# Deliberate Self-harm in the South West: Setting a Research Agenda

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This report addresses the rapid increase in rates of deliberate self-harm (DSH), particularly amongst young people, in the South West of England. We discuss a recent audit of suicide and self-harm figures released by the South West Public Health Observatory (2010)[12] in relation to the extant literature on DSH. Much of this literature is dominated by a medical model, and is characterised by a diverse range of terminologies, definitions, categories, approaches and understandings about DSH, however a small but growing body of sociological, social psychological and ethnographic work also exists. A number of interventions have been proposed or trialled in recent years; however these have been largely led by health providers rather than target populations. We argue that the self-harm reduction agenda would benefit from an investigation of the attitudes and beliefs of those at risk of, or actively self-harming, and furthermore, that this calls for a research strategy that combines both quantitative and qualitative approaches. This should be coupled with a focus on determining the information needs and support mechanisms preferred by specific segments of self-harmers.

## Introduction

> *Self-mutilation has been trivialised (wrist-cutting), misidentified (suicide attempt), regarded merely as a symptom (borderline personality disorder), and misreported by the media and the public*[1:xii].

A range of terms have been used to refer to deliberate self-harm behaviours including: "self-injury, self-mutilation, self-harm, self-abuse, auto-aggression, and self-inflicted violence"[1:xvii] amongst others. In addition to this there is little agreement in the extant literature on the informing intentions and actions – the types – self-harm behaviour[1].

We adopt both the following definitions in order to acknowledge the broad spectrum of DSH behaviours and categories:

> *"self-harm (self-poisoning and self-injury) is broadly characterised as any act intended to harm one's own body, without a conscious intent to die"*[1: 122].

> *"the deliberate, direct, nonsuicidal destruction or alteration of one's body tissue"* (Favazza, in Strong)[1: x]

Here the latter definition points to a significant distinction – between DSH that is inflicted on the body in general and, more specifically, DSH that directly alters bodily tissue. This distinction points to the potential differences in the functions and meanings of different types of self-harm behaviours and is further addressed later in the report.

Using both the definitions provided above DSH behaviours may therefore incorporate the following:

- Self starvation
- Alcohol and illicit drug abuse
- Self poisoning including known poisons and unsafe quantities of prescription and non-prescription drugs
- Deliberate recklessness (e.g. involving cars, trains, heights etc)
- Self laceration (including cutting, piercing, biting, burning)
- Self battery (head banging)
- Omission (e.g. sleep deprivation, or failure to seek appropriate medical treatment)

One contentious issue is the conflation of deliberate self-harm with actual or attempted acts of suicide[1]. As understandings of DSH have evolved many researchers now strongly argue that DSH does not represent a desire to die, but rather a "morbid form of self-help"[1: xi-xii] and a "functional alternative to suicide"[2: 3]. This is not to say that there are no links between self-harm and suicide – some repetitive self-harmers may become suicidal, demoralised and depressed because they feel unable to relinquish self-harming, or feel that it has gotten out of control[1] – however, it is not the overriding intention behind, or function of, most acts of deliberate self-harm.

DSHing occurs across a diverse range of people, including those with or without mental illness, those that have suffered sexual abuse, those with a history of substance abuse, those with a range of psychosocial problems, those who have been victims of bullying[3], and members of the lesbian, gay, bisexual and transgender community[4].

There appear to be gender differences in both the motivations for and functions of self harming behaviour, at least among adolescents. For example, a study of 13 – 18 year olds found the following[5]:

| Girls | Boys |
|---|---|
| Harm behaviour occurs alone for the following motives:<br>• Self hatred<br>• Self punishment<br>• Depression<br>• Loneliness | Harm behaviour occurs alone or with peers for the following motives:<br>• Communication with/influence of others<br>• Boredom |

Women are 3 – 4 times more likely than men to report DSH[6] but it is not known if this ratio applies to non-reported self harm incidents as young women are also 70% more likely to seek help before DSHing[7]. Men may now be deliberately self-harming at a rate as high as women, possibly due to increased identification of past abuse as a trigger for DSH coupled with social encouragement of emotional awareness[8, 16]. It is therefore worth noting, as Adler & Adler do, that previous assumptions that self-harm is confined to white, wealthy girls, have been overturned by increasing rates of self-harm among "boys, men, people of colour and those of lower socio-economic status"[9:544].

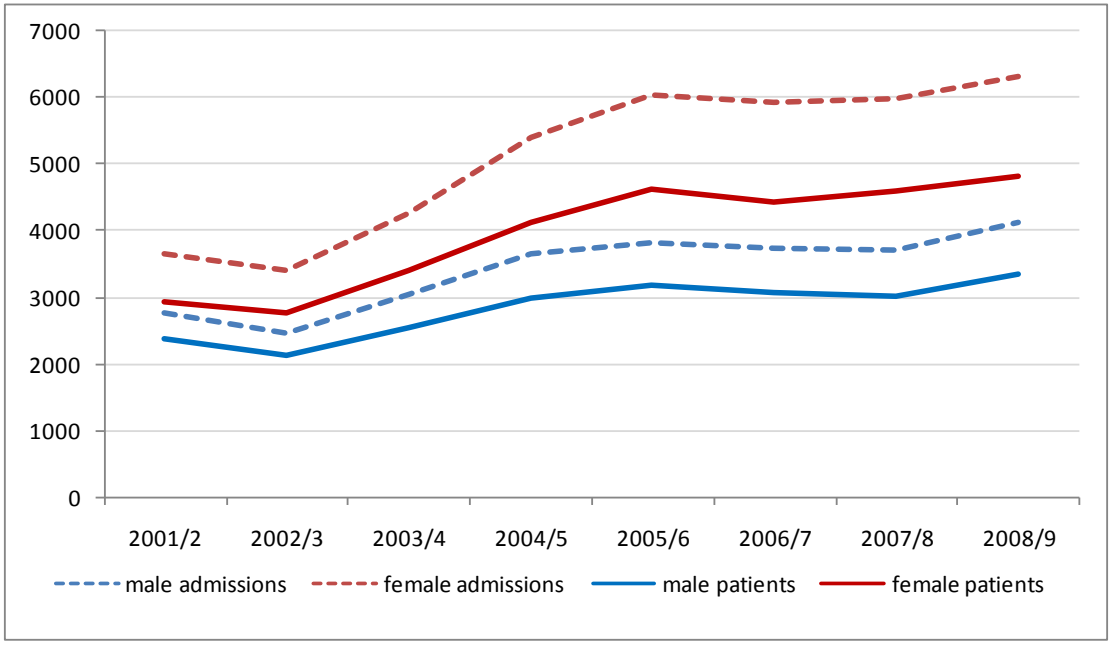
The functions fulfilled by DSH appear to be as diverse as the forms of DSH itself, but on the whole these can be characterised as a mechanism for coping with stress, distress, painful thoughts and memories, and depersonalisation or numbness[17]. It is in this regard the distinction pointed out earlier becomes salient – much of the work that touches on the functions of self-harm refers to behaviours such as cutting and burning as the forced externalisation of an internal emotional state, which then results in a restored equilibrium between inner and outer or, in the case of depersonalisation, a restored sense of reality. This would accord with the definition of self-harm as an alteration of body tissue but does not seem representative of self harm behaviours that include self-starvation (this might represent the restoration of control), or alcohol and illicit drug abuse or self-poisoning, and which are more in keeping with the first, more general definition of harm done to the body.

## Self Harm Prevalence and Trends

DSHers, particularly those who repeatedly DSH use substantial health and social care resources[10]. Between 2001 and 2008 there were 71,740 admissions of South West residents to hospitals for self harm. Of these 68,197 were 15 years or over, but 61 with unattributable postcodes were removed. Therefore 68,138 admissions were analysed, 27,217 men and 40,921 women. In the same period 46,821 individual patients resident in the South West were admitted for self harm. However, some of these patients were admitted more than once, and a few moved local authority. The convention is that patients are counted for the first admission in a local authority each year. Counted in this way 57,452 patients were treated; 54,366 were 15 years or over, but 57 with unattributable postcodes were removed. Therefore 54,309 were analysed: 22,257 were men and 31,752 were women[12].

As shown in Figure 1, numbers of admissions and patients rose rapidly between 2002/3 and 2005/6, followed by a period of stabilisation. However since 2008/0 the numbers have again been on the increase with the fastest rise occurring in young women aged 15-19 and 20-24.

***Figure 1: Trends in admissions and patients aged 15 years and over admitted for self harm in South West 2001/2 to 2008/9[12]***




Rates of DSH by teenagers in the UK are recognised as among the highest in Europe[11]. In England, hospital admissions for DSH have risen by 41% from 2001/2 to 2008/9. Within the South West region of England, hospital admissions have risen by 73% over this period[12]. These figures are likely to significantly underestimate the overall number of cases: it is suggested that only 1 in 6 – 7 cases of deliberate self harm result in formal medical treatment[13]. Only 12.6% of a community sample of adolescents had been hospitalised[14]. Prevalence rates of adolescent self harm appear to range from 5 – 15% depending on the actual definition used[15]. In studies where young people have been asked to self-define self-harm, the rates appear to be considerably higher, ranging from 25% to over 40%[16]. The reasons for the significant increases are not known, however there is some evidence that DSH involving young people is beginning earlier in life[17]. In non-clinical groups, DSH generally begins in adolescence, peaks by the mid 20s and declines or ceases by the 30s independent of formal medical attention[16]. However there is also evidence to suggest an additional trend whereby self-harm begins in early childhood and persists through adulthood[2].

Several key questions arise in relation to the above:

- What percentage of deliberate self-harmers follow this cycle?
- Did their behaviour leave long-term physical or emotional damage?
- How and why did they 'emerge' from DSH behaviour cycles?
- What sources of formal or informal help did they seek, use or value?

- What support do they recommend for others?

As a cautionary note, Murray & Fox[18] (2006) warn against the identification of prevalent trends in types of self-harm based solely on samples gained from medical settings, such as Accident & Emergency admissions. They argue that particular forms of DSH, such as self-poisoning, can be over-represented in these samples, while behaviours such as cutting and burning are under-represented and more prevalent in actuality[18]. Furthermore, while instances of self-harm that end up in A&E are more likely to be life-threatening forms of self-harm, other instances involving cutting and burning are less likely to require hospitalisation. Adler & Adler[9] call for the demedicalisation of self-injury, stating that many self-harmers never seek help from mental health professionals and a large percentage of self-harm never receives medical attention[19]. There is therefore also a need to access under-researched self-harm populations such as "long-term chronic [self-harmers], youthful participants who remain outside of treatment and people who feel positive about self-injury"[9: 538].

While official statistics do not break down DSH severity, it is suggested that an additional layer of analysis based on a continuum of DSH would improve knowledge[20]. This continuum is proposed as ranging from:

- Good enough self-care
- Compromised self-care
- Mild self harm
- Moderate self harm
- Severe self harm.

No statistics are available to support this proposal, however if verified, it could indicate a range of different interventions, particularly as there appear to be several different segments of deliberate self-harmers, some of whom will require specialist medical treatment, often as in-patients, and some for whom effective assistance may be able to be delivered in community settings. Possible segmentation and the implications of this are discussed in the following sections.

## Past Intervention Effectiveness

A challenge to understanding the diverse segments of deliberate self-harmers is that most studies of motivations and treatments have been conducted with populations within the health-care system, and in particular, in-patients[21]. Overall findings and the identification of needs from these studies are summarised here. DSHers are known to have low rates of compliance with aftercare[22] and between 12 – 25% of patients will repeat DSH and represent at hospital within a year[3]. For some, provision of medication is seen as being 'fobbed off' rather than helping to address behavioural causes[23]. This suggests that the needs of these vulnerable individuals may not be fully met by conventional health service provisions or interventions aimed at reducing DSH rates.

We do not suggest that the role of counsellors is in any way inadequate or negative, but reports of the value of their roles are based on perceptions of counsellors themselves rather than being compared and contrasted with the perceptions and preferences of their clients[24]. It may be that some segments of DSHers may prefer and benefit from a wider integrated range of support options including self help provided via electronic technologies as well as face-to-face options. There is some evidence of a preference for specialist community-based rather than hospital-based support[25].

There are calls for schools to play a central role by providing 'emotional literacy' training programmes[6]. This may not be the most effective strategy as experiences from the international Health Promoting Schools (HPS) programme illustrate. The HPS initiative is an international holistic, multi-factorial approach, targeting personal, cognitive and social skills in order to improve physical activity, healthy eating and emotional health. Sustained improvements on these factors have been demonstrated in many countries in which the approach has been used[26, 27] but associated programmes aimed at decreasing illicit substance use and reducing suicide potential have been less successful[28].

Not only is there a need to provide education and support for those in school environments who may identify potential DSHers or who need to deal with actual DSH incidents and who may feel they are inadequately equipped to deal with the issues [17], additional training in the wider health service provision environment appears to be warranted. Negative attitudes by health service providers towards repeat DSHers is known to hinder the latter's involvement with services[29] and even Accident and Emergency staff feel their training is inadequate, leading to concerns that they could make DSH situations worse [16].

There is also a call for more resources to be made available to those working with DSHing children and adolescents[17]. The nature and optimum use of existing and possible future resources are likely to be influenced by a greater understanding of the factors likely to motivate potential and actual DSHers to change behaviours.

Mass media awareness raising campaigns risk being seen as potentially normalising and generating an unhealthy interest in DSH[16]. Interventions undertaken in isolation are also unlikely to be effective. For example, an intervention in which postcards were sent at regular intervals over a twelve month period to DSHers who had presented at a hospital emergency department did not reduce further self harm rates[30]. There are numerous possible reasons for this, including both the medium used and the messages contained therein. There is a rich body of literature detailing the impact different forms of message framing, such as positive versus negative framing, and the use of rational versus emotional phrasing can have on behaviour[31, 32].

## Relevance of the Social Marketing Approach

The recent Health White Paper explicitly acknowledged that:

> *"Recent years have proved that one-size-fits-all solutions are no good when public health challenges vary from one neighbourhood to the next"*[33]

In considering the complexity of factors impacting on potential DSH interventions, we believe that a key question is:

> *"What works, for whom, in what circumstances, and for how long"* [34, 264].

In the UK, a previous white paper *Choosing Health*[35] specifically advocated the adoption of the principles underpinning social marketing in order to more effectively promote public health issues, acknowledging that existing communication strategies were not effective. The centrality of social marketing in the dissemination of innovation in health promotion is also acknowledged in the academic literature[36].

Social marketing focuses on the generation of insights into attitudes, beliefs and values that underpin actual behaviours, thus helping to bridge intention-behaviour gaps. It draws on many disciplines to bring about voluntary behaviour change as well as addressing 'upstream' factors such as supporting policy and environmental change[37].

This approach is consistent with the Department of Health's 2006 recommendation[38] for a refocusing on behaviour change efforts to a patient / client-centred approach rather than an expert led approach:

> *"Tackling today's threats to health means examining the way we live. This is a challenge that we have to embrace; we have to see the world as it is. We have to understand the reality of how people live their lives, not make assumptions about how things are. We must be sensitive to people's needs and work with them to make the changes that they can and want to. Why? Because once we do this, we really are better equipped to support people in changing their lifestyle for the better. Without such a people-centred approach we are blind to the challenges people face and risk providing support that is inappropriate and ineffective".*

## Trans-disciplinary Approach

Within a social marketing behaviour change perspective, we suggest that a trans-disciplinary approach to investigating the factors underlying DSH behaviours for those segments not requiring in-patient treatment may be valuable, given the likely complex interaction between social, cultural and economic factors[39] impacting on DSH behaviours. A trans-disciplinary approach can contribute to identifying, and developing strategies to overcome, obstacles to behaviour change[40]. In addition, a trans-disciplinary approach can help policy makers to understand more

comprehensively the contributions of policies to improving or worsening health-related behaviour[41].

There are three possible approaches to the combination of expertise from multiple disciplines: multi-disciplinary, inter-disciplinary and trans-disciplinary. Multi-disciplinary approaches seek input from different disciplines but these are independent of each other and may create a mosaic of interventions. In Inter-disciplinary approaches, disciplines work together to provide input but individuals stay within their own disciplinary boundaries[42].

The trans-disciplinary approach is synergistic in that it uses concepts, theories, research approaches, analytical methods and strategies for the interpretation of findings to develop shared conceptual frameworks that integrate and transcend individual disciplines[43, 44, 45]. Key features of this approach include recognition that no one group has a monopoly on knowledge and that collaborations must be created "not only between different academic disciplines but between researchers and non-academic groups with a stake in the problem under investigation"[46, 161].

Public health issues such as DSH are an ideal environment for trans-disciplinary approaches due to the influence of intrapersonal, interpersonal, organisational, community and societal influences and the multi-level interventions that will be required to address preventable causes of health problems[47, 48]. Benefits include a true integration of knowledge to address linkages between the factors influencing health behaviours[49].

## Relevance of Theory

No single theory is universally applicable to all behaviour change situations. There is an extensive body of research testing the power of a range of theoretical concepts to explain the factors driving current behaviour and to help identify the relative strength of a range of factors in behaviour supporting or inhibiting behaviour change[50].

The selection of the most applicable theories to guide intervention development and implementation. There is:

> *"Increasing evidence suggests that public health and health-promotion interventions that are based on social and behavioural science theories are more effective than those lacking a theoretical base"*[51:399].

A notable gap in the self-harm literature relates to "a unifying, evidence-based, theoretical framework within which to understand the factors that control this behaviour"[52, p. 371]. This may be due to several factors. Firstly, the concepts and theories that have been proposed are predicated on the assumption of a homogenous set of trigger factors. We believe that this assumption cannot be made and it is unlikely that a single theoretical framework will provide an overarching explanation.

Theories are not blueprints to be followed without question – they do not provide concrete answers and may not suit complex questions, however they do provide some guidance to potential trigger points or barriers that can be leveraged[53] and can be of great value to the practicing social marketer. Many call for theories to be generalisable, but in the context of social marketing one could argue that segmentation calls for theories tuned to that particular segment or behaviour. There is also a need for testability[54], to demonstrate the theory's aptness for the task.

There are a number of different types of theories. One type is explanatory theories, or theory of the problem, which describe the problem and seek to explain why it exists. By breaking that problem down into the constructs that contribute to its existence, the factors that can be used to relieve or remove that problem can be identified. Change theories, or theories of action, are more orientated to problem solving to help develop interventions[55]. The self-harm concepts and models that have been proposed to date are descriptive, as shown on the following page:

***Figure 2: The Proposed Model of the Functions of Self-Harm***[56:664]

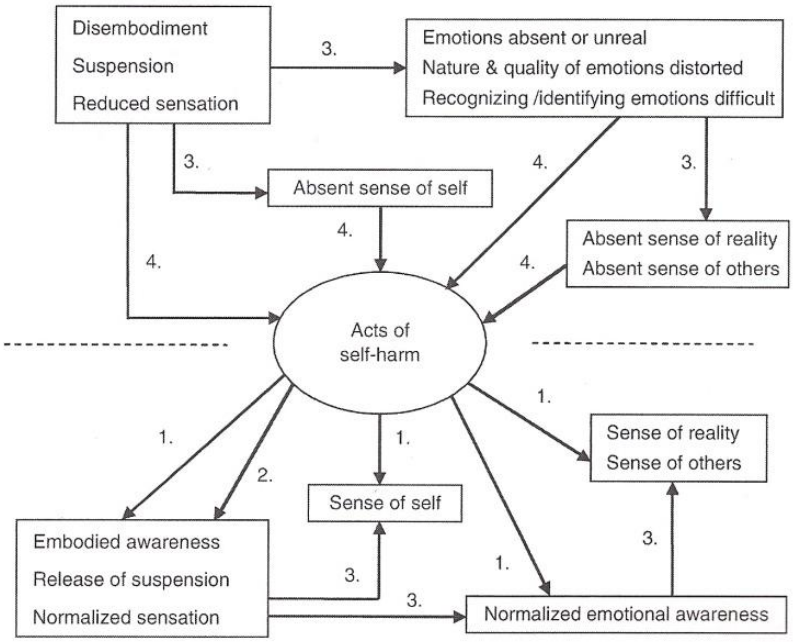
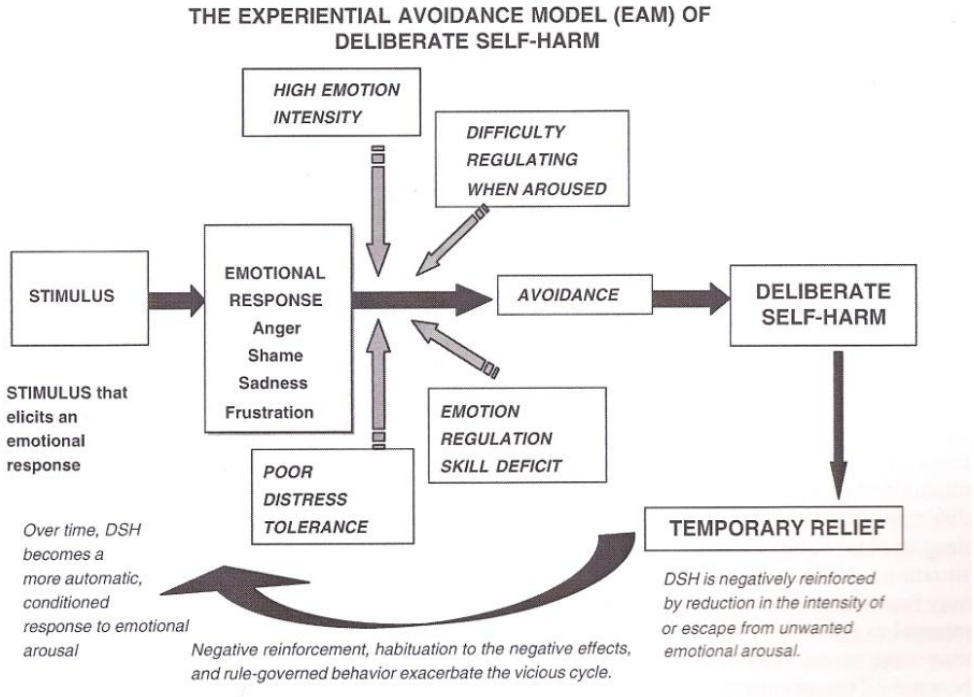



***Figure 2: The Proposed Model of the Functions of Self-Harm***[52:373]

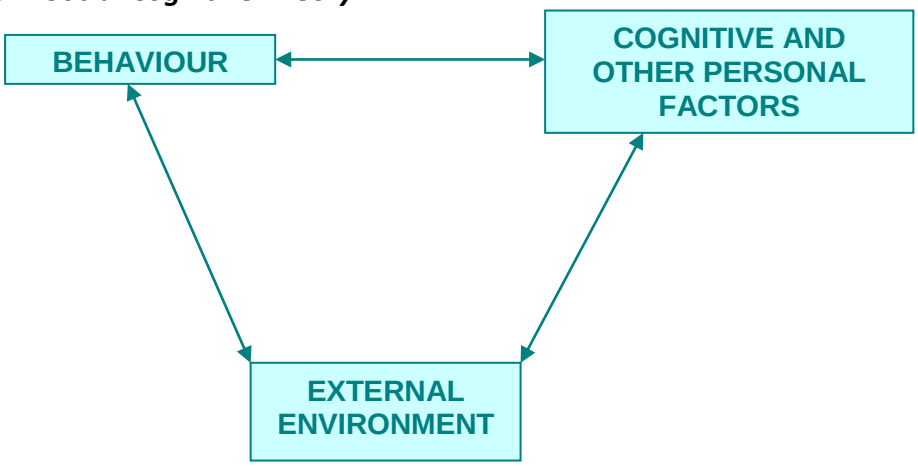


## Social Contagion

One reason for a lack of coherent theory may be because of an assumption of common motivations and therefore treatment paths across deliberate self-harmers. We suggest that this assumption cannot be made and that some segments may be motivated by very different factors to other segments. For example, one segment of the self-harming population that is not well served by these models is the group who appear to be motivated by social contagion, i.e. 'copycat DSH in which DSH behaviours are done to gain attention and approval of social groups, to display their ability to endure pain or discomfort and thereby gain social status [57, 58].

It is suggested [21] that the behaviour of this sector of deliberate self-harmers can be explained by social cognitive theory[59,60] which proposes that behavioural, personal and environmental factors are reciprocal, interacting determinants of each other (reciprocal determinism), so changing one element has implications for the others as shown in Figure 4 below ). Thus engaging in behaviours that are modelled on others who are observed to be 'rewarded' by status or attention increases the appeal of imitating this type of behaviour.

***Figure 4: Social Cognitive Theory***




There is very little research, as opposed to speculation, regarding contagion effects in community settings versus those DSH patients formally treated at hospitals and it is possible that there may be a number of counter forces operating. For example, while there may be a wish to impress some social groups by DSH-related behaviours, there may also be a desire to avoid negative feedback, stigmatisation and potential ridiculing if DSH activity is disclosed to other groups. There is also a concern that attempts to curb DSH may result in its replacement by other maladaptive behaviours[16].

Several questions arise from the above, and these may also be related to those for whom DSH behaviour is confined to a period of transient distress[14].

- How severe are injuries arising from DSH associated with social-contagion?
- What percentage of these behaviours result in formal medical treatment?

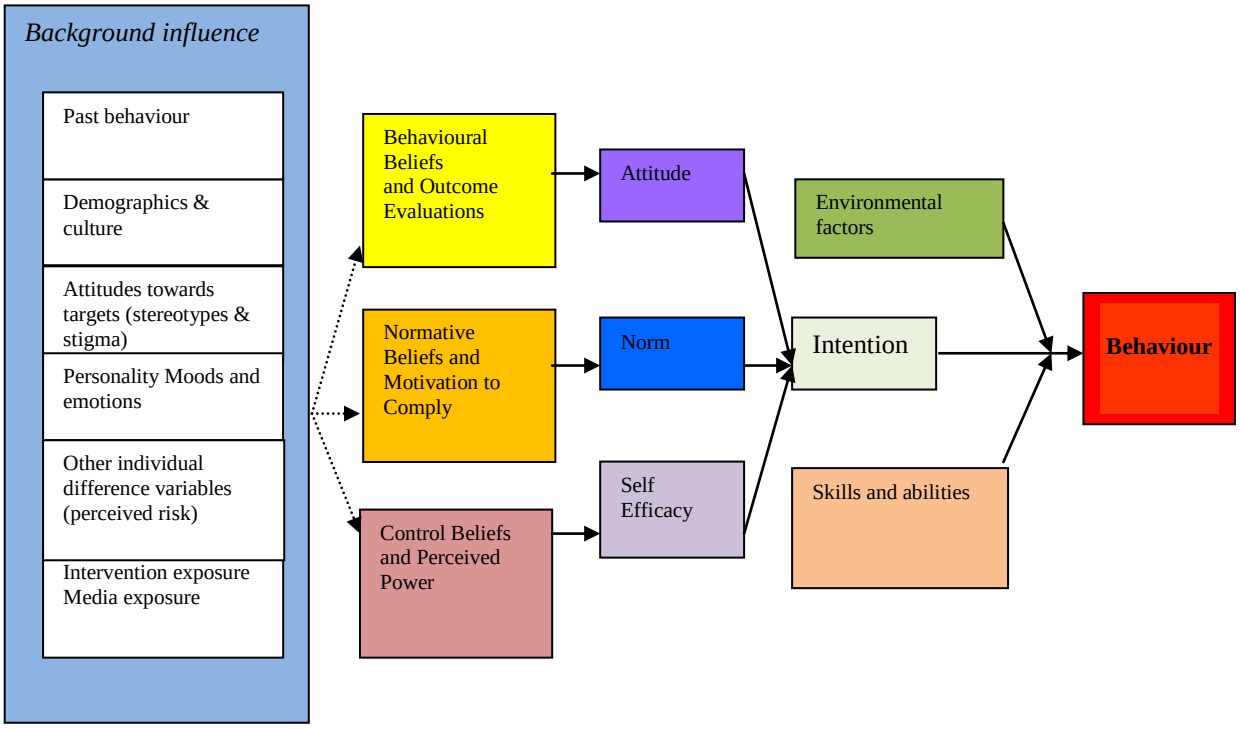
- What are the consequences for those who do not seek formal medical help?
- Does their behaviour leave long-term physical or emotional damage?
- How and why do DSHers influenced by social-contagion 'emerge' from DSH behaviour cycles?
- What sources of formal or informal help do they seek, use or value?
- What support do they recommend for others?
- How do they recommend that social-contagion cycles be broken?

## Integrated Model of Behaviour Prediction and Change

Related to SCT theory and reflecting ongoing development from, and extension of the widely used Theory of Reasoned Action (TRA)[61,62] and its successor, the Theory of Planned Behaviour (TPB)[63] is the more complex Integrative Model of Behaviour Prediction and Change (IM) shown in the following figure. This Model shares many attributes of its predecessor in explaining behaviour change as the outcome of behavioural intention, and behavioural intention as the outcomes of social norms and an individual's attitude to the behaviour. The element of perceived behavioural control (PBC) to account for variance in behaviours with incomplete volitional control i.e. where individual's lack complete control of the behaviour.

The Integrative Model places emphasis on the influence of background factors, including, importantly, the role of intervention activity and media exposure. A key contribution of research underpinning the effective use of this theory is that different population segments may be driven more strongly by attitudinal factors, normative influences or perceived self efficacy, i.e. ability to change behaviour and sustain the change[64]. This indicates that very different intervention strategies may be needed for different population segments[65,66].

***Figure 7: Fishbein et al. Integrative Model of Behavioural Prediction and Change*** (originally developed by Fishbein 2000 – and subsequently refined, for example, Fishbein & Cappella 2006 [67])




Further considerations illustrated by this model are the relative importance of attitude, perceived norms and self-efficacy:

> "*The relative importance of these psychosocial variables as determinants of intention will depend upon both the behaviour and the population being considered*.
>
> and:
>
> "*one behaviour may be primarily determined by attitudinal considerations, whereas another may be primarily influenced by self-efficacy. Similarly, a behaviour that is attitudinally driven in one population or culture may be normatively driven in another*"[67].

Where DSH-related research instruments have been validated, there has been a tendency to use introductory year university students who are predominantly female and who are given academic credits for participation[68]. We question how well these populations match the characteristics of the population segments that are the real focus for the application of relevant research instruments in this area and recommend that care be taken in selecting elements of past research instruments for future research.

## The Broader Context: Cultures of Self-Harm

> *When I listen to the stories told by cutters about their lives and the meaning self-injury has for them, I also gain insight into much broader social patterns and problems: from childrearing to child abuse, from eating disorders to the pop-culture trend of tattooing and body piercing. Their activity tells us something about ourselves as a society*[1: xviii].

> *what is carved in human flesh is an image of society (Douglas, in Strong*[1: xviii]*.)*

From a more sociological and social psychological point of view, deliberate self-harm must be seen within a wider social and cultural context. According to Adler & Adler[9: 559] "Self-injury represents, in part, a complex social process of symbolic interaction", there is consequently a need to examine the "social perceptions, interpretations, anticipations, and evaluations to plan and project lines of action" of self-harmers. Here we are not only referring to the risk factors that impact on or initiate self-harm behaviours, but also to the ways in which self-harm behaviours are represented in wider culture; what kinds of narratives or discourses are culturally available to, and reproduced by, self-harmers (including those who may only be thinking about starting to self-harm), and what forms do these take – in other words, what are the mediums of communication and how, in turn, do specific mediums (mass media, social media) influence cultures of self-harm?

## Deliberate Self-Harm Online

A significant medium of communication with regard to self-harm is the Internet. Researchers have discussed the role of the Internet as a source of health information, social communication and support that it accessible day and night[18]. In the past 2 decades there has been a dramatic increase in references to self-harm in a variety of media content and this is even more pronounced on the Internet[69]. Murray & Fox[18:2] state that "the topic of self-harm is ubiquitous on the Internet [with] hundreds of online discussion groups dedicated to the issue". However, the authors also argue that while the Internet provides connectivity on an unprecedented scale, it is also questionable whether online self-harm groups provide 'network capital' – relationships that "significantly provide companionship, emotional aid … information and a sense of belonging" [18:2].

There has been growing concern about talk and depictions of self harm online[70,71,72]). In an early study Adams, Rodham and Gavin[70] discuss the use of online self harm forums and how these impacted on their participants' sense of self in relation to their self harm behaviour. The authors argue that online forums play an important role in validating aspects of self harmers' selves that they are not able to express in the offline world, and that the social interaction on these forums might counteract the isolation and loneliness that many self harmers feel. However, the authors also question whether having self harm behaviour validated by others online might exacerbate this behaviour offline, they ask[70: 1307] "what aspects of the self are being

validated in self harm online discussion forums and … how these aspects of the self might be carried over to the offline world".

The data for Adams, Rodham & Gavin's[70] study was obtained by undertaking a series of focus groups with self-harmers in the actual online settings of a self harm discussion forum. Drawing on the work of Turkle[73] the authors argue that the anonymity offered by the online world provides participants with the opportunity to discuss otherwise taboo topics and to try on a different set of selves or identities. However, since the publication of this study in 2005 the Internet, and the ways in which people interact with the Internet, has undergone a massive shift – this has been conceptualised as the shift from the first iteration of the Internet to the second, participatory phase of the Internet or Web 2.0[74]. Web 2.0 has been characterised as the social web as it entails the proliferation of a range of social software that allows "individuals and communities to gather, communicate, share, and in some cases collaborate or play"[75]. Examples of Web 2.0 platforms include blogging and micro-blogging sites (Tumblr, Twitter); Web forums and message boards; media-sharing sites (You Tube, Flickr); and social networking sites (Facebook, MySpace, Bebo) amongst others. While the use of such platforms is not ubiquitous several popular Web 2.0 sites account for a large percentage of all Internet traffic. The ethos of the social web is informed by two significant cultural shifts: a radical erosion of the boundaries between the public and the private, and the move to active participation in, and creation of, online content. Snee[76: 3] states that "personal lives are increasingly exposed in Web 2.0 applications as part of a broader cultural shift towards openness and changing notions of privacy", while Anderson[74: 15] argues that people now see themselves as the creators of, and experts on, the online representations of their experiences and identities, posing a significant challenge to perceptions of "who has the authority to 'say' and 'know'".

The shift to a more social, participatory and user-generated Web is reflected in the kinds of online platforms used by self harmers. There are still a number of self harm forums in use, however many discussions and representations of self harm can now also be found on micro-blogging sites such as Tumblr, social networking sites such as Facebook and bebo, and video-sharing sites such as You Tube. The younger demographic of platforms such as Bebo, Tumblr and You Tube means that these are well positioned for use by young self harmers. While discussion forums are largely text based, micro-blogs such as Tumblr provide users with a highly decorative and customisable template (accounts are called 'tumblelogs') that facilitates the easy uploading and creation of multimedia content including text, photos, quotes, links, audio, and video.

As with many other social media platforms Tumblr allows users to 'follow' other tumblelogs and all of these updates appear as one stream under the Dashboard tab of a user's account. This stream of blog updates allows users to 'like' (a 'like' button enables one user to tell another that they like his or her content) and reblog posts that appeal to them. Reblogging allows content to be quickly and easily reposted from one tumblelog to another. One of the features of digital and networked technology is that it has been designed to increase the speed of content sharing and

social interactions[69] and this is very much part of the Tumblr framework. Adams, Rodham and Gavin[70] have argued that 'liking' and reblogging may constitute a form of self validation and positive feedback, or that talk about, and representations of, self harm on such sites might serve as both an individual and collective outlet for difficult emotions thereby minimising the urge to self harm. However, they argue that it is also possible sites may serve to exacerbate self harm behaviour. Many forum discussions, tumblelogs and videos have 'triggering' warnings to indicate that the content may trigger episodes of self harm. It is questionable whether these warnings are effective in reducing the potential harm of content or conversely, whether they sensationalise and promote – indirectly or directly – self harm behaviour. In a study of online self-harm forums, Murray and Fox[18] found that some participants ignored or selectively read posts with triggering warnings, while others actively sought to be triggered by the material. In this regard, Lewis et al[72] refer to the proliferation of pro-anorexia websites where similar mechanisms are seen to be at work. Furthermore, as Lewis et al[72] found in their study of self harm videos on You Tube, many tumblelogs make use of rich imagery which is often melancholic and draws on a familiar/available set of cultural resources and codes.

While it is tempting to see the kind of imagery used in self harm social media sites as normalising or glamorising self harm, it may also be that the cultural sources used by self harmers provide a cultural or discursive means of identification that acknowledges the experiences and emotions of self harmers. Interestingly Lewis et al's[72] study found that noncharacter videos (videos without a live character) on You Tube were more popular, with a greater number of views, than videos containing a live person. They argue that while some of the live character videos depict actual acts of self harm, the images used in noncharacter videos depict wounds that are much more severe in nature, and that coupled with music and text these videos provide emotional and atmospheric viewing experiences for self harmers. It is therefore crucial, they argue[72], to understand how young self harmers are affected and influenced by online content related to self harm. If actual acts of self harm fulfil a function and purpose for self harmers (such as emotional or experiential avoidance), what function(s) are fulfilled by online representations thereof?

## Conclusion

Much of the existing literature on self-harm is dominated by a medical model wherein research findings are based on samples from clinical or medical settings, and the focus is on acts of self-harm to the detriment of the broader social and cultural context of these behaviours. Furthermore, acts of DSH are almost exclusively seen as harmful and negative in this model, with a tendency to overlook the perceived benefits, gains and, for some, even the enjoyment provided by this DSHing. As DSH may be initiated by a range of factors, and may serve a number of functions, there is no single explanation, or solution, for this behaviour. A number of existing models and theories may be useful for understanding the motivations for, and functions of, DSH but these need to be tailored to the needs and perceptions of different segments of DSHers, rather than applied in a top-down manner. In order to identify these different segments there is a need for work that focuses on the

meanings, contexts and venues for the representation of DSH (i.e. the Internet) and which engages with different kinds of (non-medical or clinical) DSH populations[77].We use the points above as the basis for arguing the need for a mixed methods (quantitative and qualitative) research agenda that aims to identify a continuum of DSH behaviours and the frequency of these amongst a non-clinical population; whilst exploring the diversity of meanings, contexts and functions of DSH for young DSHers in the South West. A suggested research plan is set out in the accompanying proposal. Additionally we argue that any research agenda should aim to determine the information needs and support mechanisms preferred by different segments of DSHers as this would feed into policy-level decisions (such as the allocation of resources based on pertinent real-world data. Finally, we argue that any kind of intervention needs to take the above-mentioned benefits and gains bestowed by DSH into account and that a relevant exchange will be one that is co-created by young self-harmers. This is in keeping with the emphasis placed on co-creation by, amongst others, the Improvement and Development Agency, who argue for an approach to behaviour change that "sees citizens and communities as the co-producers of health and well-being, rather than the recipients of services.[78]"

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