPS (2013). Ethical Guidelines for Internet- mediated Research. Retrieved June 26th, 2016, from http://www.bps.org.uk/system/files/Public%20files/inf206-guidelines-for-internet-mediated-research.pdf.

BPS (2019). Careers. Your journey into psychology. Retrieved January 27th, 2019, from https://careers.bps.org.uk/area/counselling

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Braun V., & Clarke V. (2013). *Successful qualitative research: A practical guide for beginners*. London: Sage.

Breen, A.V., Lewis, S.P., & Sutherland, O. (2013). Brief Report: Non-suicidal Self-injury in the Context of Self and Identity Development. *Journal of Adult Development, 20*, 57-62.

Briere, J., & Gil, E. (1998). Self-mutilation in clinical and general population samples: Prevalence, correlates, and functions. *American Journal of Orthopsychiatry, 68*, 609-620.

Brown, M.Z., Linehan, M.M., Comtois, K.A., Murray, A., & Chapman, A.L. (2009). Shame as a prospective predictor of self-inflicted injury in borderline personality disorder: a multi-modal analysis. *Behaviour, Research & Therapy, 47*, 815–822.

Burke, L. A., & Miller, M. K. (2001). Phone interviewing as a means of data collection: Lessons learned and practical recommendations. *Forum: Qualitative Social Research, 2*. [Online: www.qualitative-research.net/index.php/fps/article/viewArticle/959].

Buser, T.J. Pitchko, A., & Buser, J.K. (2014). Naturalistic Recovery From Nonsuicidal Self-Injury: A Phenomenological Inquiry. *Journal of Counseling & Development, 92,* 438-446.

Cacioppo, J.T., & Hawkley, L.C. (2009). Perceived Social Isolation and Cognition. *Trends in Cognitive Sciences, 13, 447–454.*

Castille, K., Prout, M., Marczyk, G., Shmidheiser, M., Yoder, S., & Howlett, B. (2007). The Early Maladaptive Schemas of Self-Mutilators: Implications for Therapy. *Journal of Cognitive Psychotherapy: An International Quarterly, 21, 58-71.*

Cawley, R., Pontin, E.E., Touhey, J., Sheehy, K., & Taylor, P.J. (2019). What is the relationship between rejection and self-harm or suicidality in adulthood? *Journal of Affective Disorders, 242*, 123–134.

Cerutti, R., Manca, M., Presaghi, F., & Gratz, K. L. (2011). Prevalence and clinical correlates of deliberate self-harm among a community sample of Italian adolescents. *Journal of Adolescence, 34,* 337–347.

Chaudoir, S.R., & Quinn, D.M. (2010). Revealing Concealable Stigmatized Identities: The Impact of Disclosure Motivations and Positive First-Disclosure Experiences on Fear of Disclosure and Well-Being. *Journal of Social Issues, 66,* 570-584.

Chapman, A. (2006). Dialectical Behavior Therapy: Current Indications and Unique Elements. *Psychiatry, 3*, 62-68.

Charmaz, K. (2001). Qualitative interviewing and grounded theory analysis. In J. Gubrium & J. Holstein (Eds.), *Handbook of interview research: Context and method* (pp. 675-694). Thousand Oaks, CA: Sage.

Claes, L., Houben, A., Vandereycken, W., Bijttebier, P., & Muehlenkamp, J. (2010). Brief report: The association between non-suicidal self-injury, self-concept and acquaintance with self-injurious peers in a sample of adolescents. *Journal of Adolescence, 33*, 775–778.

Clarkin, J.F., Levy, K.N., Lenzenweger, M.F., & Kernberg, O.F. (2007). Evaluating Three Treatments for Borderline Personality Disorder: A Multiwave Study. *American Journal of Psychiatry, 164*, 922-928.

Cleary, A. (2017). Help-seeking patterns and attitudes to treatment amongst men who attempted suicide. *Journal of Mental Health, 26*, 200-24.

Cooper, J., Hunter, C., Owen-Smith, A., Gunnell, D., Donovan, J., Hawton, K., & Kapur, N. (2011). "Well it's like someone at the other end cares about you." A qualitative study exploring the views of users and providers of care of contact-based interventions following self-harm. *General Hospital Psychiatry, 33*, 166-176.

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist, 59*, 614–625.

Corrigan, P., Markowitz, F.E., Watson, A., Rowan, D., & Kubiak, M.A. (2003). An attribution model of public discrimination towards persons with mental illness. *Journal of Health and Social Behavior, 14*, 162-71.

Crowe, M., & Bunclark, J. (2000). Repeated self-injury and its management. *International Review of Psychiatry, 12*, 48- 53.

Cruikshank, J. (2011). The positive and the negative: Assessing critical realism and social constructionism as post-positivist approaches to empirical research in the social sciences. Working Paper. *International Migration Institute,42.* Oxford: Oxford Department of International Development.

Dalton, J.H., Elias, M. J., & Wandersman, A. (2001). *Community Psychology: Linking Individuals and Communities*. Belmont, California: Wadsworth.

Danermark, B., Ekstrom, M., Jakobsen, L. & Karlsson, J. (2002). *Explaining society: Critical realism in the social sciences*. New York: Taylor & Francis.

Darche, M.A. (1990). Psychological factors differentiating self-mutilating and non self-mutilating adolescent inpatient females. *Psychiatric Hospital, 21*, 31–35.

Davies, S., Bell, D., Irvine, F., & Tranter, R. (2011). Self-administered acupuncture as an alternative to deliberate Self-harm: a feasibility Study. *Journal of Personality Disorders, 25*, 741–754.

De Leo, D., & Heller, T. S. (2004). Who are the kids who self-harm? An Australian self-report school survey. *Medical Journal of Australia*, *181*, 140–144.

De Riggia, M.E., Lewis, S.P, & Heath, N.L. (2018). Brief report: nonsuicidal self-injury in adolescence: turning to the Internet for support. *Counselling Psychology Quarterly, 31*, 397–405.

DiClemente, R. J., Ponton, L. E., & Hartley, D. (1991). Prevalence and correlates of cutting behavior: risk for HIV transmission. *Journal of the American Academy of Child and Adolescent Psychiatry, 30,* 735–39.

Duggan, J., Heath, N., & Hu, T. (2015). Non-suicidal self-injury maintenance and cessation among adolescents: a one-year longitudinal investigation of the role of objectified body consciousness, depression and emotion dysregulation. *Child and Adolescent Psychiatry and Mental Health, 9*, 21.

Elder-Vass, D. (2012). Towards a realist social constructionism. *Sociologia, 70*, 5-24.

Erikson, E. H. (1950). *Childhood and society*. New York: Norton.

Evans, M.O., Morgan, H.G., Hayward, A., & Gunnell, D.J. (1999). Crisis telephone consultation for deliberate self-harm patients: effects on repetition. *British Journal of Psychiatry, 175*, 23-27.

Fairfax, H., & Gillies, F. (2012). Being with complexity: Adaptation-based Process Therapy (APT), *Counselling Psychology Quarterly, 25*, 417-429.

Favazza, A.R., & Conterio, K. (1989). Female habitual self-mutilators. *Acta Psychiatrica Scandinavica, 79*, 283-289.

Favazza, A.R., & Rosenthal, R.J. (1990). Varieties of pathological self-mutilation. *Behavioral Neurology, 3*, 77-85.

Favazza, A. R., & Rosenthal, R. J. (1993). Diagnostic issues in self-mutilation. *Hospital and Community Psychiatry, 44*, 134-140.

Favazza, A.R. (1998). The coming of age self-mutilation. *Journal of nervous and mental disease, 186*, 259-268.

Field, T.A., Beeson, E.T. & Jones, L.K. (2015). The new ABCs: A Practitioner's Guide to Neuroscience-Informed Cognitive-Behavior Therapy. *Journal of Mental Health Counseling, 37,* 206–220.

Fletcher, A. J. (2017). Applying critical realism in qualitative research: methodology meets method. *International journal of social research methodology*, *20*, 181-194.

Fonagy, P., & Bateman, A.W. (2006). Mechanisms of change in mentalization-based treatment of BPD. *Journal of clinical psychology, 62*, 411-430.

Forrester, R.L., Slater, H., Jomara, K., Mitzmanc, S., & Taylor, P.J. (2017). Self-esteem and non-suicidal self-injury in adulthood: A systematic review.*Journal of Affective Disorders, 221*, 172–183.

Fortune, S., Sinclair, J., & Hawton, K. (2008). Help-seeking before and after episodes of self-harm: a descriptive study in school pupils in England. *BMC Public Health, 8,* 1-13.

Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research, *Australian and New Zealand journal of Psychiatry,* 36, 717-732.

Frankl, V. (2006). *Man's search for meaning*. Beacon Press. New York: Random House.

Freud, A. (1992). *Ego & the mechanisms of defense*. Hogarth Press. London: Routledge.

Frumkin, H., Bratman, G.N., Breslow, S, J, Cochran, B., Kahn, P.H. Lawler, J.J., Levin, P.S., Tandon, P.S., Varanasi, U., Wolf, K.L., & Wood, S.A. (2017). *Nature Contact and Human Health: A Research Agenda, 508,* 1-18.

Gelinas, B.L., & Wright, K.D. (2013). The Cessation of Deliberate Self-Harm in a University Sample: The Reasons, Barriers, and Strategies Involved, *Archives of Suicide Research, 17*, 373-386.

Gibb, S.J., Beautrais, A.L., & Surgenor, L.J. (2010). Health-care staff attitudes towards self-harm patients. *Australian and New Zealand Journal of Psychiatry, 4*, 713–720.

Gratz, K.L. (2001). Measurement of deliberate self-harm: Preliminary data on the deliberate self-harm inventory. *Journal of Psychopathology and Behavioral Assessment, 23*, 253-263.

Gratz, K. L. (2006). Risk factors for deliberate self-harm among female college students: The role and interaction of childhood maltreatment, emotional inexpressivity, and affect intensity/reactivity. *American Journal of Orthopsychiatry, 72*, 128-140.

Gratz, K.L. (2007). Targeting emotion dysregulation in the treatment of self-injury. *Journal of Clinical Psychology, 63*, 1091-1103.

Gratz, K.L., & Gunderson, J.G. (2006). Preliminary data on an acceptance-based emotion regulation group intervention for Deliberate Self-Harm among women with Borderline Personality Disorder. *Behavior Therapy, 37,* 25- 35.

Gratz, K.L., Tull, M.T., & Levy, R. (2014). Randomized controlled trial and uncontrolled 9-month follow-up of an adjunctive emotion regulation group therapy for deliberate self-harm among women with borderline personality disorder. *Psychological Medicine, 44*, 2099–2112.

Guan, K., Fox, K.R., & Prinstein, M.J. (2012) as cited in as cited in Klonsky, E.D., Victor, S.E., & Saffer, B.Y. (2014). Nonsuicidal Self-Injury: What We Know, and What We Need to Know. *The Canadian Journal of Psychiatry, 59*, 565-568.

Guba, E. G., & Lincoln, Y. S. (2005). Paradigmatic controversies, contradictions, and emerging confluences, In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research (pp. 191-215*). Thousand Oaks, CA: SAGE Publications.

Guerry, J.D., & Prinstein, M.J. (2009) Longitudinal Prediction of Adolescent Nonsuicidal Self-Injury: Examination of a Cognitive Vulnerability-Stress Model. *Journal of Clinical Child & Adolescent Psychology, 39*, 77-89.

Hagell, A. (2013). Adolescents self- harm. *Association for Young People's Health, 13*. Retrieved from http://www.ayph.org.uk/publications/316_RU13%20Self-harm%20summary.pdf.

Hanna, P. (2012). Using internet technologies (such as Skype) as a research medium: a research note. *Qualitative Research 12*, 239–242.

Hasking, P., Whitlock, J., Voon, D., & Rose, A. (2017). A cognitive-emotional model of NSSI: Using emotion regulation and cognitive processes to explain why people self-injure. *Cognition and Emotion 31*, 1543–1556.

Hawkley, L. C., Preacher, K. J., & Cacioppo, J. T. (2007). Multilevel modeling of social interactions and mood in lonely and socially connected individuals: The MacArthur social neuroscience studies. In A. D. Ong & M. H. M. van Dulmen (Eds.), *Series in positive psychology. Oxford handbook of methods in positive psychology* (p. 559–575). Oxford University Press.

Hawton, K., Arensman, E., Townsend, E., Bremner, S., Feldman, E., Goldney, R., Gunnell, D., Hazell, P., Van Heeringen, K., House, A., Owens, D., Sakinofsky, I., & Träskman-Bendzet, L. (1998). Deliberate self-harm: systematic review of efficacy of psychosocial and pharmacological treatments in preventing repetition. *BMJ, 317*, 441-447.

Hawton, K., Rodham, K., Evans, E., & Weatherall, R. (2002). Deliberate self-harm in adolescents: self-report survey in schools in England. *BMJ, 325*, 1207–1211.

Hawton, K., Saunders, K.E.A., & O'Connor, R.C. (2012). Self-harm and suicide in adolescents. *The Lancet, 379*, 2373–82.

Hay-Gibson, N. V. (2009). Interviews via VoIP: benefits and disadvantages within a PhD study of SMEs. *Library and information Research, 33*, 39-50.

Hinshaw, S. P., & Cicchetti, D. (2000). Stigma and mental disorder: Conceptions of illness, public attitudes, personal disclosure, and social policy. *Development and Psychopathology, 12,* 555–598.

Herpertz, S. (1995). Self-injurious behaviour: Psychopathological and nosological characteristics in subtypes of self-injurers. *Acta Psychiatrica Scandinavica, 91*, 57-68.

Herpertz, S., Sass, H., & Favazza, A. (1997). Impulsivity in self: mutilative behaviour: Psychometric and biological findings. *Journal of Psychiatry, 31*, 451-465.

Hodgson, S. (2004). Cutting through the silence: a sociological construction of self-injury. *Sociological Inquiry*, *74*, 162–179.

Hook, A., & Andrews, B. (2005). The relationship of non-disclosure in therapy to shame and depression. *British Journal of Clinical Psychology, 44*, 425–438.

Howell, A.J., Dopko, R.L., Passmore, H., & Buro, K. (2011). Nature connectedness: Associations with well-being and mindfulness. *Personality and Individual Differences, 51,* 166–171.

Huband, N., & Tantam, D. (2004). Repeated self-wounding: Women's recollection of pathways to cutting and of the value of different interventions. *Psychology and Psychotherapy: Theory, Research and Practice, 77*, 413-428.

Hyde, A. L., Conroy, D. E., Pincus, A. L., & Ram, N. (2011). Unpacking the feel-good effect of free-time physical activity: Between- and within-person associations with pleasant-activated feeling states. *Journal of Sport & Exercise Psychology, 33*, 884–902.

In-Albon, T., Ruf, C., & Schmid, M. (2013). Proposed Diagnostic Criteria for the DSM-5 of Nonsuicidal Self-Injury in Female Adolescents: Diagnostic and Clinical Correlates. *Psychiatry Journal, 2013*, 1-12.

Jarvi, S.M., Hearon, B.A., Batejan, K.L., Gironde, S., & Bjorgvinsson, T. (2017). Relations Between Past-Week Physical Activity and Recent Nonsuicidal Self-Injury in Treatment-Seeking Psychiatric Adults. *Journal of Clinical Psychology, 73*, 479–488.

Jefferson, G. (2004). Glossary of transcript symbols with an introduction. In Lerner, G.H. (ed.), Conversation analysis: Studies from the first generation (pp. 13-31). Philadelphia: John Benjamins.

Johnstone, L. (2014). *A straight-talking introduction to psychiatric diagnosis.* United Kingdom: Raven books.

Johnstone, L., & Dallos, R. (2014). *Formulation in Psychology and Psychotherapy: Making sense of people's problems*. United Kingdom: Routledge.

Jung, C. G., Von Franz, M., Henderson, J. L., Jaffe, A. & Jacobi, J. (1964). *Man and his Symbols.* New York: Anchor Books.

Justice, J. (2019, July 18). *The Important Difference(s) Between Prejudice, Discrimination, and Oppression.* Retrieved from https://medium.com/hisocio/the-important-difference-between-prejudice-discrimination-and-oppression-ae028ffd550c

Kagan, C., Burton, M., Duckett, P., Lawthom, R., & Siddiquee, A. (2011). *Critical Community Psychology: Critical Action and Social Change (BPS Textbooks in Psychology)*. Chichester: BPS Blackwell.

Kalekin-Fishman, D. (1996). Tracing the growth of alienation: enculturation, socialization, and schooling in a democracy. In Geyer, F., *Alienation, Ethnicity, and Postmodernism*. Westport: Greenwood.

Kapur, N., Cooper, J., O'Connor, R.C., & Hawton, K. (2013). Non-suicidal self-injury v. attempted suicide: new diagnosis or false dichotomy? *The British Journal of Psychiatry, 202*, 326–328.

Kapur, N., Gunnell, D., Hawton, K., Nadeem, S., Khalil, S., Longson, D., Jordan, R., Donaldson, I., Emsley, R., & Cooper, J. (2013). Messages from Manchester: pilot randomised controlled trial following self-harm. *The British Journal of Psychiatry, 203*, 73–74.

Karman, P., Kool, N., Poslawsky, I.E., & Van Meijel, B. (2015). Nurses' attitudes towards self-harm: a literature review. *Journal of Psychiatric and Mental Health Nursing, 22*, 65–75.

Kelada, L., Hasking, P., Melvin, G., Whitlock, J., & Baetens, I. (2018). "I Do Want to Stop; At Least I Think I Do": An International Comparison of Recovery From Nonsuicidal Self-Injury Among Young People. *Journal of Adolescent Research, 33*, 416–441.

Klonsky, E.D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review, 27*, 226-239.

Klonsky, E.D. (2009). The functions of self-injury in young adults who cut themselves: Clarifying the evidence for affect-regulation. *Psychiatry Research, 166*, 260-268.

Klonsky. E.D., & Glenn, C.R. (2009). Assessing the functions of non-suicidal self-injury: Psychometrics properties of the Inventory of Statements about Self-Injury (ISAS). *Journal of Psychopathology and Behavioural Assessment, 31,* 215-219.

Klonsky, E.D., May, A.M., & Glenn, C.R. (2013). The relationship between non-suicidal self-injury and attempted suicide: converging evidence from four samples. *Journal of Abnormal Psychology, 122*, 231–237.

Klonsky, E.D., & Muehlenkamp, J.J. (2007). Self-injury: A research review for the practitioner. *Journal of Clinical Psychology, 63*, 1045-1056.

Klonsky, E. D., Muehlenkamp, J.J., Lewis, S.P., & Walsh, B. (2011). *Nonsuicidal Self- Injury*. Canada: Hogrefe Publishing.

Klonsky, E. D., & Olino, T.M. (2008). Identifying Clinically Distinct Subgroups of Self-Injurers Among Young Adults: A Latent Class Analysis. *Journal of Consulting and Clinical Psychology, 76*, 22–27.

Klonsky, E. D., Oltmanns, T. F., & Turkheimer, E. (2003). Deliberate self-harm in a nonclinical population: Prevalence and psychological correlates. *American Journal of Psychiatry, 160*, 1501-1508.

Klonsky, E.D., Victor, S.E., & Saffer, B.Y. (2014). Nonsuicidal Self-Injury: What We Know, and What We Need to Know. *The Canadian Journal of Psychiatry, 59*, 565-568.

Kool, N., Meijel, B., & Bosman, M. (2009). Behavioral Change in Patients With Severe Self-Injurious Behavior: A Patient's Perspective. *Archives of Psychiatric Nursing, 23*, 25-31.

Korner, A., Gerull, F., Meares, R., & Stevenson, J. (2006). Borderline personality disorder treated with the conversational model: a replication study. *Comprehensive Psychiatry, 47*, 406- 411.

Lamprecht, H.C., Pakrasi, S., Gash, A., & A.G. Swann (2005). Deliberate self-harm in older people revisited. *International Journal of Geriatric Psychiatry, 20*, 1090-1096.

Law, G.U., Rostill-Brookes, H., & Goodman, D. (2009). Public stigma in health and non-healthcare students: attributions, emotions and willingness to help with adolescent self-harm. *International Journal of Nursing Studies, 46*, 108-19.

Lear, M.K., & Pepper, C.M. (2016). Self-concept clarity and emotional dysregulation in nonsuicidal self-injury. *Journal of personality disorders, 30,* 813-827.

Lee, D. (2012). *Recovering from Trauma using Compassion Focused Therapy*. London: Robinson

Lewis, S.P. (2016). The Overlooked Role of Self-injury Scars Commentary and Suggestions for Clinical Practice. *The Journal of Nervous and Mental Disease, 204*, 33-35.

Lewis, S. P., & Arbuthnott, A. E. (2012). Nonsuicidal Self-Injury: Characteristics, Functions, and Strategies. *Journal of College Student Psychotherapy, 26,*185-200.

Lewis, S.P., Bryant, L.A., Schaefer, B.M., & Grunberg, P.H. (2017). In Their Own Words Perspectives on Nonsuicidal Self-Injury Disorder Among Those With Lived Experience. *The Journal of Nervous and Mental Disease, 205*, 771-779.

Lewis, S. P., Heath, N. L., Sornberger, M. J., & Arbuthnott, A. E. (2012). Helpful or harmful? An examination of viewers' responses to non-suicidal self-injury videos on YouTube. *Journal of Adolescent Health,51,* 380-385.

Lewis, S. P., & Mehrabkhani, S. (2015). Every scar tells a story: Insight into people's self-Injury scar experiences. *Counselling Psychology Quarterly, 29*, 296-310.

Lewis, S. P., Michal, N. J., Mahdy, J., & Arbuthnott, A. E. (2014). Googling Self-injury: The state of health information obtained through online searches for self-injury. *JAMA Pediatrics, 168*, 443–449.

Lewis, S.P., Rosenrot, S.A., & Messner, M.A. (2012). Seeking Validation in Unlikely Places: The Nature of Online Questions About Non-Suicidal Self-Injury. *Archives of Suicide Research, 16,* 263–272.

Lewis, S. P., & Santor, D. A. (2008). Development and validation of the Self-Harm Reasons Questionnaire. *Suicide & Life Threatening Behavioural*, *38*, 104–115.

Lewis. S.P., Seko, Y., & Joshi, P. (2018). The impact of YouTube peer feedback on attitudes toward recovery from non-suicidal self-injury: An experimental pilot study.*Digital Health, 4*, 1–7.

Lindgren, B.M., Svedin, C.G., & Werkö, S. (2018). A Systematic Literature Review of Experiences of Professional Care and Support Among People Who Self-Harm. *Archives of Suicide Research, 22,* 173–192.

Lloyd, B., Blazely, A., & Phillips, L. (2018). Stigma towards individuals who self-harm: impact of gender and disclosure. *Journal of Public Mental Health, 17*, 184-194.

Lloyd-Richardson, E.E., Perrine, N., Dierker, L., & Kelley, M.L. (2007). Characteristics and functions of nonsuicidal self-injury in a community sample of adolescents. *Psychological Medicine, 37*, 1183-92.

Linehan (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder (Diagnosis & Treatment of Mental Disorders).* New York: The Guilford Press.

Linehan, M.M. (2000). Behavioral treatments of suicidal behaviours: Definitional obfuscation and treatment outcomes. In Maris, R. W., Cannetto, S. S., McIntosh, J. L., & Silverman, M. M., *Review of Suicidology.* New York: Guildford Press.

Linehan, M.M. (2015). *DBT Skills Training Manual*. New York: Guildford Press.

Linehan, M.M., Comtois, K.A., Murray, A.M., Brown, M.Z., Gallop, R.J., Heard, H.L., Korslund, K.E., Tutek, D.A., Reynolds, S.K., & Lindenboim, N. (2006). Two-Year Randomized Controlled Trial and Follow-up of Dialectical Behavior Therapy vs Therapy by Experts for Suicidal Behaviors and Borderline Personality Disorder. *Archives of General Psychiatry, 63*, 757-766.

Long, M., Manktelow, R., & Tracey, A. (2015). "Knowing that I'm not alone": client perspectives on counselling for self-injury. *Journal of Mental Health, 25*, 41-46.

Lundh, L.G., Karim, J., & Quilisch, E., (2007). Deliberate self-harm in 15-year-old adolescents: A pilot study with a modified version of the Deliberate Self-Harm Inventory. *Scandinavian Journal of Psychology, 48*, 33–41.

Macdonald, J., & Morley, I. (2001). Shame and non-disclosure: A study of the emotional isolation of people referred for psychotherapy. *British Journal of Medical Psychology, 74*, 1–21.

Mackay, N.C. (2005). Accident and emergency staff's perceptions of deliberate self-harm: attributions, emotions and willingness to help. *British Journal of Clinical Psychology, 44*, 255-67.

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology, 91*, 1-20.

Mahtani. S., Melvin, G.A., & Hasking, P. (2018). Shame Proneness, Shame Coping, and Functions of Nonsuicidal Self-Injury (NSSI) Among Emerging Adults: A Developmental Analysis. *Emerging Adulthood, 6*, 159-171.

Maloney, P. (2016). Community Psychology and the Counselling Psychologist. In *The handbook of Counselling Psychology* (pp. 363-378). London, UK: Sage Publications Ltd.

Markowitz, F.E., Angell, B., & Greenberg, J.S. (2011). Stigma, reflected appraisals, and recovery outcomes in mental illness. *Social Psychology Quarterly,74,* 144-65.

Martens, W.H.J. (2006). Effectiveness of Psychodynamic Treatment in Patients with Borderline Personality Disorder. *Journal of Contemporary Psychotherapy, 36*, 167-173.

Masten, A. (2009). Ordinary magic: lessons from research on resilience in human development. *Education Canada, 49,* 28–32.

McDermott, E., Roen, K., & Scourfield, J. (2008). Avoiding shame: young LGBT people, homophobia and self-destructive behaviours. *Culture Health Sexuality 10*, 815‑829.

Miller, C. (1995). In depth interviewing by telephone: some practical considerations. *Evaluation & Research in Education, 9*, 29-38.

Mitchell, K. Y., & Ybarra, M. L. (2007). Online behavior of youth who engage in selfharm provides clues for preventive intervention. *Preventive Medicine*, *45*(5), 392–396.

Morgan, H.G., Jones, E.M., & Owen, J.H. (1993). Secondary prevention of non-fatal deliberate self-harm: the Green Card study. *British Journal of Psychiatry, 163,* 111-112.

Muehlenkamp, J.J. (2005). Self-injurious behaviour as a separate clinical syndrome. *American Journal of Orthopsychiatry, 75*, 324-333.

Muehlenkamp, J., Brausch, A., Quigley, K., & Whitlock, J. (2013). Interpersonal Features and Functions of Nonsuicidal Self-injury. *Suicide and Life-Threatening Behavior, 43,* 67-80.

Muehlenkamp, J. J., & Gutierrez, P. M. (2007). Risk for Suicide Attempts Among Adolescents Who Engage in Non-Suicidal Self-Injury, *Archives of Suicide Research, 11*, 69-82.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychology of Sexual Orientation and Gender Diversity, 1*, 3–26.

Miller, P., & Rose, N. (1986). *The Power of Psychiatry*. Cambridge: Polity Press.

Neal, A. G., & Collas, S. F. (2000). *Intimacy and alienation: Forms of estrangement in female/male relationships.* New York: Garland

Nezu, A.M., Nezu, C., & D'Zurilla, T. J. (2013). Problem-Solving Therapy: A Treatment Manual. New York: Springer Publishing Company.

NICE (2009). Borderline personality disorder: recognition and management. Retrieved from http://www.nice.org.uk/CG78.

NICE (2011). *Self-harm in over 8s: long-term management*. Retrieved from http://www.nice.org.uk/CG133.

Nock, M.K. (2010). Self-Injury. *Annual Review of Clinical Psychology, 6*, 339-363.

Nock, M.K., Joiner, T.E., Gordon, K.H., Lloyd-Richardson, E., & Prinstein, M.J. (2006). Nonsuicidal self-injury among adolescents: Diagnostic correlates and relation to suicide attempts. *Psychiatry Research, 144,* 65–72.

Nock, M.K., & Mendes, W.B. (2008). Physiological Arousal, Distress Tolerance, and Social Problem–Solving Deficits Among Adolescent Self-Injurers. *Journal of Consulting and Clinical Psychology, 76*, 28–38.

Nock, M.K., Prinstein, M.J., & Sterba, S.K. (2009). Revealing the form and function of self-injurious thoughts and behaviors: A real-time ecological assessment study among adolescents and young adults. *Journal of Abnormal Psychology, 118*, 816-827.

O'Connor, R.C., Rasmussen, S., Miles, J., & Hawton, K. (2009). Self-harm in adolescents: self-report survey in schools in Scotland. *British Journal of Psychiatry, 194*, 68-72.

O'Connor, R.C., Rasmussen, S., & Hawton, K. (2014). Adolescent self-harm: A school-based study in Northern Ireland*. Journal of Affective Disorders, 159*, 46–52.

O'Connor, S., & Glover, L. (2017). Hospital staff experiences of their relationships with adults who self-harm: A meta-synthesis.*Psychology and Psychotherapy: Theory, Research and Practice, 90*, 480–501.

Ogundipe, L. O. (1999). Suicide attempts vs. deliberate self-harm. *British Journal of Psychiatry, 175*, 90.

Parker, I., Georgaca, E., Harper, D., McLaughlin, T., & Stowell-Smith, M. (1995). *Deconstructing Psychopathology*. London: SAGE Publications Ltd.

Pattison, E. M., & Kahan, J. (1983). The deliberate self-harm syndrome. *American Journal of Psychiatry, 140*, 867–872.

Penn, D.L., & Wykes, T. (2003). Stigma, discrimination, and mental illness, *Journal of Mental Health, 12,* 203-8.

Pilgrim, D. (2013). The Failure of Diagnostic Psychiatry and some prospects of Scientific Progress Offered by Critical Realism. *Journal of Critical Realism, 12,* 336.

Plener, P.L., Libal, G., Keller, F., Fegert, J.M., & Muehlenkamp, J.J. (2009). An international comparison of adolescent nonsuicidal self-injury (NSSI) and suicide attempts: Germany and the USA. *Psychological Medicine, 39*, 1549-58.

Reinharz, S. (1993). Neglected voices and excessive demands in feminist research. *Qualitative Sociology, 16*, 69-76.

Rodham, K., Gavin, J., Lewis, S.P., Bandalli, P., & St. Denis, J.M. (2016). The NSSI Paradox: Discussing and Displaying NSSI in an Online Environment. *Deviant Behaviour, 37*, 1110–1117.

Rodham, K., Gavin, J., Lewis, S.P., St. Denis, J.M., & Bandalli, P. (2013). An Investigation of the Motivations Driving the Online Representation of Self-Injury: A Thematic Analysis. *Archives of Suicide Research, 17*, 173–183.

Rodham, K., Hawton, K., & Evans, E. (2004). Reasons for deliberate self-harm: Comparison of self-poisoners and self-cutters in a community sample of adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 43,* 80-87.

Rogers, C. (1957). "The necessary and sufficient conditions of therapeutic personality change". Journal of Consulting Psychology, 21, 95-103.

Rogers, C. (1959). A theory of therapy, personality and interpersonal relationships as developed in the client-centered framework. In (ed.) S. Koch, *Psychology: A study of a science. Vol. 3: Formulations of the person and the social context*. New York: McGraw Hill.

Rosenrot, S. A., & Lewis, S.P. (2018). Barriers and responses to the disclosure of non-suicidal self-injury: a thematic analysis. *Counselling Psychology Quarterly*, *10,* 1-21.

Ross, R. R., & McKay, H. B. (1979). *Self-mutilation*. USA: Lexington Books.

Rossouw, T. I., & Fonagy, P. (2012). Mentalization-Based Treatment for Self-Harm in Adolescents: A Randomized Controlled Trial. *Journal of the American academy of child & adolescent psychiatry, 51*, 1304-1317.

Roulston, K. (2001). Data analysis and 'theorizing as ideology'. *Qualitative Research, 1*, 279-302.

Rowe, S.L., French, R.S., Henderson, C., Ougrin, D., Slade, M., & Moran, P. (2014). Help-seeking behaviour and adolescent self-harm: a systematic review. *Australian & New Zealand Journal of Psychiatry, 48*, 1083-95.

Ryan, G., & Bernard, H. (2000). *Data Management and Analysis Methods. In* N. K. Denzin and Y. S. Lincoln (Eds.) The SAGE h*andbook of qualitative research (769-802),* 2nd ed., Thousand Oaks, CA: Sage Publications.

Saunders, K.E.A., Hawton, K., Fortune, S., & Farrell, S. (2012). Attitudes and knowledge of clinical staff regarding people who self-harm: A systematic review. *Journal of Affective Disorders, 139*, 205–216.

Schoenleber, M., Berenbaum, H., & Motl, R. (2014). Shame-related functions of and motivations for self-injurious behavior. *Personality Disorders: Theory, Research, and Treatment, 5,* 204–211.

Seko, Y., & Lewis, S. (2018). The self-harmed, visualized, and reblogged: Remaking of self-injury narratives on Tumblr. *New media & society, 20*, 180–198.

Staples, J.M., Neilson, E.C., Bryan, A.E.B., & George, W.H. (2018). The Role of Distal Minority Stress and Internalized Transnegativity in Suicidal Ideation and Nonsuicidal Self-Injury Among Transgender Adults. *The Journal of Sex Research, 55*, 591-603.

Shaw, S.N. (2006). Certainty, Revision, and Ambivalence: A Qualitative Investigation into Women's Journeys to Stop Self-Injuring, *Women & Therapy, 29*, 153-177.

Silverman, D. (2000). *Doing qualitative research: A practical handbook*. London, Sage.

Slee, N., Garnefski, N., Leeden, R., Arensman, E., & Spinhoven, P. (2008). Cognitive–behavioural intervention for self-harm. *British Journal of Psychiatry, 192,* 202–211.

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

Soloff, P. H., Lis, J. A., Kelly, T., Cornelius, J., & Ulrich, R. (1994). Self-mutilation and suicidal behavior in borderline personality disorder. *Journal of Personality Disorders, 8,* 257–267.

Stanley, B., Winchel, R., Molcho, A., Simeon, D., & Stanley, M. (1992). Suicide and self-harm continuum: Phenomenological and biochemical evidence. *International Review of Psychiatry, 4*, 149-155.

Swannell, S. V., Martin, G. E., Page, A., Hasking, P., & St. John, N. J. (2014). Prevalence of nonsuicidal self-injury in nonclinical samples: Systematic review, meta-analysis and meta-regression. *Suicide and Life-Threatening Behaviours, 44*, 273–303.

Sweeney, A., & Taggart, D. (2018). (Mis)understanding trauma-informed approaches in mental health. *Journal of Mental Health*, DOI: 10.1080/09638237.2018.1520973.

Taliaferro, L. A., McMorris, B.J., & Eisenberg, M.E. (2018). Connections that moderate risk of non-suicidal self-injury among transgender and gender non-conforming youth. *Psychiatry Research, 268,* 65–67.

Taliaferro, L., & Muehlenkamp, J. (2017). Nonsuicidal self-injury and suicidality among sexual minority youth: risk factors and protective connectedness factors. *Academic Pediatrics,17*, 715–722.

Tangney, J.P., & Dearing, R.L. (2002). *Shame and Guilt*. The Guilford Press, New York.

Tangney, J. P., Stuewig, J., & Mashek, D. J. (2007). Moral emotions and moral behaviour. *Annual Review of Psychology, 59*, 345–372.

Tantam, D., & Whittaker, J. (1992). Personality disorder and self-wounding. *British Journal of Psychiatry, 161*, 451-464.

Tapolaa, V., Lappalainen, R., & Wahlström, J. (2010). Brief intervention for deliberate self-harm:

an exploratory study. *Suicidology, 1*, 95-108.

Taylor, P.J., Jomar, K., Dhingra, K., Forrester, R., Shahmalak, U., & Dickson, J.M. (2018). A meta-analysis of the prevalence of different functions of non-suicidal self-injury. *Journal of Affective Disorders, 227*, 759- 769.

Taylor, P.J., McDonald, J., Smith, M., Nicholson, H., & Forrester, R. (2019). Distinguishing people with current, past, and no history of non-suicidal self-injury: Shame, social comparison, and self-concept integration. *Journal of Affective Disorders, 246*, 182–188.

Taylor, T.L., Hawton, K., Fortune, S., & Kapur, N. (2009). Attitudes towards clinical services among people who self-harm: systematic review. *The British Journal of Psychiatry, 194*, 104-110.

Townsend, E., Hawton, K., Altman, D.G., Arensman, E., Gunnell, D., Hazell, A., House, A., & Van Herringen, K. (2001). The efficacy of problem-solving treatments after deliberate self-harm: meta-analysis of randomized controlled trials with respect to depression, hopelessness and improvement in problems. *Psychological Medicine*, *31,* 979-988.

Turner, B. (1987). *Medical Power and Social Knowledge*. London: Sage.

Turner, B.J., Austin, S.B., & Chapman, A.L. (2014). Treating Nonsuicidal Self-Injury: A Systematic Review of Psychological and Pharmacological Interventions. *The Canadian Journal of Psychiatry, 59*, 576-585.

Tyrer, P., Thompson, S., Schmidt, U., Jones, V., Knapp, M., Davidson, K., Catalan, J., Airlie, J., Baxter, S., Byford, S., Byrne, G., Cameron, S., Caplan, R., Cooper, S., Ferguson, B., Freeman, C., Frost, S., Godley, J., Greenshields, J., Henderson, J., Holden, N., Keech, P., Kim, L., Logan, K., Manley, C., MacLeod, A., Murphy, R., Patience, L., Ramsay, L., De Munroz, S., Scott, J., Seivewright, H., Sivakumar, K., Tata, P., Thornton, S., Ukoumunne, O. C., & Wessely, S. (2003). Randomized controlled trial of brief cognitive behaviour therapy versus treatment as usual in recurrent deliberate self-harm: the POPMACT study. *Psychological Medicine, 33*, 969-976.

VanDerhei, S., Rojahn, J., Stuewig, J., & McKnight, P.E. (2014). The effect of shame- proneness, guilt-proneness, and internalizing tendencies on nonsuicidal self-injury. *Suicide & Life-threatening Behaviour, 44,* 317‑330.

Wadsworth, Y., & Epstein, M. (1998). Building in dialogue between consumers and staff in acute mental health services. *Systemic Practice and Action Research, 11*, 353–379.

Walsh, B. W., & Rosen, P. M. (1988). *Self-mutilation: Theory, research, and treatment*. New York: Guildford Press.

Whitlock, J., Eckenrode, J., & Silverman, D. (2006). Self-injurious behaviors in a college population*. Pediatrics, 117*, 1939-1948.

Whitlock, J., Muehlenkamp, J., & Eckonrode, J. (2008). Variation in nonsuicidal self-injury: identification and features of latent classes in a college population of emerging adults. *Journal of Clinical Child & Adolescent Psychology, 37(4),* 725-735.

Whitlock, J., Muehlenkamp, J., Purington, A., Eckenrode, J., Barreira, P., Baral Abrams, G., Marchell, T., Kress, V., Girard, K., Chin, C., & Knox, K. (2011). Nonsuicidal Self-injury in a College Population:

General Trends and Sex Differences. *Journal of American College Health, 59,* 691-698.

Whitlock, J., Prussien, K., & Pietrusza, C. (2015). Predictors of self-injury cessation and subsequent psychological growth: results of a probability sample survey of students in eight universities and colleges. *Child and Adolescent Psychiatry and Mental Health, 9*, 1-12.

Willig, C. (2008). *Introducing Qualitative Research in Psychology, (second edition).* Berkshire, England: McGraw Hill.

Willig, C. (2012). Perspectives on the Epistemological Bases for Qualitative Research. In Cooper, H., *APA Handbook of Research Methods in Psychology: Vol. 1. Foundations, Planning, Measures, and Psychometrics* (pp.5-21). Washington, D.C., USA: American Psychological Association.

Xavier, A., Gouveia, J.P., & Cunha, M. (2016). Non-suicidal Self-Injury in Adolescence: The Role of Shame, Self-Criticism and Fear of Self-Compassion. *Child Youth Care Forum, 45*, 571–586.

Yalom, I.D., & Leszcz, M. (2005). *The Theory and Practice of Group Psychotherapy*. New York, USA: Basic Books.

York Cornwell, E., & Waite, L. (2009). Social disconnectedness: Perceived isolation, and health among older adults. *Journal of Health Social Behaviour, 50*, 31-48.

Zachariadis, M., Scott, S. & Barrett, M. (2010). Exploring critical realism as the theoretical foundation of mixed-method research: evidence from the economics of IS innovations. *Working Paper Series 3*. Cambridge Judge Business School, University of Cambridge.

Zarbo, C., Tasca, G.A., Cattafi, F., & Compare, A. (2016). Integrative psychotherapy works. Clinical and health psychology, 6, 2021.

Appendices

A qualitative study into people's experiences of interventions on their

Journey to ceasing non-suicidal self- Injury (NSSI).

➢ What is your understanding of non- suicidal self-injurious behaviour?

➢ Tell us about at what age you started to self-injure.

➢ NSSI behaviours (if not answered in above questions - e.g. How often did you self-injure? How long is it since you last self-injured?)

➢ Tell us about the times you have reached out for support/interventions? (if any)?

➢ What support (groups, family, friends) interventions did you find helpful?

  o Least helpful?

➢ If you did not reach out for support, can you please explain why?

➢ What other strategies did you try (if any) rather than self-injuring?

➢ Do you feel that there were any other contributing factors that assisted you in ceasing non-suicidal self- injury?

➢ Tell us about what support you would have wished for, if you feel that it was something that you did not receive at the time?

➢ Is there anything else you think we should know, or are there any questions we should have asked but did not?

A qualitative study into people's experiences of interventions on their journey to ceasing non-suicidal self- Injury (NSSI).

A Thematic Analysis.

Semi-structured Interviews

Participant Information Sheet

Who are the researchers and what is the research about?

Thank you for your interest in this research. The focus of this research is to gain in depth understanding of your experiences of interventions on your journey to ceasing non-suicidal self-injury (NSSI). This research is important as it has the potential to provide critical information regarding the kinds of treatment, intervention, and support that was accessed and helped in ceasing non-suicidal self-injury (NSSI), with the hope of assisting others who need such support. My name is Lorna Robinson and I am a Counselling Psychology postgraduate student in the Department of Health and Social Sciences, University of the West of England, Bristol. I am completing this research for my doctoral thesis. My research is supervised by Dr. Zoe Thomas (see below for her contact details).

What does participation involve?

Participation is entirely voluntary. If you choose to participate in the research you will be asked to attend a confidential interview (Either face to face, by telephone or Skype), where you will be asked some questions about your experiences and perceptions. It should take no more than 60 minutes to complete. The interview will be recorded and transcribed into a written document to be later analysed.

Prior to the interview I will ask you to fill in a form asking you to answer some general questions about yourself, for example your age? You will be encouraged to ask any questions you may have, as I will then ask you to read and sign a consent form before the interview begins, confirming that you agree to participate.

Who can participate?

Anyone over the 18 who is interested in taking part.

How will the data be used?

The data will be anonymised (i.e. any information that can identify you will be removed) and then the interview will be analysed along with the other interviews for my research project. This means extracts from your interview may be quoted in my dissertation and in any

publications and presentations arising from the research, but your real name or any identifiable information will be removed.

The information you provide will be treated confidentially and personally identifiable details will be stored separately from the data. All recorded will be destroyed once thesis is submitted.

What are the benefits of taking part?
You will get the opportunity to share your story of your journey so that this can potentially lead onto better ways of supporting people who NSSI?

How do I withdraw from the research?
If you decide you wish to withdraw from the research please contact me via email lorna2.robinson@uwe.ac.uk but this is only up until May 2018, at which point the research will be submitted to the university and the researcher will no longer be able to edit out information.

Are there any risks involved?
We do not anticipate any particular risks to you with participating in this research; however, there is always the potential for research participation to raise uncomfortable and distressing issues. For this reason, we have provided information of a low-cost counselling service in the local area and a local support group for self-injury.

http://www.bristolmind.org.uk/our-services/meeting-minds-counselling-service

www.sishbristol.org.uk

If you have any questions about this research please contact:

Lorna Robinson. Email: Lorna2.Robinson@live.uwe.ac.uk

Or my research supervisor: Dr. Zoe Thomas, Department of Health and Social Sciences, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY
Email: Zoe2.Thomas@uwe.ac.uk

This research has been approved by the Faculty Research Ethics Committee (FREC)

**A qualitative study into people's experiences of interventions
on their journey to ceasing non-suicidal self-injury (NSSI)
A Thematic Analysis**

Consent Form

Thank you for agreeing to take part in this research on ceasing non-suicidal self- injury. My name is Lorna Robinson and I am a Counselling Psychology Postgraduate student in the Department of Health and Social Sciences, University of the West of England, Bristol. I am collecting this data collection for my doctoral thesis. My research is supervised by Dr. Zoe Thomas. She can be contacted at the Department of Health and Social Sciences, University of the West of England, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY [Tel: (0117) 3281234; Email: Zoe2.Thomas@uwe.ac.uk if you have any queries about the research.
Before we begin, I would like to emphasize that:
- your participation is entirely voluntary
- you are free to refuse to answer any question
- you are free to withdraw up until May 2018.
You are also the 'expert'. There are no right, or wrong answers and I am interested in everything you have to say.

Please note by signing this form you indicate that you have read the contents of this form and of the participant information sheet and you consent to participate in the research.

A copy of this Information Sheet and Informed Consent Form has been provided to the participant.

Signature of participant:

This research has been approved by the Faculty Research Ethics Committee (FREC

Participant 4 Lines 415-4400		Coding
P	And if I did self-harm, erm, the first time I would be suspended from therapy for a day.	Punitive, no support. No alternative
I	Hmm.	
P	The second time, a week and then the third time I would be discharged from all therapy from then on ever, you know.	No support
I	Right.	
P	[Sharp intake of breath]. So having…being in the early stages really of having quite a serious problem with self-harm, you know, bad cutting and things…	When intervention important
I	Hmm.	
P	…there wasn't any alternative, you know, I…you know, just…to get…to have therapy you have to stop self-harming and there's no negotiation and there's no…	Alone, powerless, rejected. No way out. Rigid. No voice. Not heard.
I	Hmm.	
P	…talking about self-harm, there's no nothing.	Taboo subject
I	Yes.	
P	[Sharp intake of breath]. So the first time 'cause, you know, I was being checked.	Scrutinised. Lack of respect. Crossing personal space, Naughty child approach.
I	Hmm.	Rejected, Alone
P	Erm, I was discharged, erm, for a day. Erm, what happened the second time was awful because it was one of my suicide attempts 'cause it was life was just dreadful.	Vulnerable, dangerous, lack of support, life threatening.
I	Hmm.	
P	And so I was in hospital after taking an overdose and I phoned the day hospital from the hos…from the general hospital to say that I	Feeling alone, reaching out

	wouldn't be there that day and why and they said, "Well, no one can talk to you and you know you're suspended now for a week." So I was completely, you know, cut off from any kind of support therapy for that week.	Rejection Unhelpful language Left adrift. Nothing. Rejected. Confused. Judged.
I	Hmm.	
P	And then [slightly laughs] it sounds like a confession.	

Participant 8 Lines 310-340	Coding
P I think on the ward erm, they, kind of, tend to punish you [sniffs].	Punitive
I Punish you?	
P For self-harming they either put you on closer obs. They don't want to talk to you about it and it's, like, they just use it as, as a method of controlling you and saying, "Right, okay, you're not allowed out," or they'll have to put you on close observation. So they put someone, usually a man, to sit outside your door, which is really scary and very…er, for me it would be unsafe erm, and it's more, kind of, controlling and overwhelming, whereas…	Respond in a perceived unhelpful way. Controlling, disempowered Restricted, punitive, disempowered. Being watched Feeling guarded Feeling vulnerable
I And…mmm.	
P …nobody sits with you and says to you, you know, "Okay, maybe you don't know what happened and why you did it," but at the crisis house the women…the workers would come and have a one-to-one with you and just…they just want to know. Even if you don't want to talk they'll just sit down with you and it's, like, you feel, you feel, kind of, they're safe enough to be	Not feeling cared for and understood Feeling validated Interest, support, care, warmth Empowering

	approached about the self-harm and so that helps you reduce your self-harm. That's what happened to me, I mean, I started talking about stuff erm, it helps me, kind of like, diffuse that, that…I erm, I can't really think of how to explain it.	Safe, trust, non-judgemental Helpful, reduce self-harm Talking help take the power away. Make sense.
I	It's a…It was like…	
P	Erm, I think…	
I	…another outlet in a way.	
P	Yeah, the impulsive, unknowing why, you know, like, I was…I learnt how to talk about things…	Different coping strategies
I	Mmm.	
P	…rather than just go for the razor blade all the time.	Alternative ways of dealing and processing feelings
I	Right, right erm…	
P	And they gave me the time to do that as well.	Space and time. Patience
I	Mmm.	
P	But sometimes there were times that I didn't Know why I…I didn't know, I just did it and that was okay too.	Unconditional positive regard Acceptance
I	Right.	
P	They would say that that's okay, but it's the fact that they, kind of, validate your feelings and they want to spend time with you and, you know, it's supporting and help you ground yourself with other methods. You know, it doesn't always work, but it's…I think it's the way that…It's like the therapeutic approach that they used.	Worthy, being there. Acceptance, validation. Kindness, empathy. Alternative coping strategies Respect, equality, lack of power difference

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