

Portfolio for Professional Doctorate in Counselling Psychology (DPsych)

The Rejected Self:

Young People's Experiences of Self-hatred, Self-harm and Finding Acceptance

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Preface

This portfolio consists of three distinct pieces of work that are related to my training to become a counselling psychologist and my developing interests during this journey. The overarching theme of the portfolio is self-hatred, self-harm and finding acceptance, specifically in young people. It draws together experiences of/relating to physical self-harm and psychological extreme negative views about the self, such as self-hatred and self-disgust. It highlights the importance of the relationship with the self, self-criticism and shame and their impact on psychological wellbeing in adolescents and young people, with a focus on the process of finding acceptance of the self, including one's emotional states and difficulties.

This portfolio sets out to enhance awareness among practitioners of the power of a rejected or hated self, and of the need to be mindful of working with someone who presents this state of mind; to be aware of the potential for others, including professionals, to contribute towards the individual's invalidation and shaming processes. The portfolio urges clinicians to take a broader perspective on self-harm, and the person behind the act, focusing on the relationship they have with themselves, and on fostering self-compassion and self-acceptance. This portfolio presents two different trajectories of self-harm that begins in adolescence: self-harm that is an indicator of later clinical difficulties, and the less pathological behavioural pattern commencing in adolescence that stops over time/with age.

The first part of this portfolio takes the form of a qualitative exploratory research study into the experiences of young people who engaged in repetitive self-harm during adolescence and their understanding of their self-harming experience. The second part takes the form of a clinical case study with a young adult who has a history of self-harm and high levels of shame, and suffers from

Obsessive Compulsive Disorder (OCD). It looks at the difficulties in working with OCD where the compulsion takes the form of a shameful cognition/belief about the self, and the process of fostering acceptance towards one's self and one's emotions. The third part consists of a paper for publication which presents a summary of the doctoral research findings in Part 1, focusing specifically on the theme 'Relationship with the self'. This preface will provide a summary of the key components of this Doctoral Thesis Portfolio and will conclude with personal reflections on my learning and personal development during the research and training process.

Part 1: Research

This section comprises an original research study that aims to explore the in-depth lived experience of repetitive self-harm during adolescence. It explores the experiences of young people who engaged in self-harm during adolescence and subsequently stopped. Data was collected via semi-structured interviews and analysed using the method of interpretive phenomenological analysis (IPA). In-depth analysis of the participants' accounts revealed five main themes, which encapsulated the shared aspects of the participants' experiences. The findings of the study are considered in relation to existing research and psychological theories of self-harm, and adolescence. Implications for the practice of counselling psychology are also discussed. This research is timely considering the growing concern regarding the prevalence of self-harm in adolescence, and evidence to suggest that rates in the UK, and much of the western world, are growing. Research in this area is important in order to gain a greater understanding of the phenomenon and to help develop effective treatment plans/guidelines for self-harm, which are currently limited.

My interest in conducting research in the area of self-harm stems from a personal and professional interest in the topic, having worked with young people who self-harm and having engaged in the behaviour myself for a time during my adolescent years. I was interested in the wider experiences of the individual who self-harms rather than focusing solely on the act itself and its functions. I was struck by a preoccupation in the literature with functions of self-harm and of trying to understand the reason for the behaviour. There seemed to be a focus on the 'why?', potentially at the cost of the 'what?'. This is perhaps due to the fact that self-harm appears to be a difficult phenomenon for people to make sense of, including those who have self-harmed, as it goes against the human drive to protect the self. I considered that this fixation on 'why' might be getting in the way of furthering insight into the phenomenon; perhaps self-harm is not something that can be summed up in a concise 'one size fits all' theory. This thinking is likely influenced by the pluralistic nature of counselling psychology training which teaches that there are multiple ways to view a psychological problem.

Additionally, I wanted to explore experiences relating to the cessation of repetitive self-harm behaviour which begins in adolescence, as limited research is available in this area and findings could offer implications for practice for professionals working with clients who hurt themselves. Despite research into self-harm over the past two decades, particularly in the domains of functionality and associated risk factors, there has been little research into the lived experience of individuals from a counselling psychology perspective. Specifically, relating to the stage of adolescence, when self-harm commonly begins and is most prevalent.

The research aimed to communicate the voice of the individual who self-harms and to appreciate the behaviour as a form of expression and consider what it might represent, rather than

searching for a definitive reason to explain ‘why?’. The research findings suggest we might consider approaches related to the self as opposed to a focus on the self-harming behaviour.

Part 2: Professional Practice

This second section takes the form of a client study that demonstrates my clinical work as a counselling psychologist. It intends to exhibit my ability to put theory into practice and work effectively, appropriately and sensitively with clients. The client study is based upon 26 sessions of cognitive behavioural therapy incorporating elements of acceptance and commitment therapy (Hayes, 2005) and compassion focused therapy (Gilbert, 2009), with a client suffering from OCD, the compulsion being cognitive in nature. The client presented with suicidal ideation and a past history of self-harm in adolescence. He displayed an extremely negative self-concept and relationship with himself. The study touches upon the impact of shame as well as paranoia on the therapeutic process, and the beneficial process of gaining insight into ones’ difficulties and one’s self. It highlights how the process of gaining insight can aide in self-acceptance and alleviation of suffering. The study is also concerned with how invalidation of paranoid thoughts and beliefs about the self can be damaging to the individual who holds such beliefs. It highlights the need for a delicate balance between validating the individuals’ experience and suffering, whilst also being able to impart contradictory views and help to shift such rigid beliefs.

Part 3: Publishable Article

The final section to this portfolio presents an article planned to be submitted for publication in the *Journal of Counselling Psychology*. The paper is a succinct summation presenting the larger doctoral research and specifically focuses on the theme ‘Relationship with the self’. I deemed that this theme warranted further consideration due to there being limited available research exploring

these experiences from the individual's perspective, particularly in the context of adolescence. I was particularly struck by how participants related to themselves and the shift in this domain, as well as the role of self-compassion. I am interested in how these experiences may assist in informing the practice of counselling psychology in the role of supporting those who self-harm. The findings are discussed in relation to the existing literature and in relation to identity theory, as well as the literature on self-compassion. The article concludes with implications for clinical practice as well as directions for future research.

Personal Reflections

This portfolio represents the conclusion of a four-year process of training in both practical clinical work and research. The different sections of the portfolio reflect certain aspects of my learning and development and personal and professional discovery, over the course of my training. During this time, I have reflected on and worked through my own relationship with myself and the process of not being good enough: not being a good enough researcher, not being a good enough practitioner which at times led to the temptation to refer certain clients on. This process involved resolving my past experiences of self-harm to gain a more integrated sense of self, particularly in my professional identity as a counselling psychologist, as opposed to retaining a hidden part of myself. Despite the past four years having been challenging and demanding, I feel that as the process is coming to an end I feel more secure and have a stronger sense of self both as a person and as a practitioner. I hope to keep developing as I continue on the journey of discovery and development, and into the next stage of my career.

PART 1: RESEARCH

The Experience of Adolescent Self-harm: An Interpretative Phenomenological Analysis

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Abstract

The aim of this study was to investigate how individuals with a history of adolescent self-harm perceive their experience of repetitive self-harm. This study explores the experiences of young people who engaged in repetitive self-harm during adolescence but have subsequently stopped. Due to the lack of qualitative research on this topic and the potential for stigma relating to self-harm, it was considered pertinent to focus on individuals' lived experience. Seven female participants (aged 22 to 30 years old) gave accounts of their experiences via face-to-face semi-structured interviews. The interview transcripts were then analysed using interpretative phenomenological analysis (IPA). Five superordinate themes emerged from the data: 'Isolation', 'Others don't understand', 'Rejection and Acceptance', 'Relationship with the self' and 'Autonomy'. Situated within these themes were subthemes capturing specific different facets of the experience, including certain transformations related to the cessation of their self-harm. The findings revealed that participants began to stop self-harming towards late adolescence when factors in their lives began to shift, particularly in the areas of acceptance and autonomy. The findings shed light on resolution of the behaviour. The findings support existing theoretical models of self-harm and previous research, and are discussed in the context of the developmental stage of adolescence. This study offers concluding thoughts around the implications of the findings in relation to the practice of counselling psychology, specifically when working therapeutically with adolescents who self-harm.

1. Introduction

This chapter presents an overview of the existing literature relevant to this study, specifically self-harm during adolescence. It begins with an introduction to the topic including the various definitions, prevalence rates, and trends of self-harm. It then reviews the theories and research available regarding the functions and psychological conceptualisations of self-harm, and includes a section focusing specifically on adolescence and self-harm. The chapter subsequently explores individual phenomenological accounts of self-harm and research on resolution of the behaviour. Although there is little research available focusing on how individuals experience self-harm and resolution during their adolescent years, the existing studies in this area are reviewed in this chapter. Finally, the rationale behind his study is presented and the research aims are outlined.

1.1 Self-harm

Self-harm has become a public health concern in the UK and much of the western world. This is highlighted by the inclusion of the figures for self-harm hospital admissions as an indicator in the Public Health Outcomes Framework for England (2013-16). Additionally, the Department of Health (2012) refers to self-harm in their guidelines for suicide prevention. Upon its inclusion in the most recent edition of the Diagnostic and Statistical Manual (DSM), Non-Suicidal Self-Injury Disorder was described as a “condition requiring further study” (APA, 2013). One of the reasons for concern is the disorder’s high prevalence in young people and evidence of a significant rise in rates over the past few years (see Morgan et al., 2017). Many authors and researchers highlight that self-harm is important due to its connection with future suicidality (see Andover & Gib, 2010; Cooper et al., 2005). There is evidence that self-harm that begins without expressed suicidal intent may be followed by acts with greater suicidal intent (Wilkinson, Kelvin, Roberts,

Dubicka & Goodyer 2011). Additionally, adolescent self-harm might signal a risk of affective disorder in young adulthood (Fergusson, Horwood, Ridder, & Beautrais, 2005). This study argues that self-harm is also a matter of concern due to its association with depression, as well as the suffering and feelings of isolation experienced by those who engage in the behaviour.

A vast quantity of knowledge surrounding self-harm has been amassed over the last few decades, nevertheless, we lack accurate methods of preventing the behaviour (Nock, 2012) as well as specific, established, and effective interventions, especially for those without a personality disorder diagnosis. There is a lack of published research on the lived experience of individuals who self-harm hence there exists gaps in our insight into why people engage in the behaviour, and the effect and impact it has on their lives.

1.2 Definition of Self-harm

1.2.1 Terminology. Defining ‘self-harm’ is problematic. There exists wide variation within this category of behaviour, including type, frequency (for example, repetitive behaviour versus isolated incidents), and intent (Nock, 2010). There is no universal clinical consensus concerning the terms used to describe the phenomenon. Self-harm, self-injury, self-injurious behaviour, self-mutilation, non-suicidal self-injury (NSSI), deliberate self-harm (DSH), deliberate self-injurious behaviours (D-SIB), self-cutting, and suicidal behaviours are some of the many terms often used interchangeably among researchers and clinicians. This inconsistency in terminology results in ambiguity regarding what construct is actually being investigated and makes it difficult to draw accurate comparisons between studies (Wilkinson, 2011). Self-harm is the term most commonly used in the UK, while self-injury is more common in the US (Newton & Bale, 2011).

As this study is concerned with the experience and voice of its participants, it seems pertinent to consider their views on the matter of terminology. In *Healing the Hurt Within*, Sutton (2005) describes how her participants viewed the term ‘self-harm’ as too broad a description, and ‘self-mutilation’ as inaccurate or even offensive. After listening to participants, the author settles on the term ‘self-injury’, which she describes as a mechanism of coping with intense emotional suffering, acknowledging the absence of the intention to commit suicide (Sutton, 2005).

1.2.2 Intent. In the past, professional manuals and guidelines have not distinguished between self-harm and suicidal acts. The National Institute for Care and Excellence guidelines specifically state that self-harm acts should be considered “irrespective of their motivation” or intent (NICE, 2013). However, direct self-harm and suicidal acts differ in a number of significant ways. First, the methods involved differ; cutting and burning are more common in self-harm, whereas hanging, self-poisoning, or acts involving firearms are more often involved in suicide attempts. Additionally, self-harm is more common than suicidal behaviours and, as might be expected, results in less medically severe damage and fewer fatalities (Muehlenkamp & Gutierrez, 2004; Muehlenkamp, Claes, Havertape, & Plener, 2012; Nock, Borges, Bromet et al., 2008). Most significant is that individuals who self-injure do not intend to end their own life via the act (Klonsky, Victor, & Saffer, 2014). Despite these differences, the two terms were used interchangeably for quite some time, and in some studies there is still no differentiation made. This causes difficulty in drawing conclusions from research, and has slowed advancement of the study of this phenomenon.

In recent years, definitions have been updated. Previously, self-injury was only featured in the DSM under the criteria for Borderline Personality Disorder (BPD). However, the most recent edition, the DSM–5 (APA, 2013), refers to NSSI as an independent condition,

acknowledging its prevalence in populations without a BPD diagnosis. In addition to this change, suicidal behaviour was also allocated a separate disorder category.

1.2.3 Type. Self-harm is a complex phenomenon, and as a result, the specific behaviours considered to constitute self-harm are debated. The most common forms of self-harm reported by adolescents and young adults include cutting, scratching, hitting or banging objects or oneself, biting, skin tearing, and burning oneself (Briere & Gil, 1998; Heath et al., 2008; Klonsky, 2007a, 2007b; Laye-Gindu & Schonert-Reichl, 2005; Whitlock, Eckenrode, & Silverman, 2006). Research has found cutting to be one of the most prevalent methods in community populations (Hawton & Harriss, 2008; Hawton, Harriss, & Rodham, 2010).

Self-poisoning is often included in the category of self-harming behaviours. Although commonalities do exist, there are significant ways in which self-injury and self-poisoning differ (see Chandler, 2014; Claes, Vandereycken, & Vertommen, 2007). Self-poisoning generally involves consuming medication that exceeds the recommended allowance, while self-injury involves inflicting harm on the body leading to immediate and evident damage that can produce lasting scarring. Conversely, damage as a result of self-poisoning may not be apparent and is unlikely to leave any external marks (Chandler, 2012), although it does require hospital treatment more frequently than self-injury (Hawton, Rodham, Evans, & Weatherall, 2002). Self-injury appears to be more prevalent than self-poisoning in adolescents (Hawton et al., 2002).

Additionally, it is sometimes suggested that self-harm may include other less immediate forms of harmful behaviours, e.g., drug misuse, disordered eating, or excessive exercise that can cause indirect or even direct harm to the body (see McAllister, 2003; Hooley & St Germain, 2014a). Eating disorders and drug addiction, however, are classified as separate from NSSI by the DSM-

5, as well as in other professional guidelines, evidencing that they have differing defining features. It would follow, therefore, that the phenomenological features of the disorders might also differ.

There has been some debate around whether certain culturally accepted forms of harming the self, such as piercing, tattoos, and scarification should be included under the definition of self-harm (Favazza, 1996; Rayner and Warner, 2003). However, there appears to be a difference in the features associated with such acts, suggesting distinct types of phenomena. One proposed definition of self-injury is: “The intentional and direct injuring of one’s body tissue without suicidal intent and for purposes not socially sanctioned” (Klonsky, May, & Glenn, 2013, p.231).

Another important feature is the frequency of the behaviour. Self-harm can be a reaction to a one-time crisis or a repetitive behaviour that can become habitual (Favazza, 1996). The majority of adolescents report having engaged in self-injurious behaviour three or more times (Nixon, Cloutier, & Janson, 2008; Nock & Prinstein, 2004), indicating it is frequently a pattern of behaviour. With repetitive self-harm, the individual’s experiences and reasons for self-harming may change or vary over time. Hurting oneself only once is quite different from the behavioural pattern of repeatedly harming oneself over a course of months or years, yet many studies appear to draw conclusions that are based on grouping these categories together.

1.2.4 For the purposes of this study:

- Scarification, piercings, tattoos, and other culturally sanctioned forms of marking the body are not considered to fall under the definition of self-harm;
- Alternative self-destructive behaviours, such as disordered eating or drug use, are also not classified as self-harm. This study focuses on self-harm that causes direct and observable bodily damage;

- Self-harm is considered intentional but without suicidal intent, recognising that suicidal intent and self-injurious behaviour can, and frequently do, co-exist;
- This study aims to investigate the overall phenomenon and experience surrounding the behavioural pattern of repetitive self-harm, not purely the act itself;
- Given that ‘self-harm’ is the most commonly used term in the UK and by participants of this study, it shall be used here. However, this term is intended to refer specifically to NSSI, which the researcher considers a more accurate reflection of the phenomenon under investigation and is defined by Klonsky et al. (2013) as “the intentional and direct injuring of one’s body tissue without suicidal intent and for purposes not socially sanctioned” (Klonsky, May, & Glenn, 2013, p.231). When referencing other studies, the terminology used by the study’s authors is adopted.

1.3 Prevalence

The majority of studies investigating prevalence rates of self-harm have been conducted in the USA. Reported prevalence figures for self-harm in community samples of adolescents in the USA and UK range from approximately 13%-45% (Lloyd-Richardson et al., 2007; Plener et al., 2009; Ross & Heath, 2002; Martin, Swannell, Harrison, Hazel, & Taylor, 2010; Hawton et al., 2002; Swannell, Martin, Page, Hasking, & St. John, 2014), compared to an approximate rate in adults of 4% (Briere & Gil, 1998; Klonsky et al., 2003). The wide variation in rates of self-harm has been predominantly attributed to the fact that the large-scale epidemiologic reviews that provide prevalence estimates for physical and mental disorders have not included measures of self-

harm. Thus, estimates from small, regional studies that differ in their definitions and assessment of self-harm have been relied on instead, resulting in high levels of variation— for example, broader definitions generally lead to higher rates being reported (Nock, 2010).

In an international review of studies reporting prevalence data in adolescent samples, Muehlenkamp and colleagues (2012) found that rates of NSSI in adolescents ranged from 5-37% in community samples, with a mean lifetime prevalence of 18% for NSSI behaviour. They concluded that the different assessment styles used in the different studies accounted in part for the large variability in rates across studies. Assessment measures using single items were associated with significantly lower rates (12.5%) than measures that used multiple item behaviour check lists (23.6%) (Muehlenkamp et al., 2012). The authors also explained how the variation in estimates reported across geographic regions are likely a reflection of cultural differences.

The various ways in which self-harm is assessed means that there is a lack of clarity regarding overall prevalence rates. Ross and Heath (2002) noted that in a community sample of adolescents, lifetime prevalence was significantly lower when participants were interviewed compared to the screening questionnaire. Additionally, it has been observed that the frequency of self-harm required to meet a study's criteria can also impact prevalence figures (i.e., rates increase when only one self-harm incident is required) (Nock, 2010). A large number of studies use a dichotomous variable, i.e., any versus no lifetime incidents, which lacks specificity. Brunner et al. (2014) found that although prevalence of D-SIB was found to be high in adolescents (27.56%), a significant number comprising that figure only engaged in occasional D-SIB during a brief period in their life (19.73%), a much smaller percentage (7.83%), engaged in repetitive self-harm. It is this latter category that has been correlated with greater psychological difficulties (Brunner, Parzer, & Haffner, 2007). Furthermore, studies sometimes do not differentiate between repetitive self-

harm and isolated incidents, or if they do they fail to clarify when making generalizing statements in their conclusions. It has also been suggested that the secretive nature of self-harm makes it difficult to determine accurate incidence rates. Overall, data regarding prevalence rates of self-harm remains inconclusive.

1.3.1 The increase. In 2008, the U.S. Centers for Disease Control and Prevention reported an increasing trend in NSSI over the previous 10-20 years, a finding strengthened by anecdotal evidence from teachers, clinicians, and other health professionals (Nock, 2010). More recently, this same rise has been observed in the UK. From 2005/2006 to 2014/2015, there was a dramatic, 7,000 individual increase of young people presenting to A&E with severe cases relating to self-harm (NHSDigital, 2016). Over the same period, the number of girls treated following cutting themselves rose by 285%, and the number of boys by 186%. Morgan et al. (2017) reported an apparent 68% increase in overall incidence rates of self-harm from 2011-2014, based on all UK clinical records, among adolescent girls aged 13-16.

Lifetime prevalence rates of self-harm are higher in adolescents and young people than in adults, implying rates have increased over time. However, some authors propose that older people are less likely to report self-harm due to memory loss or reporting bias. Although evidence suggests the rate has risen in recent years, it is still unclear how dramatic this increase has actually been. It could be that young people have been more likely to disclose and seek help for self-harming in recent years due to an improvement in the societal narrative around mental health and self-harm.

1.3.2 Gender. There is disparity in the literature regarding gender and self-harm, with several studies finding self-harm more common among females (e.g. Giletta, Scholte, Engels, Ciairano & Prinstein, 2012; Madge et al., 201; Morgan et al., 2017), while others have reported no

gender differences (e.g. Klonsky, 2011; Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007; Jacobsen & Gould, 2007; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). Brunner et al. (2014) conducted a study across European countries, and found that in the majority of countries, females were associated with higher rates of both occasional and repetitive D-SIB. However, no differences were seen in some countries for occasional D-SIB or repetitive D-SIB.

It has been suggested that prevalence rates are influenced by the notion that women are more likely than men to disclose their self-harm and seek help (Nixon et al., 2008). Men, in general, appear to be more reserved in their help seeking behaviour for both general health and mental health issues (Doherty & Kartalova- O’Doherty, 2010; Jeffries & Grogan, 2012; Klineberg, Biddle, Donovan, Gunnell et al., 2011; Mackenzie & Knox, 2007; McCusker & Galupo, 2011). There is research to suggest this can be partly attributed to social gender norms and the concept of masculinity (Nam et al., 2010; Yousaf et al., 2015;) whereby help seeking creates a gender role conflict for men (Pederson & Vogel, 2007). Mackenzie and Knox (2007) concluded that men’s negative attitudes relating to psychological openness might be a contributing factor to their lower rates of mental health service use. The same could be said for men’s disclosure of self-harm.

Overall, there is inconclusive data regarding gender rates, however there does appear to be a gender difference regarding methods of self-harm. Specifically, women are more likely to engage in cutting, whereas men are more likely to hit or burn themselves (Klonsky et al., 2014).

1.4 Onset and Duration

The average age of onset for self-harm is consistently reported as falling between 12 and 16 years of age in studies from the USA (Klonsky, 2011; Nock, 2009b). Onset is distributed evenly during adolescence and early adulthood, with around 25% of individuals reporting self-harm

beginning between the ages of 10-14, 27% between 15-16, and 38.6% between 17-24 (Whitlock et al., 2006). Klonsky's (2011) large-scale study found a mean age of 16.1, with a median age of 14. Interestingly, the median age of the most recent self-injury occurrence was 24.9, suggesting self-harm continues beyond adolescence into early adulthood. However, the nature of self-harm was unknown, i.e., whether this was an isolated incident or repetitive pattern. Fifty per cent of the sample continued self-harming into early adulthood, but the majority (70%) had ceased by age 25. The median age of "offset" was found to be 20 years old.

The duration of repetitive self-harm is under-researched, but where it has been studied it usually varies by population type and age of onset (Heath, Toste, Nedecheva, & Charlebois, 2008). For example, Whitlock and colleagues (2006) found that among university students, individuals who previously engaged in repetitive NSSI but who reported not having self-injured in the past year and had no intention of engaging in self-injury again. Forty per cent reported stopping within one year of commencing, with the majority (78.9%) reporting stopping within one to five years. This suggests, in general, a relatively short duration of self-harming in the university student population. At present, there is a lack of longitudinal data available on prevalence rates of NSSI, and thus the course and trends of the behaviour remain unknown (Nock, 2010).

1.5 Functions and Theoretical Understandings of Self-harm

Adolescents and young people commonly provide a range of reasons for their self-harming behaviour. Some of the most common reasons given are: to relieve emotional pain, to stop negative feelings, to feel something, to punish themselves, and to seek help or support (Brown et al. (2002); Lloyd-Richardson et al., 2007; Nixon et al., 2002; Nock & Prinstein, 2004; Ross & Heath, 2003). The primary motives reported by a sample of English school students were to "get relief from a

terrible state of mind”, “to punish themselves”, and “to show how desperate they were feeling”, i.e., self-harm was a way to express their internal states (Rodham, Hawton, & Evans, 2004). Despite a number of frequently reported motivations in the literature, there are differing occurrence rates of functions reported across different studies using different methodologies.

The different functions of self-harm reported by individuals have given rise to a range of theories and models proposed for understanding the behaviour. The range of definitions for self-harm indicate the various ways it has been conceptualised in the literature. While the purpose of this research is not to evaluate the efficacy of such theories, an overview of their main conjectures and limitations will offer valuable information and context. The most prominent theories are explored in the following section.

1.5.1 Psychodynamic theory. Early etiological theories of self-harm had their basis in psychoanalytic theory, focusing on the premise of drive theory, i.e., sexual drives and aggression turned inward and the conflict between drives towards life and death. Some theorists posit that engaging in self-harm was a way of preventing an individual from total destruction or suicide (Jacobson & Batejan, 2014). Although this is an interesting concept, empirical evidence to support this theory is lacking. More recent psychodynamic models of self-harm have claimed that “self-harm must be understood as having meaning within interpersonal and intrapsychic relationships” (Briggs, Lemma, & Crouch, 2008, p.1). These models view self-harm as a manifestation or expression of an underlying emotional issue, which the individual may be unaware of.

One popular psychoanalytic theory used in the explanation of self-harm is Object Relations theory (Klein, 1957). This theory posits that people who self-harm experience difficulty separating internal representations of themselves from the representations of others, due to their early experiences of a deficient attachment relationship with their primary caregivers, i.e., the internal

boundaries between themselves and their parents became blurred, which then continued into future relationships. Due to this lack of distinction, when they experience negative feelings towards someone with whom they are emotionally close, they also feel negatively towards themselves – in other words, they turn these feelings inwards. As the skin can be seen as a very tangible and basic barrier between the individual and their environment, by directly marking the skin, self-harm allows individuals to establish a very concrete distinction between themselves and others, separating their identity from the other (Suyemoto, 1998).

An attachment system understanding of self-harm is utilized by mentalization-based therapy (MBT) (Bateman & Fonagy, 2010), an increasingly popular therapeutic treatment used with individuals with a diagnosis of BPD, and adolescents. Self-harm is seen as a manifestation of a collapse in mentalizing ability, that is, the ability to make sense of the mental states of the self and others (Bateman & Fonagy, 2013). The emergence of this reflective function is connected to early attachment organisation between caregiver and infant. If the caregiver does not accurately provide representation of the infant's mental state through mirroring, the infant will internalize an "alien self" (Fonagy, György & Jurist, 2004) and lack mentalizing ability. This alien self leads to self-hatred and the desire to attack the self.

The objective of MBT is therefore to restore the client's mentalising ability by bringing attention to their state of mind and any change in their state of mind of mind, from one moment to the next. This approach has rendered promising outcomes for individuals who have BPD, including reducing rates of self-injury (Bateman & Fonagy, 2008; Bateman & Fonagy, 2009).

1.5.2 Psycho-physiological theories.

Some theorists hypothesize that self-harm may serve to regulate mood via biological mechanisms, primarily through triggering the release of endorphins (Nock & Mendes, 2008).

Endorphins are endogenous opioids that are produced in response to tissue damage. In such situations, they act to suppress pain as well as generate euphoric feelings (Hawkes, 1992), thus self-harm may lead to a shift in mood via this function. Evidence for this notion comes from accounts of reduced pain sensitivity during incidences of self-harm and findings of altered endogenous opioids levels in individuals who self-harm (Sher & Stanley, 2009). In addition, it has been posited that the release of endorphins may be related to self-soothing brain functions (Gilbert, 2010), something that individuals who self-harm tend to lack.

However, it is important to note that the majority of research addressing the neurobiological underpinnings of self-harm has been conducted with women who have a diagnosis of BPD. It therefore remains unclear whether the endogenous opioid explanation has any relevance for individuals who self-harm but who do not have BPD. Additionally, more often than not, the studies do not differentiate between suicidal and non-suicidal self-injury therefore making it hard to draw clear conclusions.

Research using animals has suggested a physiological basis to self-harm via various other pathways, namely dopamine and serotonin neurotransmission, and amygdala hyperactivity (e.g., Herpetz, Sass, & Favazza, 1997; Coccaro et al., 1989). For example, some studies indicate that both monkeys and humans who engage in self-injury show decreased levels of serotonin neurotransmission (Simeon et al., 1992; Tiefenbacher, Marinus, Novak, & Meyer, 2003) and that self-harm may modify the dopamine system in a way that leads to the behaviour becoming somewhat addictive (Sivam, 1995). However, these hypotheses have not yet been corroborated.

1.5.3 Affect regulation models. Individuals who self-harm often report acute negative emotions, such as sadness, desperation, and frustration directly before an act of self-harm, stating that the enactment of self-harm leads to a reduction in this negative affect, as well as a sense of

relief or calm (Klonsky & Muehlenkamp, 2007). Research asking participants to describe their feelings immediately following an act of self-injury found that some type of positive change in emotional state was reported by the majority of respondents (Nixon, Cloutier, & Aggarwal, 2002).

A substantial quantity of empirical evidence supports the affect regulation function, in both adults and adolescents (e.g. Arney, Crowther, & Miller, 2011; Klonsky, 2007; Nock & Prinstein, 2004, 2005; Nock, Prinstein, & Sterba, 2009). Most of this research is based on self-report measures with participants giving or selecting reasons for self-harm.

Nock and Prinstein (2004) found that one of the most common reasons for engaging in NSSI in a sample of adolescent inpatients was to reduce negative emotional experience (others included the generation of feelings and social reinforcement). Nock and Prinstein (2005) replicated these results, and posited that self-injury is maintained by automatic negative reinforcement (ANR) (i.e., the temporary relief of negative emotional states by feelings of comfort and/or release of tension), and that this removal of negative experience then reinforces the self-harming.

1.5.3.1 Experiential avoidance model. In a similar vein, the experiential avoidance model of self-injury (Chapman, Gratz & Brown, 2006) describes how harming the self is used as a means of avoiding or escaping from an undesired internal state. This model explains how repetitively using self-harm in this way can produce conditioning of the behaviour. Similarly, Linehan (1993), creator of Dialectical Behaviour Therapy (DBT), a therapeutic treatment for individuals with BPD who self-harm, suggests that self-injury is used to reduce undesirable affect by creating a shift in attention away from painful emotional stimuli. DBT therefore aims to stimulate awareness and acceptance of feelings and experiences whilst also encouraging change in behaviour (Muehlenkamp, 2006).

1.5.3.2 Feeling generation model. In Klonsky's (2011) epidemiologic study, the reason most frequently given by participants for self-injuring was the desire to feel something because they were feeling numb or empty. Correspondingly, Nock and Prinstein (2004) found that 23.5% of participants stated that the reason for self-injury was to "feel relaxed", while 34% reported that they wished to "feel something, even if it was pain". This led to authors describing what they call the feeling generation model and to the conclusion that this form of repetitive self-harm is maintained by automatic positive reinforcement (APR), which they combined with ANR and incorporated into a model of self-injury. However, there exists some evidence that suggests only a small percentage of individuals give this reason for self-injury (e.g. Nixon et al., 2002; Shearer, 1994).

Overall, there appears to be compelling evidence of self-harm commonly being part of some form of emotional regulation strategy. The experiential avoidance and feeling generation models are seemingly consistent with individual accounts of episodes of self-harm and may indeed provide an explanation for continuation of the behaviour. However, these models lack an adequate explanation for the development of self-harming behaviour, particular over other forms of experiential avoidance and feeling generation (e.g., substance use). This failure to account for the onset and cessation of the behaviour is a limitation common to all behavioural and cognitive theories. It has been proposed that Social learning theory (Bandura, 1971) might provide an explanation for the onset of self-harm by suggesting that the behaviour is learnt via exposure from peers or the media (Jarvi, Jackson, Swenson & Crawford, 2013). However, it is difficult to know/prove whether this is in fact the case or not, especially considering some individuals claim that they arrived at the idea of self-harm with no prior exposure (see Adler & Adler, 2011).

1.5.4 Self-punishment hypothesis. The self-punishment theory of self-harm (see Klonsky, 2007b) proposes that self-harm is way of expressing anger against oneself and punishing the self for perceived flaws or transgressions. Self-punishment is frequently reported as a reason for self-injury (Brown, Comtois, & Linehan, 2002; Polk & Liss, 2008; Rodham et al., 2004), with studies finding that over 50% of adolescents who self-injure give reasons related to self-punishment or self-directed anger (Nixon et al., 2002; Laye-Gindhu & Schonert-Reichl, 2005). However, comparatively lower percentages have been found in other studies (see Klonsky 2007b), and the reason for these varying percentage rates across studies is unclear. Klonsky (2006) found that, although affect regulation and self-punishment were both reasons selected by the majority of participants, affect regulation motivations were rated as primary and self-punishment as secondary, which Klonsky (2007b) suggests may account for some of the variance.

Gilbert and colleagues (2010) suggest that self-harm may be an extreme form of self-criticism and a strategy for addressing high levels of shame by punishing the self for apparent flaws or “cutting the bad out” (Harris, 2000 p.1), an expression of self-contempt and inferiority. One hypothesis applying evolutionary psychological theory states that self-criticism could act as a type of submission, used to avoid attack from others perceived as a threat (Gilbert, 2009). Thus, self-punishing self-harm may be a pre-emptive action taken in response to perceived punishment from others, thereby regaining the individual’s sense of control (Chapman et al., 2006). However, empirical evidence to support this theory is lacking.

1.5.5 Social functions. Social and interpersonal motivations of self-harm have been reported by both adults and adolescents in numerous studies (e.g., Hilt, Nock, Lloyd-Richardson & Prinstein, 2008; Nock & Prinstein, 2004/2005). However, it appears evident that they are not the most popular motivation for self-harm, with intrapersonal reasons being significantly more

common (see Nock & Prinstein, 2005; Scoliers et al., 2009; Ramusen, Hawton, Philpott-Morgan, & O'Connor, 2016). Nock and Prinstein (2004) hypothesized a four-function model of NSSI that incorporates interpersonal functions into their automatic reinforcement affect regulation model discussed above. These two interpersonal functions are 'social negative reinforcement (SNR)', that is, trying to prevent or avoid certain social outcomes, and 'social positive reinforcement (SPR)', attempting to receive desired social outcomes, such as attention or care from others. Nock and Prinstein (2005) found that younger and ethnic minority participants were more likely to report SNR and SPR motivations. Adolescents in psychiatric units were more likely to give reasons associated with affect regulation functions.

Nock (2008) alongside Hagen, Watson, & Hammerstein (2008), have speculated further on the interpersonal function of self-injury. They contend that self-injury arises as a way of communicating to and eliciting responses from others when less dramatic attempts at doing so have been unsuccessful. Therefore, they view self-injury as a type of self-help that has been adapted due to experiences, as opposed to the stigmatised 'attention seeking' and 'manipulating' labels that were prominent in earlier social explanations and narratives of self-injury.

1.5.6 Integrated models. More recently, researchers and theorists have begun to incorporate different functional factors into integrated models. As seen above, Nock and Prinstein (2004) began integration with their four-factor model that suggests NSSI has either interpersonal or intrapersonal (affect regulation) functions and is maintained by either positive or negative reinforcement. All four functions were supported by empirical evidence. Following this, one of the first truly integrative models was presented by Nock (2009). This model incorporates a range of both distal and proximate factors, including biological predisposition, environmental vulnerabilities, response to stress, and coping mechanisms (both intrapersonal and interpersonal),

as well as other self-harm vulnerability factors. Thus, providing a much more comprehensive view of self-harm including its range of functions, as well as its development and maintenance.

It is important to point out that research and individual accounts show that the functions of self-harm are not mutually exclusive; participants often list a number of functions for their behaviour and have suggested these can change over time (West, Newton and Barton-Breck, 2013; Moran et al., 2012). Although a general consensus seems to have been established with regards to the central functions and motivations of self-harm, how they are applicable to different individuals, or to the same individual at different times, remains unanswered. It seems likely that phenomenological investigation may afford deeper insight into these questions, thus supporting the development of more dynamic and integrative theoretical models of self-harm, as well as having considerable implications for treatment (Babiker & Arnold, 1997).

1.6 Adolescence

As this thesis focuses specifically on self-harm in adolescents, a definition of adolescence is necessary. This section presents this definition and provides a brief discussion of this particular stage of development and its connection with self-harm. Although developmental psychologists state that it is difficult to identify the exact beginning and end points of adolescence (Coleman, 1995), the general consensus is that adolescence begins after the beginning of puberty. The age limits for adolescence used in studies ranges from 18-25 years. For the purpose of this research adolescence will refer to the ages of 12-18 years, as 18 is the age generally considered by western society to be the end of adolescence. It is the end of primary education and the cut off age for Child and Adolescent Mental Health services in the UK. This however could be considered a curtailed

range, and it is acknowledged that adolescence and the issues associated with it may well continue into later years.

Adolescence is considered a period of transition between childhood and the beginning stages of adulthood (Smith, Cowie, & Blades, 2003). A number of changes take place during this time, including physical, biological and neurobiological changes, as well as psychosocial changes such as gaining independence (practical and emotional) from one's parents, which has been described as a process of separation-individuation (see Blos, 1967). Adolescence is the main life stage for identity development (Erikson, 1968; Hopkins, 2014), when individuals begin to refine independent thought and develop their personal values (Coleman 1995). Coleman (1995) describes it as a period during which the innocence of childhood is lost but the responsibility of adulthood has not yet arrived. This transitional phase can potentially be a very stressful time involving intense conflict (Arnett, 1999). Due to the changes occurring, adolescents may experience an increased awareness of their own identity and image (both physical and social), as well as a preoccupation with how they are perceived by others, potentially leading to experiences of confusion, awkwardness, and distress (Smith et al., 2003). Additionally, conflict may occur if the individuals' newly established values diverge from those of their parents.

Adolescents, when presented with external emotional cues, demonstrate significantly high levels of physiological and neurological sensitivity, predominantly with regards to social rejection and acceptance (Gardner & Steinberg, 2005; Steinberg, 2010). This is due to the neurological development occurring in the adolescent brain. It has also been shown that adolescents are likely to experience emotions, particularly negative emotions, with more intensity than adults or children (Gilbert, 2012).

1.6.1 Adolescence and self-harm. Why does self-harm peak in adolescence? Some authors have suggested that self-harm is a reflection of adolescent turmoil (e.g. Conterio, Lader & Bloom, 1998). This is supported by the fact that it tends to begin during adolescence and, for the majority of individuals, declines at the end of or soon after this developmental stage. However, not all adolescents engage in self-harm, while many adults do, thus the connection is not a simple one. When evaluating the functionality of self-harming, it has been proposed that the behaviour may have an expressive and symbolic value, potentially as a physical representation of negative emotions (Bandalli, 2011). Some authors have suggested it may function as some form of ‘outlet’ for the difficulties of adolescence (Conterio et al., 1998). They suggest it may be an expression of the anxiety and distress that arises when faced with intrinsic developmental conflicts in areas such as physical changes, sexual impulses, autonomy and dependence, social acceptance, and self-image (Breen, Lewis & Sutherland, 2013). Favazza (2009) proposed that self-injury has a transcendental nature, and that by providing authenticity of the self through visible evidence of its existence, self-injury allows the individual to reach, at least temporarily, an integration of body, mind, and spirit. This might be particularly relevant in the period of adolescence when issues of identity, morality, and integration of the self are significant.

Moran and colleagues (2012) suggest that adolescent self-harm might be connected to neurobiological developmental changes that lessen the effectiveness of teenagers’ emotional regulation capacities, something which later resolves with when the prefrontal cortex has fully developed (see Dahl, 2008). Hawton, Saunders, & O’Connor (2012) suggest that over the course of the adolescent years, as the personality develops, individuals become better at coping, and thus less likely to resort to self-harm. The increase in risk-taking during adolescence, which is potentially explained by underlying biological changes or evolutionary adaption, may also play a

role. Interestingly, Patton and colleagues (2007) found that incidence of self-injury was associated with the end or approaching end of puberty, as opposed to age, particularly for girls.

The occurrence of self-harm during adolescence has been independently connected to symptoms of anxiety and depression, antisocial behaviour, engagement in risky sexual activity, excessive alcohol and cannabis use, and smoking (Moran, et al., 2012; Patton et al., 2007). Concern over sexual orientation, bullying, and a history of sexual abuse also appear to have a connection with self-harm.

1.7 Individuals' Experience of Self-harm

Although a solid foundation of literature surrounding non-suicidal self-harm now exists, it derives primarily from a clinical perspective using the medical model of diagnosis-treatment, including risk factors, functions, and treatment efficacy. Research has tended to focus around the act of the 'harm' with relatively few explorative studies into how it affects wider life experiences and their experience over the course of time.

West, Newton and Barton-Breck (2013) explored experiences of "self-hurting" using a methodology resembling thematic analysis. They found that the act of physically harming oneself was only one part of the participants' experience, and that participants discussed the role of their self-harm and their understanding of their self-harm over time. The researchers noticed how the role of self-harm and its function varied at different stages in the individuals' lives. They argued, therefore, that self-harm should not be considered a fixed, static act, but rather as something variable in nature. The small number of studies investigating the individual's experience of self-harm are presented in the following sections.

The relatively small number of qualitative studies that have been published on the experience of people who engage in self-harm, are predominately in relation to the care they receive while in treatment. Most of these studies identify themes of not being understood and feeling stigmatised (e.g. Lindgren, Wilstrand, Gilje & Olofsson, 2004). Stigma was also found to be an issue for those with experiences of self-harm in a non-clinical population (Straiton, Roen, Diesenid, & Hjelmeland, 2013). Straiton et al.'s (2013) study, which used thematic analysis, highlighted the potential shame experienced by such individuals, possibly as a response to this stigma, indicated by the ways in which they seemingly attempted to manage shame, such as minimising their experience or trying to find justifiable reasons to validate the behaviour (e.g. 'I was a teenager', 'I was too drunk'). The study underscored an important issue regarding the impact of the perceptions of society towards self-harming behaviour on the individual who self-harms.

In Brown and Kimball's (2013) study, *A Phenomenology of Self-Harm*, face-to-face interviews were carried out with 11 U.S. participants, which were analysed using a phenomenological methodology. One of the themes that emerged was "self-harm is misunderstood". Other messages conveyed by the participants were "self-harm is not suicide" and "self-harm is an addiction". They also discussed "isolation and difficulty expressing emotions", "difficulty coping", "help that's not helpful", "self-harm as a release", "the need to be punished", "physical pain versus emotional pain", and "self-harm is control". An additional area identified was advice to professionals, highlighting the feeling of being misunderstood and the experience of unhelpful support by professionals. The advice was summarised in three messages: "We're Not Suicidal, Don't Judge Us, and Get Educated" (Brown & Kimball, 2013, p.202).

1.7.1 Individuals' understanding. A number of qualitative studies have explored why individuals self-harm from their viewpoint and understanding of their self-harming behaviour.

Polk and Liss (2009) administered an online survey with descriptive and open-ended questions to 139 female and 16 male participants, ranging between 18-47 years old, with 63% reporting a psychiatric diagnosis. Thematic analysis revealed participants reported they engaged in self-harm “to release emotion, “to feel alive or to decrease dissociation”, “to provide control and self-punishment”, and “to not commit suicide”, i.e., as a mode of survival. These findings align with the theoretical functional theories of self-harm.

Curtis (2016) examined the accounts of 22 young women who had engaged in NSSI as well as suicidal behaviour, in order to explore the meanings of their self-injury. The analysis revealed that their descriptions clearly stated a distinction between NSSI and suicidal behaviour, not just in the behaviours themselves, but also in underlying objectives. It also found that an individual’s movement between the behaviours was cyclical rather than linear, i.e., some people continued to self-harm after a suicide attempt. This contrasts with the literature asserting that self-harm is a continuum culminating in suicide. With regards to the functions served by NSSI, participants named reasons such as: to gain a sense of control and power (this was particularly salient in the context of sexual abuse), to shift the focus from emotional pain to physical pain, to show strength and a sense of defiance, to punish oneself, and to regain control over the body. Some individuals also described it as an attempt to get help. These functions are supported by other studies previously discussed (e.g., Klonsky et al., 2014). Curtis concludes that feeling better was the overall aim of self-injury, and that, in general, it usually accomplished this objective, at least temporarily.

Harris (2000) uncovered that, despite most health care professionals approaching self-harm with an assumed rational logic (e.g., ‘there is no sense in hurting yourself’), to the individual who self-harms the act of hurting oneself possess situated internal logic. This implies that the individual

creates some kind of meaning for their behaviour. Straiton and colleagues (2013) attempted to understand how those who had self-harmed understood their experience using online questionnaires to obtain the perceptions of 122 participants aged between 18-35 in a non-clinical population. Thematic analysis revealed that social circumstances and emotional experiences were more significant than a diagnosis of a psychiatric disorder when participants described what leads to self-harm.

This finding reflects criticism of the introduction of NSSI as a DSM-5 disorder. It has been argued that the diagnosis, while acknowledging that self-harm exists outside of a BPD diagnosis, pathologises a specific response to emotional distress. In response to the proposed inclusion, the British Psychological Society (BPS) expressed concern that individuals may be negatively impacted “by the continued and continuous medicalisation of their natural and normal responses to their experiences, responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses” (BPS, 2011; p. 566). Other societies and individuals have communicated similar perspectives (e.g., Godlee, 2011).

1.7.2 The experience of self-harm in adolescence. Having reviewed the literature, there appears to be limited research on the lived experiences of adolescents, that is, research that communicates their voices rather than studies where participants are given pre-determined options to select from. Additionally, the research that has been carried out is often set within inpatient settings. A curious observation is that there appears to be more studies exploring the experiences of parents of children who self-harm. This may be due to the fact that adults are potentially easier to recruit for ethical and access reasons, however, it may also represent reluctance of researchers to talk with adolescents themselves.

A study investigating how adolescents talk about self-harm observed that most had difficulty forming a coherent narrative or finding words to explain their experiences (Klineberg et al., 2013). Hill and Dallos' (2012) qualitative study on narratives of adolescents concluded that adolescents perceived a profound absence of empathy from others regarding their self-harm, which seemed to inhibit them from creating coherent narratives. Adolescents also found it challenging to discuss the difficulties related to their self-harm, "giving narratives that were poorly integrated with little true resolution" (p.549). The researchers' discussion of their findings suggested implications for identity formation. A thematic analysis of autobiographical online accounts of NSSI concluded that identity processes, which are particularly relevant in adolescence and early adulthood, may contribute to vulnerability to NSSI (Breen, Lewis & Sutherland, 2013). Specifically, they explain that NSSI may provide "a source of self-identification in the service of developing self-identity and that it may provide a basic sense of a coherent self who persists across time" (p.60).

1.8 Resolution of Self-harm

There have been comparatively few studies on the course of repetitive self-harm over time, and resolution of the behaviour. Some evidence suggests a developmental decline in the tendency to self-harm that comes with age (e.g., Zanarini, Frankenburg Hennen, Reich & Silk, 2005). As previously discussed, it is difficult to ascertain established figures for the average age of cessation of self-harm due to the lack of data on this topic. However, by considering that the mean age of onset is early to mid-adolescence and that there is some evidence to suggest the majority of individuals cease self-harming within a year, or five years (Hamza & Willoughby, 2014; Whitlock et. al., 2011), it seems likely that most adolescents who self-harm will cease by the end of

adolescence or during young adulthood. However, it is important to note that there is undoubted variation in what constitutes stopping self-harm. One could assume that stopping the behaviour is a concrete one-time occurrence, when in fact a number of individuals stop engaging in repetitive self-injury but may relapse in times of difficulty or crisis.

Considering the research and anecdotal evidence, it appears that self-harm that begins in adolescence tends to be a behaviour that stops with maturity. This is an interesting characteristic of the phenomenon, and a feature that differentiates it from other clinical behavioural symptoms. Hamza and Willoughby (2014) explored engagement in self-injury over time in a sample of 666 Canadian college students with a mean age of 19.11 years. They found that the majority of those who began self-injuring in their first year of university stopped one year later, and further that those who continued had high psychosocial risk, i.e., risk for problem behaviours, problems with parents, difficulties with peers, internalizing behaviours such as depressive symptoms, emotional reactivity, social anxiety, and suicidal ideation.

Moran and colleagues (2012) explored the natural history of self-harm with a primary focus on the stage of transition from adolescence to young adulthood. Data on self-harm was collected via participant surveys and telephone interviews at seven stages between mid-adolescence and young adulthood (mean age 15.9-29.0 years). Of the participants who self-harmed in adolescence, 9 out of 10 reported no self-harm in young adulthood, although young women were more likely to continue the behaviour. Self-cutting in particular became less common. They concluded that their findings suggest that adolescence is a factor in explaining self-harm and that most adolescent self-harm is spontaneously resolved over time. However, the researchers also emphasised the vulnerability of young people who self-harm and experience mental health difficulties that require further support and intervention. Continuation of self-harm into adulthood was correlated with

repetition of self-harm over a substantial period in adolescence, pointing to the potential addictive nature of the behaviour and suggesting that the role played by self-harm may alter over time. The research involved 1,800 Australian adolescents and young adults in a longitudinal study. However, only 51% (967) of participants completed every stage, potentially resulting in some inaccuracy of the recorded frequencies and correlations.

The conclusion that most self-injuring behaviour in adolescents resolves spontaneously (Moran et al., 2012), as well as evidence that most young people who self-harm do not present for clinical interventions (Hawton et al., 2012) suggests that a number of individuals stop without ‘treatment’. It is unclear how many young people who engage in self-harm receive any kind of therapeutic intervention. In one study, it was found that fewer than half of adolescents who self-harmed were in any kind of psychological therapy and less than half were receiving psychopharmacological treatment (Deliberto & Nock, 2008). Moreover, it was noted that fewer than half of adolescents who had engaged in self-injury within the month before participation were receiving psychological or psychopharmacological support. It should be noted that this study was conducted nine years ago, and therefore figures may have changed, especially with the increase in dialogue around mental health and increase in access to psychological services. Recent anecdotal evidence, however, does suggest that there exists a large number of teenagers not receiving treatment for self-harm, which is reinforced by the tendency for self-harm to be hidden. Furthermore, findings suggest that adolescents who self-harm find it difficult to access help (Evans, Hawton, & Rodham, 2005). Interestingly, in the current study, the majority of participants reported accessing useful psychological help after they had ceased self-harming.

Hamza and Willoughby (2014) also investigated motivation for stopping self-injury, and found that those who reported higher motivation to stop were more likely to stop, suggesting that

individual desire to stop is important for recovery. Similarly, a “desire for wellness” was found to be a salient factor in cessation of self-harm in a sample of university students with a history of the behaviour (Gelinias & Wright, 2013). Deliberto and Nock (2008) found that most of the adolescents they interviewed could give a rationale for wanting to stop their NSSI. Their motivations focused primarily on self-injury being an unfavourable and unhealthy behaviour, with a lesser number identifying that they wished to stop due to the shame that arose from engaging in the behaviour, as well as unwelcome attention from others, the upset caused to family and friends, and to avoid physical scarring.

In addition, participants who stated that they had learned about self-harming through friends described wanting to stop for external social reasons. Correspondingly, those who stated that the initial idea of self-harm arose internally gave internal motivations for wanting to stop. The researchers suggest that further information surrounding how the concept of self-harm is conceived by the individual, as well as what factors are associated with cessation, could help tailor aspects of prevention and treatment interventions towards individual clients. They note that this has already been done for clients who have attempted suicide (e.g., Rudd, Joiner, & Rajab, 2001). The present study posits that learning about individuals’ experiences of repetitive self-harm and the experiences around stopping is an important addition in assisting the tailoring of treatment.

Why does self-harm become less common in later adolescence and early adulthood? It has been suggested that with maturation also comes improved coping abilities and problem-solving skills, and that, as young people become more independent, the impact of family problems declines (Hawton & O’Connor, 2012). Additionally, Hawton and O’Connor (2012) have suggested that due to the contagious effect of self-harm in adolescence via exposure to self-harm from peers (see

Nock, Prinstein, & Sterba, 2009), self-harm may lessen after adolescence as peer relationships have less of an impact.

Anderson and Crowther (2012) conducted research aiming to reveal individual factors or characteristics associated with continuing to engage in NSSI. A large sample of 214 university undergraduates included individuals who had never self-injured as well as those with both current and historic NSSI. They found that the latter two groups reported experiencing significantly more intense emotional responses, greater difficulty identifying their feelings, being less able to regulate their emotions, and greater emotional avoidance than individuals who had never engaged in NSSI. Compared to those still self-harming, individuals who previously self-harmed displayed significantly greater acceptance of their emotions and significantly better ability to control impulses.

1.8.1 Individual perspectives of resolution. Literature surrounding cessation of self-harm has focused predominately on treatment efficacy and outcome measures as opposed to individual experience. Some research into which interventions are perceived as helpful or unhelpful by the individual who self-harms has been conducted. In a review of *Adolescent Non-Suicidal Self-Injury (NSSI) Interventions*, Gonzales and Bergstrom (2013) highlight certain factors identified in various small-scale studies. Factors perceived as helpful were higher education and a relationship with one long-term health care professional. The review found a greater focus on unhelpful factors, such as high expectations in treatment units and too much attention following a self-injurious act, as well as medication that was considered counterproductive by participants in one study. A group of women in a small qualitative study explained that being encouraged to relax when experiencing urges to self-harm actually increased their self-harming behaviour. Communication, distraction, comfort, and hope were themes that emerged when a group of women with BPD were asked to

describe what helped stop engagement in self-harm (Weber, 2002). It should be noted that these studies were conducted within clinical populations, and thus are specific to that context and not to community samples. The studies also referred to stopping individual acts of self-harm, as opposed to exploring stopping repetitive behaviour.

Gelinas and Wright (2013) aimed to explore how individuals cease self-harming. Using an unspecified qualitative analysis, they explored reasons and strategies for, as well as barriers to, stopping self-harming in a sample of university students. Participants reported a variety of reasons for stopping, such as realising that the act did not fulfil the purpose intended, to avoid tissue scarring and negative attention from others, and interpersonal reasons, such as to avoid upsetting family members. These echoes reasons given by adolescents in Deliberto and Nock's (2008) study. Participants also mentioned important factors such as receiving help and support, a desire for wellness, and discovering novel coping techniques. Regarding strategies for achieving cessation, the most common was substitution with positive coping behaviours, such as journaling, poetry, and breathing exercises. In addition, participants reported engaging in alternative negative coping behaviours, such as drug taking and purging; this substitution process was not necessarily conscious at the time. It has been reported that replacement of symptoms is a common phenomenon seen in self-destructive behaviours (Farber, 1997; Sansone & Sansone, 2007). Seeking professional help was also frequently cited as a valuable strategy in stopping self-harm, as was seeking social support, although to a lesser degree. The researchers determined that building social networks, as well as developing the ability to effectively communicate one's feelings and difficulties to others are likely important factors in self-harm cessation and should be considered as part of treatment interventions. Another less frequently reported strategy for stopping was described as rationalization and self-talk. Self-talk and self-worth exercises are

techniques that Shaw (2006) identified as helpful within participant accounts in her qualitative study investigating the cessation of self-injury in a small sample of U.S. college students, whom she interviewed three times. It appears that these strategies, as well as acknowledging one's own worth and the negative outcomes of harming the self, could be valuable in the resolution of self-harm.

Gonzales and Bergstrom's (2012) review of NSSI treatment highlighted that understanding the meaning of NSSI was viewed as an important factor in the healing process. The meanings related to self-cutting were also found to be important contributing factors to cessation in research that analysed the descriptions of 347 adolescents aged 13-18 years (Rissanen, et al., 2013). Personal, as well as interpersonal factors were also salient, whereas aspects relating to care were less significant in this study. Shaw (2006), in contrast, concluded from her research that professional treatment was an important contributor in cessation of self-injury. However, it was the relational and interpersonal features of professional treatment (i.e., empathy, validation, culturally appropriate responses) that participants most commonly described as helpful.

Kool, Meijel and Bosman (2009) investigated how the process of cessation occurs, as well as contributing factors. Their sample included 12 female participants, aged 26-60 years (mean age: 39 years), who no longer engaged in self-harm, and who had all received treatment. Using grounded theory analysis, they identified six stages in the recovery process: connecting and setting limits, increasing self-esteem, increase in self-understanding, increase in autonomy, stopping the physical behavioural pattern of self-harm, and finally, maintenance. The actual cessation of the self-harming behaviour does not take place until the fifth step, signifying that other significant changes must take place before the behaviour itself subsides. Shaw (2006) also observed a difference between the emotional elements and the physical cessation of self-injury. Notably,

Shaw concluded that cessation of self-injurious behaviour does not directly correspond with emotional robustness, and that the individual may still require additional help. Additionally, Shaw posited that an individual's level of motivation to stop self-harming may inform which therapeutic approach is best.

1.8.2 The experiences of individuals who have stopped self-harming. There exists a lack of qualitative research on longer-term perspectives of self-harm, particularly regarding the experience and perspectives of those who no longer physically harm themselves. To the author's knowledge, few studies have examined narratives of individuals who previously engaged in self-harm but have since stopped. Sinclair and Green (2005) interviewed individuals who had not self-harmed for a period of at least two years. When describing their experiences, these individuals pointed to a loss of control over their lives, with regards to either alcohol abuse, depression that was untreated, or, in adolescents, insecurity within their family relationships. Correspondingly, their descriptions indicated that cessation of self-harm was connected to recognition of alcohol's role in maintaining self-harm and thus reducing consumption, gaining independence from a chaotic family, and/or a recognition of self-harm as a symptom of previously undiagnosed mental health issues. Another salient theme was the resolution of identity or adolescence-related stressors. The researchers reasoned that while such situations persisted, self-harming also persisted, but that resolution of these circumstances meant the need to self-harm no longer existed. Although it does shed some light on the cessation of self-harm, there are elements of the study that are not necessarily transferable to the sample under investigation in the present study. Participants were recruited from a representative cohort who had received hospital treatment following an episode of deliberate self-poisoning. In this way, it differs significantly from the present study, which aims

to explore the perspectives of individuals who previously engaged in repetitive self-injury, primarily self-cutting.

A fairly recent study analysed accounts of past self-injury focusing on the self-injured body using Frank's (1995) typology of illness narratives (see Chandler, 2014). Participants "emphasis[ed] lack of regret over their past practice of self-injury, suggesting involvement in the practice had ultimately changed either the individual or a situation for the better" (Chandler, 2014, p.4). This finding was replicated by West et al. (2013), with the majority of participants positively assessing their self-harm, viewing it as a valuable process. However, participants also mentioned ambivalent feelings towards scars, with detailed reports of attempting to hide them, potentially indicating the presence of shame.

Certain themes relating to resolution and change arose, such as transforming the self and re-envisioning scars. Chaos narratives were less common, with narratives taking on a more transformative, positive nature. When describing early experiences of self-harm, however, narratives became more chaotic. It was suggested that how recently a person had self-harmed accounted for some of the difference in narratives, i.e., chaos narratives are more likely if self-injury remains a problem (Chandler, 2014). This difference indicates that individuals make some sense of their behaviour over time, with thoughts and experiences becoming more ordered in their minds. The process of stopping might, in some way, be connected to the process of making sense of the behaviour. Additional research is needed to supplement these findings.

1.9 Perceptions of and Attitudes Towards Self-harm

Young people repeatedly report experiencing stigma in relation to self-harm (Cello & YoungMinds, 2012; Lindgren et al., 2004; Straiton et al., 2013). A number of unsubstantiated

myths concerning self-harm have been maintained, including the notion that people who self-harm are attention seeking and manipulative, that self-harm does not hurt, and that the severity of the injury determines the seriousness of the problem (Fox & Hawton, 2004). The presence of such beliefs will unavoidably influence the perception of, and the response to, individuals who self-harm. Evidence suggests that negative views remain prevalent and are experienced across age ranges. The majority of adolescents in a community population in East London held negative perceptions about self-harm, which was often associated with difficulty comprehending the behaviour (Klineberg, 2011). Interestingly, these attitudes were observed in adolescents both with and without personal experience of self-harm. It has also been reported that self-harm commonly incites feelings of discomfort, confusion, frustration, anger, and even disgust in others (Anderson, Standen, & Noon, 2003; Babiker & Arnold, 1997, Favazza, 1996; Law, Rostill-Brookes, & Goodman, 2009; Shepherd & McAllister, 2003; Walsh & Rosen, 1988). Regardless of intention, it may be difficult for individuals to stop such feelings from influencing their behaviour towards those who self-harm.

Young people have emphasised that others' reactions to their self-harm affects how they understand and make sense of their self-harming behaviour (Adams, Rodham, & Gavin, 2005; Moran et al., 2012; Mental Health Foundation, 2006). Spandler (2001) found that, following experiences of negative responses and attitudes towards their self-harm, there was a trend for young people to self-harm further. The type of help from adults that young people described as being of value was listening, showing respect, taking a non-judgmental stance, and not displaying fear (Spandler, 2001).

Rayner and Warner (2003) explored general population views of self-harm and found that participants distinguished between self-harm and suicide attempts, and that self-harm was

perceived as either a coping strategy or a form of communication. Participants associated self-harm with the experience of negative feelings and described the need for support for individuals who harm themselves. In addition, participants were questioned about possible treatment options, resulting in three major themes: the need for positive regard, acceptance, and long-term support. Despite these views reportedly being held by the general public, there is extensive evidence which illustrates that individuals accessing help for self-harm have been treated in less than supportive ways by those in positions providing care and support (Mental Health Foundation, 2006; Timson, Priest, & Clark-Carter, 2012; Cello & YoungMinds, 2012; Royal College of Psychiatrists, 2014). Patients who self-harm are more likely to be perceived as difficult or demanding by mental health professionals (Huband & Tantum, 2000; Schoppmann, Schrock, Schinepp, & Buscher, 2007).

It has been frequently reported that youth who engage in self-harm are often reluctant to seek out and receive professional help (Evans et al., 2005; Fortune, Sinclair, & Hawton, 2008a; Cello & YoungMinds, 2012). Berger, Hasking and Reupert (2014) advise that this may, in part, be due to the “negative attitudes and inaccurate knowledge of health professionals” (p.201). Such negative attitudes may be somewhat related to the feelings self-harm incites in mental health professionals, such as anger, frustration, and upset. It has been identified as one of the most distressing and upsetting behaviours professionals encounter in their clinical practice (Gamble et al., as cited in Deiter, Nicholls, & Pearlman, 2000). Accounts from studies exploring the experience of young people who have engaged in self-harm and their experiences of other people’s responses and attitudes could help facilitate the understanding of self-harm, and inform how it could be approached and treated.

1.10 Rationale for the Present Study

Despite the considerable increase in research on self-harming behaviours over the last few decades, there is not much published research on the lived experience of people who self-harm. Few studies exist that focus on the meaning of the behaviour from the perspective of the individual, especially studies using methods guided by individual accounts as opposed to clinical hypotheses. There is, in fact, seemingly more literature regarding the experiences and observations of health professionals and other people in response to self-harm. Research conducted often uses quantitative methodology focusing on prevalence, functionality, and associated factors. A more substantial base of research that explores the unique narratives and experiences of those who self-harm is needed to better understand the behaviour. Research that produces personal accounts of self-harm can help to attain a broader understanding of the phenomenon. This will assist health professionals, including counselling psychologists, as well as teachers and the general public in becoming more aware of the complexities of the behaviour and learning how they might be best able to provide support. Additionally, the knowledge acquired might have implications for the direction and design of future services (Lancet, 2010).

Thus, the purpose of this exploratory study is to contribute to the existing literature by using a qualitative phenomenological methodology to explore the experiences of self-harm from the unique perspective of the individual. Assuming a phenomenological stance (Willig, 2008) places value on the individual's subjective experience and meaning-making processes. This respect for the individual experience and personal meaning-making corresponds with counselling psychology values. This study intends to move away from a clinical paradigm and avoid pathologising. It also aims to take into account wider socio-cultural and environmental contexts that might factor into self-harm, as opposed to locating the problem in the individual, which is

frequently seen within the narrative surrounding self-harm (Chandler, 2014), for example, ‘they have difficulty naming emotions’, ‘they struggle to regulate their affect’, ‘they are impulsive’ (e.g. Gratz, 2007).

Although self-harm is increasingly prevalent in individuals with no other diagnosed mental illness (Whitlock & Selekman, 2013; Gollust, Eisenberg, & Gliberstein, 2008), a large majority of research has been conducted within inpatient and outpatient psychiatric settings (Huband & Tantam, 2004). A significant number of such studies explore self-harm in the context of women with BPD. Although this is an important area, the academic literature surrounding this topic has not given equal attention to self-harm in individuals that sit below a clinical threshold. This has begun to change in recent years, with more studies focusing on community populations, often in schools or universities. Despite this, more research is needed. This study is based on the idea that attending to narratives that are not constrained to clinical populations and factors, but rather focused on the broader topic of self-harm, will help contribute to nurturing a more compassionate, non-judgmental approach to care for clients who have self-harmed.

Upon review, it is perceived that within the self-harm literature, ‘harm’ is given more attention than ‘self’, with most research clinically focused on the expression of the ‘injury’ rather than the person performing the act. This leaves large gaps in understanding how the phenomenon more widely affects people’s lives and identities (Adams et al., 2005). Overall, the qualitative research that has been conducted suggests that, for individuals who self-harm, the tangible act of harming is a relatively small part of their experience. Overall, it would seem that feelings related to the experience of self-ham are of most importance to the individual (Rowland, 2014). Findings indicate that individuals wish for other important issues in their lives to be responded to and addressed with as much seriousness as their self-harming (e.g. Sinclair & Green, 2005).

Considering that adolescence is the period when self-harm is most likely to commence, self-harm within this developmental period remains under-researched. Researchers state an urgent need to develop therapeutic interventions for adolescents who self-harm (Ougrin, Tranah, Leigh, Taylor, & Asarnow, 2012). Increasing the understanding of the role of self-harm in the specific context of adolescence will help enlighten professionals and improve the quality of treatment and treatment options. This study aims to achieve this by shedding light on the individual experiences of those who self-harmed in adolescence by looking at the course of the behaviour over time.

Insufficient research has been conducted investigating the course and form of self-harm over time, with the majority of studies focusing on assessing the presence and function at any one time. Therefore, little is known about self-harm over the course of weeks, months, or years (Nock, 2010). Furthermore, little is understood about the resolution of self-harm, specifically that which begins in adolescence; it is recognised that the behaviour tends to stop towards the end of adolescence/beginning of early adulthood, but with regard to the processes that take place, much remains unknown. Research has investigated factors relating to cessation of self-harm, but there has been fewer studies regarding the experiential properties of stopping. The research also lacks longer-term perspectives from those who no longer harm themselves. The lack of such qualitative research, especially from those who have ‘recovered’, is particularly important due to the dearth of effective preventative and treatment interventions; individuals’ retrospective accounts of self-harm experiences might not only be insightful, but also assist in the development and implementation of more effective treatment programmes.

This study, therefore, aims to explore the individual lived experiences of repetitive self-harm in those who began the behaviour during adolescence and have subsequently stopped. The study aims to focus on the phenomenon as a repetitive pattern of behaviour over time and

illuminate the wider experiences of the person who self-harms, as opposed to focusing purely on the act itself. Furthermore, this study investigates the experiences of individuals within the community rather than in clinical settings.

1.11 Research Aims

In conclusion, the aim of this present study is:

- To explore the accounts of individuals who engaged in repetitive self-harm during adolescence (and subsequently stopped);
- To explore their understanding of their experiences of repetitive self-harm that began in adolescence.

1.11.1. Research question. The research question is:

- How do individuals who self-harmed during adolescence (and have since stopped) make sense of their self-harm?

2. Methodology Chapter

This chapter describes the methodological process of the study in detail from initial methodology choice through to the analysis procedure. Firstly, the theoretical foundations of the chosen research method are laid out, as well as the researchers' rationale for this choice. A step-by-step account of the research process is then given, including sample choice, recruitment procedure, data collection, and analysis structure. Ethical considerations are also highlighted. Finally, a section is dedicated to researcher reflexivity, which includes the researcher's thoughts and reflections on personal experiences related to the study and any appropriate reflections regarding the methodological process.

2.1 Research Framework and Rationale

2.1.1 Aims and design. The aim of this study was to investigate how individuals with a history of adolescent self-harm perceive their experience of repetitive self-harm. Data was collected from seven participants using semi-structured interviews and then analysed using interpretative phenomenological analysis (IPA; Smith, Flowers & Larkin, 2009).

2.1.2 Rationale for a qualitative research paradigm. As the literature review has revealed, research regarding adolescent self-harm is dominated by quantitative studies which predominately focus on prevalence, functions and risk factors. More recently an increasing number of qualitative studies have been conducted which look at individual accounts, and this trend is growing. However, there persists vast gaps in knowledge of how self-injury affects people's wider life experiences and identities (Adams, Rodham, & Gavin, 2005), particularly within non-clinical populations. This is what the present study is concerned with. Therefore, a

qualitative methodology has been employed to explore the unique, subjective experiences of individuals who engaged in self-harm during adolescence.

The emphasis in quantitative studies is on *confirmation*, as opposed to qualitative research where the focus is on *discovery* and *exploration* (Ponterotto, 2005). The latter suits the research topic as not much is known about retrospective perspectives of self-injurious behaviour and thus an exploratory stance is taken rather than hypothesis-testing. Smith and Dunworth (2003) explain that the difference between the two avenues of enquiry lies in the fact that quantitative studies can provide a ‘snapshot’ at certain points in time, whereas qualitative studies can offer a portrayal of what is taking place in between those points.

Given the lack of existing knowledge and research within the topic of adolescent self-harm, a qualitative methodology would create the opportunity for generating novel insights into individuals’ experiences. Qualitative enquiry is concerned not with an explanation but with an understanding (McLeod, 2003). It is believed that additional comprehensive exploratory qualitative studies would add depth to our understanding of the topic and that such understanding might “inform treatment and provide a meaningful context for research” (Klonsky, 2007b, p.227). By using a qualitative approach the present study aims to shed light upon the lived experience of individuals with a history of adolescent self-harm, thus adding depth to the existing literature and opening up new avenues for exploration.

2.1.3 Interpretative phenomenological analysis. This study uses the method of interpretative phenomenological analysis (IPA; Smith, Flowers & Larkin, 2009) to explore the subjective experience of participants. IPA is a creative process with a commitment to gaining an understanding of an individual’s perception and how they make sense of their experiences. IPA is

underpinned by certain philosophical and theoretical ideas of knowledge, namely phenomenology, hermeneutics and idiography, which are explained below.

2.1.3.1 Phenomenology. IPA is influenced by the philosophical concept of phenomenology, that is, the study of human experience and “how things are perceived as they appear in consciousness” (Langdrige, 2007, p. 7). Broadly speaking, phenomenology represents consideration of the form in which something appears or manifests, as opposed to seeking to explain the thing through causal relationships, or evolutionary processes (Moustakas, 1994). The founder of the phenomenological concept, Husserl (1975), asserted the acquisition of knowledge by “reference to the things and facts themselves, as these are given in actual experience and intuition” (p.6). He posited that we must step outside of our natural attitudes, that is, our everyday, and become aware of our reflections. By taking a phenomenological attitude we redirect our focus from the ‘real’ object, to the experience of such an object, thus allowing for understanding of subjective experiences in the context that they arise (Smith, Flowers, & Larkin, 2009). Husserl argued that it is only when we “return to the things themselves” that we comprehend “how the world is a lived experience rather than an object to be studied” (Langdrige, 2007, p. 12).

Husserl (1936/1970) described the concept of intentionality relating to the relationship between mental acts and the physical world. This idea states that there is always an intentional object of consciousness. Husserl places emphasis on the experience of things as and how they appear to us as we attend to them in our consciousness (Langdrige, 2007). Therefore, phenomenological psychology, unlike much of traditional psychology, does not concern itself with trying to understand cognition, attempting to comprehend what is going on in someone’s head and identify thinking patterns in the brain (Langdrige, 2007). Rather the psychological undertaking

is centred on what takes place between a person and their inhabited world which includes the intersubjective, i.e., the relationships between people (Langdridge, 2007).

2.1.3.2 Hermeneutics. Husserl's student Heidegger (1927) initiated a movement towards hermeneutics in phenomenological philosophy by accentuating that the process of interpretation is present in all understanding. He disputed the idea that things could be studied solely in their appearing, that is, their essence ascertained in a removed or neutral fashion. Whereas Husserl (1950) considered the "epoché", i.e., 'bracketing off' of one's own preconceptions, in order to see things as they truly are, Heidegger believed this to be too idealistic. He proposed that people cannot be separated from the world they live in, thus it is impossible to separate or put to one side one's means of perceiving and recognising the essence of a phenomenon (Langdridge, 2007).

IPA is a phenomenological approach which accepts that it is not possible to obtain direct access to an individual's lived experience (Willig, 2008). The researcher plays a significant and active role in the analysis of the data, through their individual interpretations. Thus, the analysis produced is regarded as an interpretation of the participant's experience (Willig, 2008). As Heidegger (1927) explains, "whenever something is interpreted as something, the interpretation will be founded essentially upon fore-having, fore-sight, and fore-conception. An interpretation is never a presuppositionless apprehending of something presented to us" (p.191-192). It is in this that IPA grounds itself and thus the process of researcher reflexivity, detailed in a following section, is so crucial. IPA, rather than viewing the researcher's perceptions as bias that must be eliminated, sees it as a resource in interpreting the participants' experiences. However, in order to understand how that resource is used and its effect on the interpreted data, one must know what their own assumptions, preconceptions, and judgements are. This researcher reflexivity is explored later in section 2.7.

Larkin, Watts and Clifton (2006) suggest that the phenomenological aspect of IPA “give[s] voice” to the participants’ experiences, while the interpretative element “make[s] sense” of and puts into context these experiences, through a psychological lens. Therefore, the IPA method must first collect a descriptive account from the individual participant, which aims to get as near to their experience as possible. Next, an interpretive process is undertaken by the researcher, situating this ‘description’ in the wider social, cultural and theoretical context (Smith & Osborn, 2003). Thus, two stages of meaning-making occur, with the analyst attempting to make sense of the participant’s sense making processes. Smith and Osborn (2003) term this a double hermeneutic.

2.1.3.3 Idiographic. IPA is idiographic in that it is concerned with the particular of individual meaning, and does not seek to make claims relating to a group population, or to determine generalised theories of behaviour (Eatough & Smith, 2008). IPA tends to use a relatively small participant sample and encourages close engagement with each participant’s account during analysis, focusing on specific individual meaning.

Although IPA, in such ways, follows an idiographic prescription, Smith et al. (2009) explain that it does have potential to determine generalisations cautiously, by situating them in the particular. They propose ‘theoretical generalisability’ where readers can evaluate a study’s findings in light of their existing experience and professional knowledge. Thus IPA, by focusing on the particular, can elucidate the universal and thus greatly add to our understanding of a phenomenon (Warnock, 1987); the idea being, that to understand people’s experiences in general, we first must discover what individuals experience and then identify common characteristics.

2.1.4 Rationale for IPA. Phenomenology is concerned with the varied and multifarious quality of human experience (Spinelli, 2003). My view that human experience is unique and cannot be put into neat labelled categories fits with this supposition. My interest in how individuals

make sense of their worlds leads me to a phenomenological approach. Willig (2008) distinguishes phenomenological research into two categories: descriptive and interpretative. Descriptive analysis aims to capture the individuals' experience as it is understood by them, thus taking the collected data at "face value" (Willig, 2012). In comparison, interpretative research uses an interpretive lens to identify underlying observations and themes that may not be available to the individual. As I acknowledge that one cannot gain direct access to an individual's experience, it is this deeper level of meaning that recognises the interpretative function of the researcher that I am concerned with.

When deciding upon a research methodology, I was aware of the sensitive nature of the topic. I sought a method which would meet the need for sensitivity. It was important that the participants felt comfortable talking within the research setting and context. The data collection advocated by IPA, typically involving one-to-one interviews, allowed for dedicated engagement with participants. The idiographic nature of IPA meant that a relatively small sample could be used in comparison to other methodology designs. As a result, time could be taken to create an empathic and supportive engagement with the participant, being attentive to each participants' responses and how they might be feeling during the interview.

It was considered that IPA would provide an effective qualitative methodology for investigating this chosen topic, as it met the sensitive needs necessitated by the topic as well as the researcher's desire to explore the lived experience of the individual. In addition, Smith (2004) claims that an IPA methodology is applicable when researching a reasonably under-studied topic, as is the case with individual perspectives of self-harm during adolescence.

2.1.5 IPA over other methods. The importance of the interpretative element of research was never questioned for this study and therefore methodologies such as thematic analysis, which

examine data themes at face value were not considered. Neither was the focus on psychological processes of self-harm, rather than social ones, ever in doubt, and therefore methodologies such as grounded theory, which focuses on producing explanatory theory for social processes (Glaser & Strauss, 1967), were not considered. However, the phrase ‘how do individuals make sense’, in my initial research question, and the concept of sense-making, instigated a number of paths of investigation, including phenomenological (individuals’ sense-making of their lived experience), narrative (the structures and processes of the meaning making), and autobiographical (how they make sense of their self-harm in the context of their life story). Therefore, narrative inquiry was also considered as a method to explore the latter. Narrative psychology is based on the idea that human beings give meaning to their behaviour and experiences and thus in order that we might understand others and ourselves we should investigate the structures of meaning-making that allow us to make sense of our minds and world (Polkinghorne, 1988). How individuals choose to narrate their stories and what tools they employ may say something about the meaning of the experience to the individual. I considered that hearing individuals’ narratives and exploring the tools employed to tell them would be a very interesting exploration, especially considering the stigmatisation of self-harm and the research suggesting individuals who self-harm tend not to disclose it, presumably as it may lead them to feel shame and/or elicit uncomfortable feelings in others (see Introduction). However, the aim of narrative analysis to investigate “the ways in which people construct meaning in their lives” (Willig, 2008, p.133), contrasts with the desire to purely examine such meanings as they appear, and gain insight into the individuals lived experience. IPA focuses more on comprehending, symbolizing and making sense of individuals’ modes of perceiving, their motivations, and actions etcetera, in comparison to stressing “the ways in which language constructs people’s worlds, and the performative aspects of talk” (Eatough & Smith,

2006). Although I was interested in this line of inquiry I realised I was more interested in *what* stories people tell, that is, the content/features of individuals' experiences, rather than *how* individuals tell their story, at least as a starting point.

I considered using critical narrative analysis (CNA), a phenomenological method of narrative analysis described by Langdrige (2007), which places more focus on suspicious hermeneutics of interpretation, as well as using the empathic interpretation present in IPA and other phenomenological methodologies. I considered that this may be a useful methodology due to its foundations in phenomenology, but also as it retains the narrative element which ties in with my interest in making sense of life journeys. However, I considered it was best to have some idea of what individuals were saying first before looking at it through a suspicious lens. Perhaps because, as someone who engaged in self-harm during adolescence, I would be considered as part of the population under investigation, I was biased towards a more empathic exploration. Therefore, IPA, with its focus on empathic interpretation seemed the most appropriate methodology.

2.1.6 Research paradigm. Numerous authors (see Ponterotto, 2005; Willig, 2012) assert that it is essential for researchers to be aware of, and have a firm understanding of, their own epistemological positions, so that they are able to formulate meaningful evaluations. Epistemological reflexivity encourages recognising and clarifying the researcher's primary assumptions about knowledge, which allows the researcher to consider the implications this may have on the research process and findings.

When considering the acquisition of knowledge, an important consideration is the extent to which we believe there is a single reality that can be accessed and known. This ontological stance can be viewed on a spectrum of realist to relativist (Ponterotto, 2005). At one end of the spectrum is the belief in an objective, single reality and that within this reality there exists universal

truths that can be discovered. At the other end is the belief that there is no true reality: 'reality' is subjective and there exists multiple, constructed realities.

For the purpose of this research an extreme realist approach is rejected and with it the positivist paradigm. However, nor it is accepted that reality is wholly constructed through conversations and social interactions. Therefore, an extreme relativist position, based on social constructionism, is rejected. Gadamer (1960) asserts that things come into being only through language, which is a notion I concur with; however, he also accentuates that this does not necessarily mean there is nothing beyond language. I believe experience exists before and without language and thus is not just a socially constructed phenomenon. There is an embodied experience in the individual before it is put into words and thus given further meaning. However, despite this existence, the experience we have access to and can know (i.e., obtainable knowledge) is undoubtedly constructed by the individual through language and discourse, and is affected by the context of the telling.

Considering this, as a phenomenological researcher I do not think it is possible to produce truths, nor do I aim to do so. Truth might only be perceived as something that is created as a way of making sense of the situation in which one finds themselves, therefore "what is true in one situation need not be true in another" (Landridge,2007, p.30). I was aware that the participant's descriptions of their experiences, as well as my analysis of them, would be impacted by the cultural, societal, linguistic and historical context. Thus, gaining direct access to the reality of 'how it was experienced by them' was an arbitrary endeavour.

In this way, this study was carried out with a constructivist-interpretivist paradigm as its primary foundation and anchor, with the assumption that one "cannot partition out an objective reality from the person...who is experiencing and processing and labelling their reality"

(Ponterotto, 2005, p129). Although I knew I could not gain direct access to the reality of how it was experienced by participants, I considered it possible that the interpretative component of IPA would provide insights into their subjective experiences of repetitive self-harm. Thus, I chose to assume a contextualist position within this paradigm, which views knowledge as influenced by the context of the situation, limited and conditional, but which maintains there is such a thing as a phenomenon, which is possible to effectively examine by using different perspectives (Madill, Jordan, & Shirley, 2000). Hence, I also consider that IPA is not the only method to gain insight into this phenomenon, and in the absence of time constraints perhaps I might have taken a pluralistic methodological approach to this research. Within a contextualist framework there exists the aspiration to locate some grounding of the findings (Madill et al., 2000), this is especially apparent given my rejection of a radical relativist-constructionist stance. This was done by adopting a position nearer to that of critical realist which helps “grounds discursive accounts...in social practices whose underlying logic and structure can, in principle, be discovered” (Parker, 1996, p.4).

2.2 Sampling

2.2.1 Sample Size. I aimed to recruit six to eight participants via purposive sampling. There are no formal guidelines on sample size in qualitative research but Smith et al. (2009) recommend six participants for novice IPA researchers. The range of six to eight was decided on due to considerations of what I wanted to achieve from the research and the time constraints. I wanted to attend to as many different subjective perspectives as possible, to provide a sound insight into the phenomenon. However, I also wanted to be able to provide an in-depth analysis of each

of the transcripts and focus on the particular in keeping with the idiographic approach to knowledge.

2.2.2 Recruitment. This study used purposive sampling when recruiting participants. Participants were recruited through recruitment flyers (see Appendix A) posted in universities, and on notice boards in community settings such as charities and coffee shops. Additionally, adverts were posted on the social media sites Facebook and Twitter. I was aware that I might get a high uptake from the student population, however I did not want to recruit solely from university settings, as this would narrow the sample, specifically focusing on students, consequently, not meeting the research aims. Therefore, after I had recruited four who had responded from adverts within universities, I did not recruit any more via this avenue. Recruitment was initially quite slow with not many volunteers coming forward, perhaps due to the sensitive and secretive nature of the topic. Once I had reached seven participants who met the inclusion criteria I stopped recruiting due to time constraints. All of these participants were female.

2.2.3 Inclusion/ Exclusion Criteria. Sample recruitment involved myself as researcher selecting participants based on predetermined inclusion criteria. This was done in order to achieve a homogenous sample, which was deemed suitable as the research question that is being addressed is specific to the characteristics of a particular group of interest. A number of factors were considered when deciding on the inclusion/exclusion criteria, including age, gender and mental health, ensuring I had a sample that corresponded with the research aims. I required a balance between convergence and divergence; a group that were similar to an extent, yet which provided differing views and individual perspectives.

The inclusion criteria stated that participants must have engaged in repetitive self-harm during adolescence (age 12-18) and have since stopped. Self-harm refers to repetitive non-suicidal

self-injury that is “direct and deliberate destruction of body tissue in the absence of any observable intent to die” (Nock, 2010, p.342). Participants were required to be over 18 years of age, firstly due to ethical considerations of interviewing adolescents. Additionally, the research is interested in the phenomena of repetitive self-harm that begins in adolescence and resolves with maturity. The upper age limit of 30 was decided upon to enhance proximity to the experience.

Both genders were included in the criteria, however those who participated were all female. During the recruitment phase no men came forward, however, after I had completed recruitment and interviews, two male respondents did make contact. In total, 14 women responded, thus, including the two male respondents, the ratio of female to male respondents was 7:1¹.

Participants were excluded if they had a diagnosis of a severe and enduring mental disorder. The reason for this exclusion criterion is that this study is concerned with self-harm as a phenomenon and behaviour in itself, not as a behavioural symptom of a severe and enduring mental health disorder. The majority of past research has focused on self-harm in clinical populations, predominantly those with a diagnosis of borderline personality disorder (BPD). However, it is clearly evidenced that repetitive self-harm occurs outside of such a diagnosis and is prevalent in non-clinical populations, particularly adolescents. This research aimed to focus on this population.

In conclusion, participants were selected based on the following criteria:

- They engaged in self-harm during adolescence
- They had stopped² this self-harm

¹ Not all female respondents met criteria or followed through after initial contact.

² ‘Stopped’ relates to stopping of the repetitive pattern of self-harm, as considered by the participant. Interestingly, as will be seen in the analysis, isolated incidents of self-injury were reported after having ‘stopped’.

- They were aged between 18-30 years

This information was collected at pre-interview telephone screenings. Please see Table 1 below for information regarding participants and the nature of their self-harm.

Table 1 Table of Participant Information

Name	Age	Age when began self-harming	Age of cessation	Type of self-harm	Isolated incidents	Isolated urges	Profession
Katia	26	15	16/7*	Cutting	No	Yes	Student - business
Francis	22	13	18	Cutting	Yes	Yes	Student - Social work
Yasmine	24	13	18	Cutting, head banging	No	No	Student - business
Alice	25	14	18	Cutting, burning	Yes	Yes	Student - psychology
Megan	23	12/3*	18	Cutting, scratching	Yes	Yes	Student - mental health
Lily	25	13/4*	18 and 21**	Scratching, cutting	Yes	Yes	Musician
Beth	30	13	17	Cutting	Yes	Yes	Post grad researcher

* / indicates where the participant was unsure of the exact age

** Lily started repetitive self-harming again for a short period when she was 21.

2.3 Data Collection

Seven one-to-one semi-structured interviews were conducted with individuals who engaged in repetitive non-suicidal self-harm during adolescence and have since ceased. Interviews took between 60 and 80 minutes. The interviews were digitally recorded, and then transcribed.

2.3.1 Interview schedule. An Interview Schedule (see Appendix B) detailed certain questions that would be used as a guide to conduct the interview. Care was taken in constructing the questions so that they were neutral and open-ended, to avoid influencing the participant's answers. Questions covered participants' experience of self-harm, the experience of stopping and perspectives on their past experience. "Minimal probes", for example, "how did you feel about that?", as advised by Smith and Osborn, (2003, p. 63), were utilised to gain a rich level of experiential description.

The schedule was used as a guide rather than a rigid prescription. Hence, during the interview I had the flexibility to be led by interviewees' responses. The interviewee had a "strong role" (Smith & Osborn, p.63) in how the interview proceeded, with me constantly monitoring the effect of the interview on the participant. I was aware that new avenues may enlighten the investigation and be incredibly valuable, and therefore I allowed a certain amount of movement away from the schedule. However, Smith and Osborn (2003) warn the interviewer to think about the extent to which moving away is appropriate; I did not diverge further than I considered acceptable. By using active listening and clarification of what I understood as being said I aimed to create an empathic relationship with the participant and also to stay as close to their experience as possible. My skills as a person-centred counsellor helped tremendously in this process. However, as I ultimately chose the questions asked and significantly impacted the interview

process, it should be made explicit that the interpretative feature of IPA was alive in the generating of data in addition to the analysis.

The interview schedule was comprised of only a small number of general questions. This was due to the nature of the research question and the desire to collect a wide range of experiential details. As reviewed in the Introduction chapter, the topic under investigation has not been well-researched, and therefore to choose specific qualities to focus on would not be in line with a phenomenological approach. An exploration of the topic is needed first in order to delve further into certain aspects of the experience. Allowing interviews to contain only a few set questions of a general nature, meant that the interviews would be more directed by the participants as to what was significant about their experience, rather than the researcher dictating this.

Prior to the collection of data, a pilot interview was carried with myself in the position of participant/interviewee and a fellow colleague as interviewer. This process helped to test out and amend the questions, ensuring they generated the required data. It also gave me the opportunity to see what existing themes and responses came up for me when reflecting on the topic (see 'Reflexivity' section for further detail).

2.3.2 Interviews. Prior to commencing the interview, participants were presented with an information sheet outlining the research aims and procedure (see Appendix C) and encouraged to ask any questions they might have. They were then asked to read and sign a consent form, confirming that their participation is voluntary, and outlining that they are free to withdraw at any time (see Appendix D). Via the participant information sheet, as well as verbally, interviewees were advised that if they felt uncomfortable with any of the questions, to let me know, and that they should feel free to abstain from answering questions they did not wish to. Similarly, they were informed that the interview can be stopped at any time should they request. Prior to the

interview commencing, interviewees, were informed that confidentiality would be maintained throughout and that the data gathered will only be for the purpose of this research and will be destroyed once the research is completed.

2.3.3 Interview setting. Interviews were carried out in pre-booked private rooms at City, University of London.

2.3.4 Data storage. Interviews were digitally recorded and transcribed verbatim. All recorded data, including research notes kept, transcripts and digital recordings, were kept anonymous with coding and pseudonyms used throughout. Audio files and digital interview transcripts were password-protected and stored on a personal laptop and an external hard drive. Interview transcripts were also stored in hard copy format in a locked filing cabinet in my home.

2.4 Analytic Procedure

IPA is subjective, and as suggested by its name, should be adequately interpretative. It seeks to go further than a straightforward description of data, to arrive at a meaningful interpretation of what is there. The analysis, and therefore the findings, is a shared product of the participant and the analyst (Smith et al., 2009). The analytic process promotes a ‘reflective engagement’ with the accounts of individuals (Smith et al., 2009). Therefore, the individual accounts are analysed one at a time and cases are integrated only when sufficient engagement with each separate case has taken place (Willig, 2013). In this way IPA has been generally characterised as an iterative and inductive cycle. In order to examine a given part, one observes the whole, and to examine the whole one observes the parts.

In carrying out the analysis of each transcript, I followed four procedural steps outlined by Smith et al (2009). These were: reading and rereading, initial noting, developing emergent themes

and lastly, searching for connections across emergent themes. I began by deeply engaging with the individual's account by listening to the audio recording whilst reading the transcript. I then engaged in thorough repeated reading of the text to create an immersive experience of myself in the data. I sought to hold in mind the participants' voice when reading to ensure that they remained the focus of analysis instead of the text becoming detached from the person. During the initial readings, I made notes on my preliminary observations and ideas.

The next stage entailed making more detailed and comprehensive annotations focusing on the semantic content and language use (see Appendix F for example of transcript). As advised by Smith et al., (2009) I focused on three categories: "descriptive" (content focused), "linguistic" (use of both verbal and nonverbal language) and "conceptual" (underlying meaning) (p.84). During this process, I questioned what a word or phrase meant for the participant as well as what it meant to me.

I then transferred my attention from the original text of the transcript to my exploratory comments. At this point, I had a substantial and detailed set of notes. I used these to begin identifying and developing emergent themes (see Appendix G for example). I found this a difficult process due to my desire to preserve the complexity of the participants' experience, whilst also reducing it into overarching themes. The themes were generally expressed as a word or a phrase that I, as researcher, chose to resonate the experiences of the participants. Sometimes a word from the participant's account was used.

The next stage involved looking for themes connected by apparent links and similarities and grouping them together into clusters. Smith and colleagues (2009) advise, in choosing these clusters, the researcher should identify what they perceive to be the most important and interesting features of the transcript. Smith and colleagues (2009) advocate using spatial imagery to help

discover connections. Therefore, I wrote out the themes in large text, placed them on the floor and viewed from above (see Appendix H). Following identification of certain clusters, I gave them provisional labels. During the clustering process, I repeatedly revisited the transcript and checked the theme labels against the text, thus, sticking to the iterative nature endorsed by IPA. Once satisfied with the clusters and their labels, I drew up a table that presented the superordinate cluster themes and within them their corresponding subordinate themes.

Having completed the stages above for one transcript, I applied the same steps to the rest. I expected that the analysis of the first transcription would undoubtedly influence how I interpreted and analysed the subsequent transcript, and so forth (Smith, et al., 2009). I was concerned this may inhibit the surfacing of novel themes. In an attempt to minimize this effect, I therefore made an effort to explore each account as its own entity, “bracketing off” as much as possible of what I had already perceived.

Following the analysis of all transcripts I searched for arrangements of themes across cases. The superordinate clusters from all transcripts were studied and categorised into further clusters of cross-case level superordinate themes, the intended result being that such themes encapsulate the experiences of the group of participants as a whole. To do this reconfiguration, merging and relabelling of some the themes was necessary (Smith, et al., 2009). Themes that did not correspond and reflect shared experiences were abandoned. The inclusion of themes was dictated by the richness of the text from which the themes materialized, whether the themes elucidated additional characteristics of the transcript and if they were considered important to the research question.

The final process involved selecting quotes to generate and evidence a final table of themes. I had already highlighted some significant quotes on the initial transcripts, but I went through all

transcripts again, one-by-one, recording all relevant quotes in a word document for each theme, including the participant initial plus page and line number.

I finished analysis with five superordinate themes, each comprising two to three subordinate themes. These themes represent the way in which I made sense of and organised the participants' accounts as a whole. The themes were named using a mixture of my interpretations as well as phrases used by participants which represented certain collective experiences. The titles of emergent themes were retained for some of the final order themes. The superordinate themes symbolize broader areas of experience that were uncovered, in a variety of forms, in all of the participants' narratives. The subordinate themes characterize important and specific features within the overall experience represented by the superordinate theme. Subordinate themes were organised according to similarities as well as divergences between accounts.

2.5 Quality and Validity

Smith and colleagues (2009) believe that researchers should seriously consider the validity and quality of an IPA study. When assessing the validity of this research, the pluralistic criteria outlined by Yardley (2000) was consulted. Yardley stresses that validity standards should be seen as focusing on quality issues as opposed to dictating a rigid checklist that limits the researcher's autonomy and flexibility. Yardley's main principles fall under four categories, "sensitivity to context", "commitment and rigour", "transparency and coherence" and "impact and importance" (p. 219). Below I shall outline how I attempted to address each of these standards.

2.5.1 Sensitivity to context. The social context of the relationship between interviewer and interviewee was considered. Interviews are not merely an account of internal processes and experiences but also an act of communication, desired to be of particular significance for, and have

specific effects on, the other (Leudar & Antaki, 1996). The communication, what is said, is therefore affected by the other, and the social context. Consequently, when interpreting the meaning and function of what is said, sensitivity to the linguistic context is crucial. Therefore, it was important to consider the general and specific impact of the researcher's characteristics (gender, status as health professional and/or fellow sufferer) and how this might affect what the participant portrayed. This is addressed in more detail in the reflexivity section.

2.5.2 Commitment and rigour. I endeavoured to be committed and rigorous throughout the research process. I did this by selecting a suitable sample, and completing in-depth interviews and extensive and careful analysis. I sustained prolonged engagement with the topic, especially during the middle stages of analysis, and immersed myself in the data, thus, producing a rich and thick description, which Morrow (2005) suggests the rigour of the study should be judged upon. It is accepted that my status as a novice IPA researcher may have impacted the rigour of the study. However, attempts were made to overcome this by making best use of supervision and accessible training. Rigour may also have been affected by pragmatic limitations encountered such as time constraints, and access to sample.

2.5.3 Transparency and coherence. Informed by Madhill et al. (2000), I attempted to give coherence to the study by ensuring consistency in the case it makes and whether this is, in fact, demonstrative of the data collected. For example, during analysis I made a concentrated effort to keep interpretations justified in the data. To maintain transparency, I kept a paper trail during the different stages of analysis, which I aimed to make as easy to follow as possible. The analysis is presented in clear tables with theme headings and subheadings to ensure clarity for the reader. Extracts from the transcripts have been explicitly stated to allow readers to assess for themselves how well the data corresponds to the interpretation made (Yardley, 2008).

An imperative part of determining the integrity of the study's findings is the acknowledgment that the researcher co-constructs meaning with the participant and ultimately shapes the data produced. This was addressed by engaging in personal reflexivity to make clear, as far as possible, the researcher's position, assumptions and interests around the topic of adolescent self-harm. See section 2.7 'Reflexivity' for an account of this. Every effort was made to guarantee that observations which diverged from the researcher's opinions and ideas about the topic were not overlooked but proactively embraced, explored and justified

2.5.4 Impact and importance. Yardley (2000) claims that validity of research is not only measured by how well it is executed, but also in its capacity to tell the reader something of interest or importance or of use. In fact, Yardley suggests this defines its real validity. I aspired to do this and continually reflected on and evaluated whether I was, and how best I could achieve this.

Validity checks via inter-rater reliability, triangulation or obtaining participant feedback were considered when assessing the validity of the study. IPA is concerned with subjective experience as opposed to objective reality and, as Smith and Osborn (1998) point out, confirming validity in IPA is not concerned with determining a "singular true account", but is done to substantiate the credibility of the concluding interpretation (p.69). Smith and Osborn (1998) suggest it is therefore misplaced to use inter-rater reliability when validating the finding of themes within the IPA method. Therefore, I did not obtain participant feedback or carry out any triangulation. However, as I was a novice to IPA, I discussed themes and how they related to the transcripts with my supervisor, to assist in the appropriate representation of the participants accounts.

This study is being conducted from a contextualist epistemology, therefore it is important to note that triangulation would not produce a more objective or convergent picture, only one with

added layers that could be seen as fuller or more complete (Fielding & Fielding, 1986). It could be argued that certain interpretations may have more relevance to the research question or have more conviction (Madhill et al. 2000). Thus, to evaluate validity, different interpretative accounts could be weighed against one another, and involve consultation with the participant. However, this study was not seeking knowledge through consensus; I did not see certain interpretations to have a hierarchy over others in the case of this study and did not want to lose the opportunity of the contextualist approach in its obtaining of truly novel and diverse perspectives which can often be discounted when consensus and conventional understandings are prized (Tinsley, 2005).

2.6 Ethical Considerations

Due to the sensitive nature of the data being gathered, ethics required particular consideration. In approaching this issue, the Health Care Professionals Council (HCPC, 2015) and British Psychological Society (BPS; 2015) Codes of Ethics and Conduct were followed closely, specifically with regards to informed consent, confidentiality, debriefing and protection of the participants. Approval from City's departmental Ethics Committee was obtained before the study commenced.

Prior to commencing, participants were given a general overview of the aims of the research and informed about what participation required, including interview length. Before embarking on the interview process, it was pertinent to clarify that this was a research interview and not a therapeutic meeting. This was monitored throughout the interviews in order to prevent a shift in how researcher and participant were relating to each other, as this may have affected the essence of the inter-subjective experience (Brinkmann & Kvale, 2008). This was something I initially found difficult, stepping out of my role as a counselling psychologist and into the role of

researcher, but awareness of this during the interviews and subsequent practice improved my ability.

The potential impact of participation in the study on the participant's psychological wellbeing, particularly the interview, needed consideration. Although participants were from a non-clinical population and had ceased self-injurious behaviour, they remained essentially vulnerable individuals. The potential effects of a personal in-depth interview on self-harm had to be taken into account, and every attempt was made to ensure the participants had access to appropriate support if needed (detailed below).

2.6.1 Participant wellbeing. Prior to conducting the interviews, I was aware that there was a possibility that participation in the interviews may elicit a strong emotional reaction and/ or psychological distress in the interviewee, and that by having the conversation about past experiences there is a risk that, for some participants, this may trigger impulses or urges for self-harming behaviour or other adverse coping strategies. In order to manage this risk, I used my skills as a trainee counselling psychologist to ensure that the participant was contained before they left the interview. I did this by observing their nonverbal behavioural and overall demeanour throughout the interview and upon completion, to perceive whether there are any signs of emotional distress. On finishing the interview, I asked the participant directly how they found the interview, eliciting any emotional responses to discussing sensitive material. I made sure that when the participant left the interview they were aware of how to seek further support. Each participant was provided with a resource list of contact details of support services and psychological resources (see Appendix E).

2.6.2 Researcher wellbeing. It was acknowledged that researcher wellbeing was important given the range of emotions potentially elicited from listening to interviewees and

engaging with transcripts. This was even more pronounced given the personal relationship present between researcher and topic. Self-care is important throughout the research process (McGourty et al., 2010). Therefore, I made sure I prioritised and took time to look after myself. I utilised personal therapy and the strong relationships with my peers to explore and manage any feelings that arose as a result of engaging with the topic of self-harm, on top of the demands of the thesis process. I also found the relationship with my research supervisor helpful in addressing such issues, together with writing a reflexive diary.

2.7 Reflexivity

It is necessary to keep one's gazes fixed on the things... that originate in the interpreter himself. A person who is trying to understand a text is always projecting.... Working out this fore-projection which is constantly revised in terms of what emerges as he penetrates into the meaning, is understanding what is there. (Gadamer, 1990/1960, p. 267)

I was conscious of the fact that as the researcher my past experiences, interests and pre-existing assumptions will unquestionably influence the understanding and interpretation of participants' accounts, and therefore the findings of the research. Other factors such as the researcher's gender, age, and sociocultural background also inevitably have an effect. A crucial component of qualitative research therefore is researcher reflexivity. Finlay (1998) contends that the problem of subjectivity present in qualitative research can be converted into an "opportunity" (p.453), by adopting a reflexive attitude. Insights obtained from IPA analysis are acquired via interpretation. To better comprehend participants' psychological inner world, the researcher must therefore become aware of and acknowledge their own attitudes and preconceptions (Willig, 2013).

Throughout the entire progression of the research, I therefore sought to consider, question and evaluate any effect I was having on the research strategy and design, the topic choice, data collection and analysis. To help me do this I put a number of measures in place. Throughout the research process I kept a research journal where I noted down my reflections and experiences. This helped me to keep separate what was my own material and what was being contributed by the participants. Smith and colleagues (2009) point out that an awareness of certain assumptions may not arise until partway through the research process, perhaps during the interview or during analysis. Therefore, it was imperative I continued the reflexive process, including the diary, throughout all stages of research. Reflexivity also meant being continually aware of my identity as a white, middle class, British female in my late 20s.

When considering personal reflexivity, I consulted Finlay (1998) who identifies four subjective features: the researcher's expectations, assumptions, unconscious processes and behavioural/emotional responses. I explore some of these below. My interest in this area stems from personal experience, having engaged in self-harm briefly during my adolescent years. Therefore, I am comparable to the sample being used in this research. This is important for me to be aware of due to how this affects my interpretation of the participant's data and the potential for influencing the findings. I was aware of the potential for projecting my experiences and meaning-making onto the participants, potentially causing me to be closed off to other and novel ideas and perceptions. Such perceptions and close relationship with the phenomena under investigation possibly impacted on which information I pursued in the interviews and the interpretations I generated during analysis (Finlay, 2002). I endeavoured to recognise when interpretations were being influenced by my personal experience and assumptions. This was not to achieve 'bracketing off' but to be explicit about how the research findings might have come about. I found it especially

difficult during analysis when an aspect of a participants' account diverged from personal experiences that I felt strongly about; there was a temptation to disregard it within the analysis, labelling it as unimportant. However, I used my reflective capacity to become aware of this and to override my initial instincts. I also often found it interesting when accounts differed or varied from what I might have expected and relished the finding of experiential features that were new to me.

Having experienced self-harm during adolescence and subsequently stopped stimulated my interest in the fact that the behavioural phenomena is something that often stops with maturity. The stark difference in my response to harming oneself then and now also sparked my curiosity. My interest in the topic was further inspired by the stigma and certain discourse around self-harm in wider society, but specifically, mental health professionals. I experienced this stigma as a patient and working as a trainee counselling psychologist, I have witnessed certain discourses in services I have worked in. Of course, I observe such narratives in a different light now and see less judgemental stigma and more misunderstanding and misguided attempts to make sense of the behaviour. I can also empathise with the struggle of responding to people who self-harm. Therefore, some motivation to research the topic originated from a sense of injustice in how self-harm was being perceived and stigmatised, and my own predicaments and implications of working within a setting based on medicalised models. The research stemmed from a desire for the voices of individuals who have self-harmed to be heard.

Before commencing the method, I wrote down some of my expectations of themes. I was aware of the feelings of shame involved in self-harm, both past and present, especially given the stigma and feelings and judgements it elicits in others. I was also aware of my own conflictual experience between shame and an attachment to the experience, particularly the profound

experiential feelings underlying the behaviour, as well as a lack of regret. I had a vague preconception around the role of acceptance of the self and self-harming behaviour. Additionally, I was interested in the sense of overcoming and personal development.

Despite these expectations of findings and assumptions, I believe I was acutely aware that there was the potential, almost inevitability, for many varied and different experiences. I knew this partly from my contact with clients who have self-injured, but also my belief in subjective experience. As it is not a topic openly spoken about, I had not heard many others' in-depth experiences of adolescent self-harm. Thus, before embarking I considered whether this research was also meeting a personal desire. Thus, I had to consider the consequences of the effect it might have on me, the researcher, as a person, and that I may go through change in the process.

IPA acknowledges that the researcher's preconceptions can enrich as well as impede phenomenological interpretation. I recognise that my preconceived beliefs and assumptions have influenced both the interview schedule and the interview and that this may have inspired participants to share certain experiences and not others, subsequently impacting on the themes that were accessible. For example, my pre-considered thoughts and ideas around the relationship between adolescent self-harm and shame processes may have resulted in an overstated focus on that particular element of experience. Conversely, a personal understanding of adolescent self-harm could have enhanced my understanding and empathy towards participants, consequently cultivating the research relationship which might have allowed participants to more freely express themselves.

I deliberated whether to inform participants of my past self-harm before commencing the interview, but decided against it. This decision was based on a couple of reasons, firstly to keep myself separate so as not to detract from the participants and their experience. Secondly, to avoid

participants not explaining as fully as they perhaps would have, their experiences, due to the belief that I would know or understand, or even perhaps to protect me. In the context of this study, interview participants' saw me as a health professional as well as a researcher; I believe this aspect of the context will have affected what they chose to say during the interviews. It is impossible to say exactly how this affected what they spoke of during the interview but it could mean they were able to be more open, in feeling more contained and safe with a professional 'therapist'. However, it also could mean that they were trying to present a picture to counteract judgements they believe health professionals might have, although I didn't get a sense of that with any of the participants. I was struck by how a number of times participants when explaining an aspect of their experience of self-harm would say something along the lines of, "well you would know about this better than me", as if as a mental health professional, I had all the answers.

However, despite attention to context, IPA hypothesizes there is a constant significance and level of stability between different accounts from an individual. They may, consciously or subconsciously, try to accomplish numerous things with their language, such as convincing, rationalizing or avoiding humiliation, "but there is almost always more at stake, which transcends the specific local interaction" (Eatough & Smith, 2006, p.121).

3. Analysis Chapter

3.1 Chapter Summary

This chapter focuses on the phenomenological accounts of the participants and how they have been interpreted by the researcher. Each account was an individual narrative, unique to that individual. Throughout the analytic process, however, what became evident was that, whilst no one narrative was the same, there were indeed a number of shared experiential themes across cases. The in-depth IPA analysis of the interview transcripts produced an assortment of shared rich and meaningful themes. These were arranged into five superordinate themes and 11 corresponding subthemes (see Table 2 below) using the IPA method of identifying themes within each transcript first and then searching and identifying shared themes across cases (see Analysis section in previous chapter). The superordinate themes are intended to portray a specific aspect of the participants' experience. Within each superordinate theme, the subthemes aim to highlight further particular aspects of experience thus facilitating the portrayal of the overall experience. From a phenomenological perspective, participants' experience, by its very nature, is inseparable, and thus this division into subthemes is not tangible. What it does reveal is the researcher's process of interpretation and making sense of participants' experiences. When choosing themes, the study's research questions were kept closely in mind to ensure that they corresponded directly. Due to the quantity of data produced, not all aspects of the participants' narratives can be represented. Themes were chosen according to what was deemed most salient from the researcher's perspective. That included whether they were related to the research topic, prevalent across cases and would provide findings of interest and use.

During this chapter, each theme will be presented in detail. Firstly, by introducing the overall superordinate theme, then by presenting the subthemes lying within. Direct quotes from

the participants will be included to clearly illustrate the essence of themes and to keep alive the participants' voices, thus remaining in line with a phenomenological stance. This practice situates the analysis firmly within the data and allows for transparency (Smith et al., 2009). Commentary between participant quotes reveals the researcher's analytic interpretation of the data. The intention is to present the research findings to the reader in an engaging, immersive and informative manner.

The majority of participants' biographical and demographic details are not included in order to maintain participant confidentiality. Pseudonyms are used throughout. However, certain details relating to the participants' lives are included where necessary to provide clarity or to promote understanding of the interpretation. These details are limited and do not include any information that may compromise participants' anonymity. Participant initial, page and line number are included for each quote (e.g. Y:9.11), in order to locate the quote within the transcript, promoting transparency. The text of the transcript quotes has not been edited so as to portray the participants' original expressive language. Grammatical errors, hesitations, pauses, silences and repetitions are all written as they appear in the transcripts, ensuring the quotes resonate closely with the participants' accounts. Sometimes words are included or omitted to add clarity, in such cases changes are included in brackets.

During the analytic process, effort was made to remain close to the participants' experiences, and the transcript texts. Nevertheless, it must be reiterated that the analytic findings are a co-construction of meaning created through the data from participants and the researcher. The themes generated, and extracts used, are a product specific to this researcher. This chapter puts forwards the analysis findings in their purest form, without reference to theoretical

conceptualisations and existing literature. Discussion of the findings with regard to the relevant literature and psychological theory is addressed in the following chapter.

3.2 Overview of the Findings

The superordinate themes that emerged from the data were: ‘Isolation’, ‘Others don’t understand’, ‘Rejection and Acceptance’, ‘Relationship with the self’ and ‘Autonomy’. The table below presents these five superordinate themes and their relating subthemes, which will be explored in detail below.

Table 2 Table of Superordinate and Subthemes

Superordinate Themes	Isolation	Others don’t understand	Rejection and acceptance	Relationship with the self	Autonomy
Subthemes	The hidden self	Negative judgement of others	Rejection	Self-hatred	Lack of autonomy
	Self-harm as personal	Unhelpful response from others	Finding acceptance	Towards self-compassion	Gaining independence
	Relationship to help				

3.3 Superordinate Theme: Isolation

This theme captures participants’ experiences of feeling alone, isolated, hidden and secret.

3.3.1 Subtheme: The hidden self

“part of yourself you have to hide”

This theme encapsulates the participants' accounts of experiencing a profound sense of secrecy, and hidden identity, with regards not only to their self-harm behaviour but also to their inner selves. Although each account is unique, this theme of isolation from others is woven through all participants' accounts.

Francis speaks of feeling alone, even though in the concrete sense she acknowledges she was not. She felt alone because she felt unable to talk to others about her inner experiences. She did not know of anyone who had experienced what she was going through.

"I suppose at that point I felt very alone and I wasn't. But it felt like it was something I couldn't speak about. It was about hiding them [the marks/scars]. Because I was embarrassed...If you're not talking about it- if you don't know anyone who's gone through it or is going through it...I mean you kind of learn by yourself." (F:7.29)

She speaks of the awareness of the marks on her arms and the awareness of not being able to show all of her body, which seems to symbolize not being able to show all of her 'self'.

"I mean just making sure you know your wrists aren't showing because you have cuts, so there's a part of yourself you have to hide. I'd be at school having an okay time with friends and then you're like don't put up your sleeves...they have to stay down." (F.10.27)

Her account contains a sense of inhibition, of keeping 'a part of' herself back. There seemed a necessity to this concealment displayed in the words that she chose to use (e.g. "have to"). Sometimes, when she felt okay, she would experience an internal reminder that she had

something to hide, that part of her must be kept hidden. Francis explanation of the marks on her arms portrays the experience of an embodied sense of secrecy.

Lily also describes ways in which she would be vigilant and “*careful at hiding*” her self-harming behaviour, like how she “*used to wear, like, long sleeves*”. She explains how she did not talk about her self-harm.

“I didn’t talk to anyone at the time, I think we knew one another was doing it, but yeah we didn’t... we didn’t speak to each other.” (L:30.4)

Her words highlight the sense of privacy to each individual’s experience and self-harm (see theme: Self-harm as personal). She also speaks of hiding her inner experiences and feelings along with the physical scars.

“I was being a bit of a fraud because I had to, um, pretend everything was okay and it not feeling okay. I felt quite alone.” (L:15.18)

These words portray the experience of having two selves which contrasted with each other: an outward facing self that was shown to the world and an inward facing self that was kept hidden. Lily did not feel she could show how she truly felt to the outside world thus creating an inner isolated self, and a sense of fraudulence when with others.

Lily describes how self-harm was not something that was spoken about in general and at school. She communicates how this lack of discussion generated a sense of secrecy and shame

around self-harm. Even though people were aware of it, it was not spoken of, thus generating the idea that it is something bad or shameful.

“It wasn’t talked about... we didn’t have sessions where it was talked about as a group. I think like people individually had attention. But actually, I think it would have been better if it was an open conversation because in a way that kind of breeds secrecy” (L:40.8)

Lily also mentions how in the present day she does not discuss her past self-harm. It is a part of her that remains secret. Although she seems unsure as to why this is, there are indicators throughout her narrative that suggest an element of shame.

“I don’t speak to anyone about my self-harm. Maybe because I’m a bit- um- embarrassed, maybe because it hasn’t felt relevant...?” (L:30.22)

Yasmine’s narrative is dotted with references to feeling incredibly lonely and isolated. Having relocated homes in adolescence, she describes how she felt isolated from other people due to being new and different. She too, speaks of how her inner experiences were disguised and evokes an image of ‘two selves’.

“I was extremely lonely. No one knew. I could hide it pretty well. Because I can be this funny, jokey, loud person- so they can’t see.... Everything was hidden from my parents” (Y:35.11)

This ‘hiding’ indicates the active role she played in her own loneliness, being good at concealing her experiences. Like Lily, Yasmine describes a part of herself that is still kept hidden from others. This is the part of herself that is connected to her history of self-harm and what that symbolizes about her.

“None of them know about it... because I feel like they actually will judge you. I’m not ashamed of what I did but I don’t want like a label.” (Y:27.22)

Her use of the word “*label*” suggests she fears negative associations and judgments from others. She states that she is “*not ashamed*” but her account reveals an undercurrent of shame. This ambiguity of feeling shame but also not being ashamed was observed in the majority of participants’ accounts.

Yasmine describes how she keeps inner parts of her experiences and character hidden, for example her anger, due to fear of being judged and abandoned.

“I can’t express myself well because I am scared of people leaving me. I can’t tell people I’m angry at them” (Y:32.7)

Alice states that she “*spent a lot of time on [her] own*” and that she was “*quite isolated and lonely*”. Alice’s account indicates that there were things which she was prohibited from talking about, and that certain aspects of her inner feelings and world were repressed. Her repetition of variations of “*can’t tell*” in the extract below highlights this:

“Um like separation/divorce wasn’t massively talked about so I was encouraged to keep it, you know, down low – not really tell anyone about it. So I couldn’t talk to anyone about it. And I was like you can’t tell anyone because you know at that time it’s- it’s shameful you know...the kind of stigma of being in a broken family.” (A:2.38)

Due to stigma and the instruction to keep it quiet, she experienced shame about being from a “*broken family*”. She learnt from others that there were parts of who she is that should be concealed from others.

“I had so many feelings I didn’t know what to do with them and I wasn’t allowed to as such because obviously you can’t talk to anyone about this.”

Alice's use of the word "*obviously*" implies that she felt as if she had no choice but to keep things to herself.

“And you’re made to hide, like you- you hide you’re your injuries and stuff. With long sleeves and whatever. So then you have to, you’re sort of, guilty a lot of the time because you know you are hiding something. So you’re kind of wandering around with this, um, constant feeling of just guilt on your shoulders.” (A:8.20)

Her choice of words in these extracts, “*not allowed*”, “*made to*”, “*have to*”, give the impression that others have the power. She had a somewhat passive role. Additionally, she speaks of how this secrecy creates a feeling of guilt within oneself. Perhaps she refers more to shame rather than guilt; an embodied feeling of shame, “*guilt on your shoulders*”.

Yasmine, too, expresses that she was “*not allowed to talk about [her] father*” due to her parents’ divorce, indicating her repressed voice and an environment conducive to shame.

In her account, Megan explains how she began menstruation relatively early, age 9/10, and did not tell her mother for a year, thus contributing to a hidden self.

“So I had to like, ball loo roll up in my pants... because I didn’t know what to do”

This description encapsulates the experience of shame around changes in the body and self that occur during puberty.

Megan also kept her self-harm hidden. She describes how self-harming makes you “*feel quite separate a lot of the time*” and “*become more secretive*” (M:18.21). A significant part of her experience that stands out for her was hiding:

“Because I was very, very sad...I just think how alone I felt...I guess I just remember a lot of, kind of, hiding” (M.19.14)

It is unclear whether she means physical or psychological hiding, but her words clearly describe a strong sense of secrecy. This hidden self seems linked to a profound sense of sadness.

Similar to other participants, Megan describes how self-harming was not something that was out in the open or discussed: “*no one ever asked*”. Her words hold an element of sadness that others did not reach out.

“not many people knew about me self-harming and certainly no one ever discussed it...it was never said at school about anything...And actually no one ever asked...Um it was never spoken about between my friends...like I said some of them self-harmed as well and we never really talked about it...” (M:17.25)

Megan, like Lily, makes reference to two selves: the outward self and the inner hidden self.

“I was probably depressed. Very vulnerable and needy. So like when I was at school, I was all fun and light and stuff...and I suppose that’s the person that they fancied. Then actually, like, they’d come round to my house or we’d talk and I’d be all sombre like...I don’t know, depressing.” (M:26.31)

She hid her “*depressing*” “*sombre*” self from others, with the exact opposite- someone “*fun*” and “*light*”. The contrast of the meanings of these words underlines this disparity and her experience of a discord, the lack of an integrated sense of self.

Katia speaks of her significant loneliness, despite having friends and others around:

“I was really lonely. I think I would say that I was really, really lonely, even though I had friends and everything. I, yeah, I felt super alone.” (K:41.12)

Her repetition of the variations of the word “*alone*” really highlights how desolate she felt. Like other participants, she describes not speaking about her self-harm, but seems unsure as to why. She states that this interview is the first time, since that period of time, that she has spoken about it. It is a part of herself she keeps secret.

“This is something happens a lot and no one’s talk- no one talks about it. I don’t talk to anyone about it.” (K:49.1)

“It is something that people don’t talk about at- at all because, if you ask me...I mean there must be people that do it, but I have never heard of anyone else doing it. Like ever, like I would watch things like on TV, like a documentary but with people that are quite removed and different to me” (K:46.2)

Katia’s word suggest that she has not been able to relate to anyone about her experiences. That she is very much alone with them. It is a topic that is almost ‘taboo’.

Beth states that she was “*socially isolated*” describing her time at school when she was not part of the “*in*” group and was isolated for perceived differences. This connects with another of the subthemes, ‘Rejection’ (see next section).

Beth explains how her mother became ill which was another area in her life, that was not spoken about, in fact, not permitted to be spoken about. She reasons that this lead to a “*bottling up*” of her emotions.

“My parents asked me and my brother not to talk about it with anybody outside of the family...When someone has [illness] you can’t go to them and be like, I’m really sad because you have [illness]. I think I just like learned to bottle things up and that I had to deal with stuff by myself...Because to me looking back I just think I was so young...to be dealing with that stuff by myself and there wasn’t really much help available” (B:2.14)

She dealt with things by herself and had no one to speak to. She did not feel she had a way to express her feelings:

“I didn’t really have feel like I had much of an outlet for, like anger or sadness or any of those feelings.” (B:6.30)

Beth indicates that as her feelings were repressed, her outlet became self-harm:

“It just seemed like something that I could do that would like somehow express how I was feeling. But that I could keep hidden. Or I did my best to keep hidden...I was always exceptionally careful to hide it. Because I really didn’t want the attention...the opposite” (B:7.11)

Self-harm was a form of expression, as other expression was not ‘allowed’. She made sure it was kept hidden, it was not done for others to see, but for herself. She explains how she kept her self-harm hidden for three years and this contributed to a hidden self. Interestingly, Beth describes that when her self-harming was discovered and became less hidden and more out in the open it *“forced me to confront what had been happening and talk about it in a way that I hadn’t... before” (B:6.13)*. She suggests this fits in somehow to the eventual resolution of her self-harm implying that this isolation and hiding helped to maintain the self-harm in some way.

Furthermore, Beth talks about hiding parts of herself in the present. She explains that she still has to *“hide the scars a lot of the time”* and *“cover up [her] skin”*.

“I’m hiding part of myself from people and like I have this hidden history that I can’t reveal to people. And that’s not a very nice feeling. Like...um...yeah, I guess, even if I feel like I’m relatively close to someone there, there’s still that something that I’m hiding it, kind of feels

like...yeah. It's not great...I have a sense of like when I form friendships, there's part of myself that I'm holding back. Yeah and that doesn't feel great, sad I guess." (B:24.15)

Her words reveal a sadness about her experience of not being able to be fully open with another. Her history of self-harm is a barrier to being truly vulnerable with someone else, and thus truly accepted by another person. She repeats that this experience is "*not great*" which seems like an understatement serving to mask the true intensity of the experience.

3.3.2 Subtheme: Self-harm as personal

"pain that is between you and yourself"

This theme captures a message conveyed by the majority of participants, that the act of self-harm is a very private and personal thing. This is also evidenced in the previous theme which depicts how participants choose not to share their experience with others.

Participants convey how the experience of self-harm is something that is specifically without another person involved.

"it's very much you." (F:21.17)

"So the self-harm is a very personal thing. It's just you." (A:7.9)

Alice reasons that this is because she does "*not know how*" to access help from others, and thus she resorts to self-harm (see theme: 'Relationship to help'). Additionally, she describes how the personal, private nature of self-harm is to do with shame:

'Well it's really-um, a lot to do with shame and guilt. It's really, really personal. It's all negative inward emotions.' (A:7.14)

Francis points out something which almost seems obvious, that self-harm is not something one would do with others around:

"I mean I just can't imagine me going to cut myself with my friend just sitting there watching. Realistically it wouldn't happen. It's just a very personal thing." (F:21.20)

"I mean, it's something you would do in private, alone...I feel, like it's a very personal thing." (F:21.8)

Her words convey that self-harm is a way of managing pain specifically without the help of another.

"...it's a way to deal with pain that is between you and yourself. And it's not about crying on someone's shoulder and talking about feelings. It's just about having control over your own emotions and it's very much you" (F:21.10)

Francis did not seek help at the time of her self-harming. She did not want to accept help from others as she wanted to be in control. The emphatic phrase *"very much you"* accentuates the private nature of self-harm. She refers to the self-to-self relationship (*"you and yourself"*), which

astutely sums up self-harm. This relationship is explored further in the subtheme: ‘Relationship with the self’.

Participants’ accounts portray a sense of ownership of their self-harm; having something that belongs to just them, giving a sense of control and capability, something they potentially felt they lacked (see theme: ‘Autonomy’). Beth explains how she “*wanted to keep*” self-harm to herself (B:7.27) indicating a sense of belonging and possession. She says it was “*a way of dealing with things by [her]self.*” (B:33.9). Participants’ accounts highlight that being a teenager, there are a number of expectations and restrictions made by adults that have to be adhered to, with a lack of personal ownership. Thus, self-harm is one thing that is kept for themselves. It is not just the act itself that the participants communicate as private, but also the experience that goes with it, that is, the taking one’s self off to be alone, the hiding of the scars, and the privacy of inner personal experiences and lives.

In reference to other people asking her about her scars, Beth states that “*it feels quite invasive more than anything else*” (B:9.21). This choice of word “*invasive*” highlights the personal feel to self-harm the marks it leaves, and that others asking about it is experienced as an attempted penetration into her private inner world. There exists, to some degree, a contradiction in participants’ accounts, between the complaint of lack of help available, and also the wish to keep their difficulties private. This conflict is explored further in the next theme: ‘Relationship to help’.

The sense of self-harm being personal continues into participants' present lives, with indications and statements that it is not something often shared with other people.

“Even though I told it to friends like years ago, I haven’t really spoke about it with anyone else. So, yea...It’s quite private...I actually wouldn’t feel comfortable talking about it. It’s

like something- I don't know exactly- it's just like, well, you just keep it for yourself."

(K:33.30)

The use of the word "*yourself*" in Katia's description again highlights this sense of personal belonging. She states she would not be "comfortable" talking about it perhaps suggesting the presence of a certain amount of shame.

Francis conveys that self-harm is uniquely individual to her, highlighting the personal nature.

"I feel like it's something different for everyone. I don't think there's a one size fits all kind of answer to it...I mean people do it in different ways for different reason for different periods of time...Definitely not one size fits all." (F:31.19)

Megan too indicates the individual, private nature of self-harm:

"Even though a few of us did it, it was a private thing. We were all separately self-harming for our own different reasons." (M:15.2)

These two extracts suggest that people self-harm for their own personal reasons, it can't be generalised as it has a unique meaning to the individual. Participants convey the message that self-harm is a unique expression that should not be put into boxes or have its motives assumed.

Additionally, throughout participants' accounts are indicators that talking about the topic of their self-harm was a novel experience for them. This was deduced partly from their body

language and way in which they spoke during the interviews and partly from explicit statements: e.g. *“Sorry this is the first time I have spoken about this properly”* (L:2.2). The majority of participants said words to a similar effect, except Alice, who, through a charity, openly discusses self-harm to increase awareness and reduce stigma. It was evident from her account that her experience of self-harm is something she has conveyed a number of times before. Her narrative flowed more freely, her language was more persuasive, containing a clear message, and some of her sentences felt practiced. The other participants, conversely, spoke as if they were making sense of their experience for the first time, with more hesitations, uncertainty, and sometimes a sense of revelation by what they said. Thus, the privacy of the account was portrayed not only via content but also through the telling. It was as if the researcher was being let into their hidden world.

3.3.3 Subtheme: Relationship to help

“I don’t know how I’m meant to reach out to anyone”

Under the umbrella of isolation, lies the theme ‘Relationship to help’, which represents the participants’ accounts of how they relate to help and their difficulty in this domain, that is, remaining hidden and isolated rather than reaching out to others and seeking help. Participants described in a variety of ways finding it hard to access help from others. Participants alluded to this being due to the nature of the act of self-harm that made it difficult to speak about/seek help for, but also that this was a difficulty that existed separate to the self-harm. Some participants spoke about how this difficulty in seeking help, and the tendency to keep things to themselves, has always been an issue, and for a few, remained so after self-harming stopped, into the present day, albeit to a lesser extent. Others, however, provided hints of a shift in their help-seeking behaviour over time, and connected this to their stopping of self-harm.

When answering my clarifying question, “so you didn’t seek support?” Francis reiterates that she did not reach out to others and wanted to cope with things by herself:

“I mean I knew I had all the signs, but I didn’t want to talk about it. I kept thinking oh I’ll deal with it on my own. I’m strong enough to do it by myself.” (F:5.26)

Her words imply that admitting she needed help was part of the problem. Admitting that she could not manage things herself was something she did not want to do, as if she held the ingrained belief that to cope alone is “*strong*” and thus to ask for help signifies a weakness. She speaks about having control over her life, which was part of the role self-harm played. It was something she was in control of. By accessing help from others, she would no longer feel completely ‘in control’.

“I didn’t want to speak about it to anyone. I had people I just didn’t want to...I suppose I didn’t want to accept it myself. The self-harming, the anxiety, everything...because by seeking help, you’re-you’re accepting that it’s a problem. That it’s something you can’t do on your own, that you can’t” (F:29.7)

Beth states that she did not tell other people about her self-harm and refers to a difficulty in telling others. She describes how she only had one person who knew about her self-harm, a friend who also self-harmed. She states that “*neither of us really had much support outside of that*” (each other). She suggests that she felt that she was not and would not be understood, specifically by the adults in her life. She explains that it was “*a hard thing to explain to [her] parents*”. The

use of the word “*explain*” indicating that she thought an explanation or justification of the behaviour would be needed, and that the explaining of the act of hurting oneself, as well as the disclosure itself, was difficult to do. Later she says: “*Quite often you feel like adults don’t understand you*” (B:32.33). This phrase is spoken as if on behalf of adolescents. Her words highlight a sense of child versus adults - us and them. It seems that perhaps, for Beth, it was partly in this difference between adolescents and adults where the difficulty in disclosure and seeking help lay. This idea of us and them was observed in other participants’ accounts.

Beth explains another reason she did not speak about her problems to others:

“Self-harm was a way of dealing with things by myself. Yeah I guess I thought it was-like-better to inflict pain on myself than on other people...” (B:33.9)

These words suggest that she believed she would cause pain in others and therefore reasoned it would be “*better to inflict pain on herself*”. Thus, her self-harm has a protective/preventative mechanism.

Alice, similarly, describes how it was difficult to talk to others, especially those who have not self-harmed before, one of the reasons being for a fear of being judged.

“Because it’s really hard to talk to someone who hasn’t self-harmed; people want an explanation” (A:7.9)

This last sentence suggests that, for Alice, it is perhaps the ability of others to empathise and understand that is important in the process of disclosure of self-harm and seeking help. The

fear of being misunderstood, or even having to explain one's own behaviour when you might not know why yourself, discourages one from disclosing.

The difficult relationship to help is portrayed by participants as both a difficulty of their own, located within the individual, and also a product of the lack of help and support available. Within some women's accounts, are descriptions of how they felt there was a lack of help available to them. This is something they experienced at the time, and reflecting back is something they still perceive. Beth describes how "*there wasn't much help available*". She and Lily describe how self-harm wasn't talked about at school or among friends. Alice accuses the adults in her life of not providing her with support: "*you haven't given me support to put in place*". The word "*given*" highlighting the responsibility of adults to provide, and the direct tone conveying potential anger at having been let down. Alice says she was unaware of how to *actually* reach out to others. As if she had never learned or been taught, and was lacking the knowledge. Variations of the sentence "*I didn't/don't know what to do*" are repeated throughout her account, emphasising her sense of helplessness and debilitation.

"I don't know how I'm meant to reach out to anyone else." (A:17.1)

Alice also speaks as if self-harming were something she was "*made*" to feel ashamed about. Her account is filled with references to other people's negative judgements and stigma (for further detail see subtheme: 'Negative judgements of other'). Through her account she indirectly suggests that these negative judgements and responses from others were a barrier to seeking and getting help.

Within this theme, Katia's account diverged from others. Although she describes how she felt alone and helpless, and initially did not speak to anyone about her difficulties, she also describes how she reached a point where she actively sought help as a teenager.

“And that's when I, um, I asked my mum if I could see, maybe, a therapist.” (K:13.15)

Her experience of therapy seemed to be a good one and her therapist requested that she tell some friends about her self-harming, which she did. About the process of disclosing she said:

“it wasn't easy but, the sharing was easy for me because of the support system I had”

(K:1.17)

Suggesting her access to help was made slightly easier by the support she had in place. All other participants' accounts of counselling whilst they were self-harming generally depicted the experience as unhelpful (see subtheme: Unhelpful response from others). Interestingly, Katia's self-harm lasted one of the shortest time frames compared with other participants, with no isolated incidents after the self-harming period in adolescence. This is merely an observation and whether there is any connection to her ability to access help or the support she received would be speculation.

Megan describes a difficult relationship to help in that she finds it hard to express and speak about her emotions to other people.

“I haven't felt like explaining my emotions has come very natural to me...” (M:4.34)

She mentions a number of times how expression of emotions was, and is, difficult for her and this is where self-harm came in, as a form of emotional expression. She speaks of this inability as if it were a flaw, and that this flaw was the reason that she self-harmed and also the reason she was unable to seek adequate help at the time. She very much locates the problem within herself.

Beth similarly describes how from an early age she did not open up to others. She relates this to her early experiences of her mother becoming unwell and not having anyone to talk to about this.

“I think I just like learned to-to bottle things up and that I had to deal with stuff by myself. Um, and that’s been really hard to unlearn” (B:3.1)

Beth reflects that she still experiences difficulties in “*reaching out*” to others. Her use of the word “*unlearn*” suggests it is something that became habitual. She expresses the belief that others have the inability to help. This may either be because she believes others are incapable or because what she is experiencing is so bad.

“I still find it quite hard to reach out when I need help. If I’m feeling down I still find it quite hard to ask for help. Um, I-I think it’s partly that I don’t- don’t really know how other people can help....I suppose I have a fear of, like, bringing people into something that’s like emotionally difficult for them to kind of hear about...whilst...there not really being any...anything concrete that they can do to help.” (B:33.23)

Beth describes a detachment from her close friends:

“I’ve always, sort of, slightly detached from them I suppose. I think my reluctance to talk about things that I find difficult, even now can, kind of, create some sort of barrier. Like, I-I never have my guard fully down, even with them [her friends] a lot of the time.” (B:24.7)

The use of the word “*barrier*” is very powerful and creates a strong image of how Beth remains guarded, unable to be vulnerable. It is likely that her “*reluctance to talk*” would impact on her ability to connect with others and receive help.

Lily highlights a confusion over whether self-harming has communicative properties:

“I don’t think I was doing it because I wanted people to see. Which now I think...I don’t know. Obviously you’re the expert but I’m sure there’s like a reason why some people do it... because it’s like ‘help me!’.” (L:8.24)

She explains how on one hand, it is a secretive act that one hides but on the other hand it can be a way of communicating distress and perhaps a call for help. Perhaps an alternative call for help in the absence of being able to ask for help. It seems this is something she has reflected on since her self-harming. She questions whether she wanted people to see or not, suggesting perhaps a subconscious desire for help, yet also a desire to keep it secret and private.

3.4 Superordinate Theme: Others don't understand

This superordinate theme captures the participants' experiences of not being understood, portrayed through the perceived negative judgements of others as well as the unhelpful response of others to individuals' self-harm.

3.4.1 Subtheme: The negative judgment of others

"I was so demonized"

All participants mention the negative or perceived negative judgment from others, specifically towards their self-harm and what it represents about themselves as people. The negative judgments were a dominant feature during adolescence. Although participants mention still experiencing fear of judgement now, there is the general sense that they feel judged less compared to when they were self-harming.

Alice describes how people were very "*judgmental*" about her self-harm and she was subject to mockery and disapproving judgments. She felt she was negatively stereotyped and that her school believed that she was "*ruining their reputation*". She explains how this treatment felt like a dismissal and mockery of something that felt very serious to her. It also exacerbated her feelings of isolation and helplessness.

"people...were mean, some people were mocking, you know there's lots of stereotypes around. Oh you're doing it because you're 'Emo' or whatever. They just ignore it, put it aside, dismiss it.... they don't actually think oh there might be something seriously wrong...Well it deepened the sense of helplessness and sometimes makes you feel...well

maybe I'm not gonna, I'm not gonna open up to anyone about it again because they're just gonna tell me that it's...a silly phase..." (A:20.1)

The words "*silly phrase*" spoken as the voice of others, highlights the belittling of her suffering that she experienced from others. She explains how this "*made [her] feel like a bad person*", highlighting the shame she felt.

Alice describes being "*demonized*" by other people, a very striking representation of how strongly she felt that she was portrayed in a negative light.

"I was so demonized– like this idea of hu-hurting yourself like what's wrong with you? That you are so sick in the head that you want to hurt yourself." (A:32.5)

When describing others' opinions, she uses 'dark' words with almost evil connotations: "*demon*", "*emo*", "*goth*" "*wrong*", "*sick*", portraying the sense of very strong negative judgments from others, as if people believed self-harm behaviour symbolized something was seriously "*wrong*" with her. However, she also mentions that, despite holding this belief, people did not take her self-harm "*seriously*", they did not acknowledge that she might be going through something very difficult, again her experience was dismissed. She uses the word "*wrong*" in two different ways to convey different responses: "*what's wrong with you?!*" which is filled with negative judgement and dismissal, and "*actually, there is something seriously wrong*" which acknowledges suffering and is validating. There is a lack of personal blame in the latter. This dual use of the word highlights the contrast, but also fine line, between acknowledging someone has a difficulty and making a judgement about the person for having such a difficulty. This is also applicable to

judgements about the self. Alice's view that others perceive her in a negative light perhaps might also reflect a part of Alice that believes that something is wrong with her core self.

Alice explains how her fear of negative judgement still exists:

"I've tried not to care as much about what other people think of me- but I still think you know what if they you know, like, 'oh what's wrong with her'?" (A:35.21)

She has tried to move on from it, but it still exists to an extent. Whether this is a valid concern about real stigma, or a projection of her inner beliefs or both, is unclear.

Lily refers to things she heard her peers saying at school regarding her visible cuts/scratches, mocking her. She alludes that the judgments of others were a reason she kept her difficulties hidden. During her account, I felt there was a palpable sense of shame, in the tone of voice used and pronounced pauses/silences.

"I said that it was my catI overheard them talking about it, like 'God, what's she got like a lion or something? [long pause]" (L:9.9)

Yasmine also speaks about the negative judgments of others towards self-harm and towards emotional expression. She explains that she is an expressive person who feels her emotions strongly. She communicates confusion between whether showing her emotions is a good thing or a bad thing. It could be suggested that this confusion might have played a part in the resulting self-harm behaviour, as a form of expression, due to inhibition of other forms of expression.

“I feel like expressing your emotions is a good thing, it’s not a bad thing but people see it as like a weakness or something which bothers me. So I go round always torn between what’s a weakness and what’s powerful.” (Y:19.4)

This extract indicates she is confused, and that others are her locus of evaluating what is good and what is bad. She feels it is a positive thing to express her emotions but that this contradicts others’ opinions and she worries about being negatively judged and thus ends up being confused as to how to be. Her use of the word *“powerful”* perhaps highlights the impotence she feels when she does something perceived as *“weak”*.

Megan describes the negative perceptions of others; however, she also appears to partly hold these judgements herself. She works in a mental health setting and expresses how there is a stereotype as to what a ‘self-harmer’ is: *“attention seeking...silly little girls”* or *“someone hurting themselves due to historic awful trauma”*, with the latter seeming more valid. She describes being unsettled as she believes, given the choices, it would be the former explanation that she fits into. It is almost as if the discourse for self-harm in society has not allowed her to find meaning for her past self-harm; she has been forced to place herself within one of two extreme stereotype categories.

Francis conveys anger towards the way self-harm is perceived by some people, expressing frustration towards people who make judgments from a lack of understanding.

“people look at it as someone being over dramatic...or being weak, I guess, and it...it’s not like that. And I mean I don’t do it anymore, but some people do and I don’t think it’s very...it’s not correct to think of it that way. It makes me kind of angry. I guess...because people don’t understand.” (F:4.5)

In the present day, she still fears stigma from other people. This may be, in part, due to judgment she holds towards herself.

“There’s still that fear of stigma...because it’s something you did it to yourself. Anxiety, panic attacks that’s not in your control, but cutting yourself is.” (F:9.6)

Her words imply a self-blame. She suggests that there exists more stigma and negative judgments towards self-harm compared with other mental health issues, due to its active as opposed to passive quality, i.e. it is an intentional, conscious act as opposed to something that one suffers from involuntarily.

Beth talks about how fear of negative perceptions about her self-harm is occasionally still an issue in her life, especially in certain contexts, for example at work or with people she doesn’t know that well. She states how at work, if people were to know, she fears it might negatively impact on their evaluation of her as a competent and professional worker. Self-harm, again, is seen as worse than, “*on another level*” to other mental health issues. Participants perceive there to be more stigma which equals more shame.

“I feel like people...will think that I’m a danger to myself or that, like, you’re out of control somehow. I don’t know. Most people I know have probably had some kind of experience like depression, anxiety and stuff, and it’s not particularly seen as a big deal...But I feel like if you’ve actually harmed yourself that is somehow, seen as on another level” (M:10.3)

Katia speaks less about negative judgments of others at the time of her self-harm, experiencing some positive helping relationships and responses from those closest to her (see next subtheme). However, she does speak about being judged by others in her present life. She states that people hold considerable “*stigma*” towards self-harm. She hasn’t told anyone in her present life, indicating perhaps a fear of judgment.

“They think that, um, stays with you your whole life. Maybe they’re gonna be thinking, ‘oh she did once and now she’s controlling herself.’ ...And I wouldn’t like to-to feel like they think I’m-I’m less... because I still have this-this thing on my mind that tells me I have to be perfect, and that wouldn’t make me perfect.” (K:29.17)

Katia’s words suggest self-harm has a permanency to it, it is something that goes deeper than just a past behaviour. It resembles part of the self that is out of control, unstable. She acknowledges her contribution to the perceived negative judgement of others, her perfectionist streak, and the need to be perceived in a totally positive light.

Katia reflects that adolescents are “*really afraid that people are going to think they’re making it up...just to get some attention*” (K.46.16), suggesting this was perhaps a fear she held at the time. It is evident that participants feared and still do fear the stigmatized judgments of others regarding their self-harm. They describe a range of misconceptions they observe others having, as well as assuming others will have. These assumptions are said with certainty throughout participants’ accounts.

3.4.2 Subtheme: Unhelpful response from others

“it wasn’t what was needed at the time”

Throughout her account Yasmine implies that as a teenager her feelings were not taken seriously, or “*validated*” by adults. This is an experience which one might imagine is common in adolescence but seems pronounced in these individuals’ accounts. This response from others seemed to contribute to how Yasmine felt about herself and subsequently wanting to self-harm. Alice’s narrative refers to an invalidation of her suffering, people “*dismiss[ed] it*” and presumed it was a “*silly phase*”, this invalidation was extremely unhelpful to her wellbeing and counterproductive to recovery. She experienced unhelpful responses from her mother, father, school and others around her.

“people were very judgmental or either didn’t care or were just quick to dismiss or put their own reason on why I was hurting myself...didn’t actually, you know, stop to think for a minute, actually, there is something seriously wrong...because she doesn’t know how to express her emotions.” (A:39.25)

Alice describes how others hastily made presumptions about her reasons for self-harm rather “*stop[ing] to think for a minute*”. These words imply they didn’t take time to consider her actions. She reasons that they “*didn’t care*”.

Some of these experiences she conveys with a level of retrospective understanding that seems to have come with maturation, for example, with regards to her mum she conveys an empathy of what she was going through and that she just didn’t know how to respond.

“My mum would try to get me to promise to not do it again and so when you did it again, which is pretty much inevitable that would be double the guilt. It just wasn’t helpful <sighs> ...At the beginning, she was quite, um, in denial because I am her child and I’m hurting myself she can’t understand why I’d want to do that. So her-her main objective at that point was ‘I need to get her to stop, I don’t want my child hurting themselves’. Which obviously doesn’t help when that feels like the only thing you have to hold on to...it just makes you become more secretive.” (A:20.)

Alice explains that trying to get her to stop self-harming did not help and actually even made things worse. Her words imply that this response actually encouraged secrecy. Proposing to take away self-harm was not helpful when she felt that it was the “*only thing you have to hold on to*”. These words highlight her desperation. It also points to the fact that motivation to stop self-harming had to come from within rather than imposed externally.

“Stop hurting yourself and we’re not going to give you an alternative to cope.” (A:39.33)

In this extract Alice implies a responsibility of the adults and that they had, in some way, failed their duty as parents by not providing her with a “*way to cope*”. She was left with no “*alternative*”. She is told to stop doing the thing that helps. Her words highlight a sense of authority from adults, the telling what to do rather than co-operation and equal discussion. This relates to the last superordinate theme, ‘Autonomy’.

Alice juxtaposes these unhelpful responses with the self-help group she joined where she experienced accepting and non-judgmental responses (see subtheme: ‘Finding acceptance’).

In contrast to Alice's experience of a therapeutic group, Lily describes how elements of the counselling she received were unhelpful.

"I hated the therapist. She was really like 'would Lily like to draw a picture?' Like, she really talked to me like I was a lot younger than I was...and I found that really frustrating...I didn't feel like it actually really addressed any of my, like, proper issues."

(L:11.2)

She conveys that she did not feel understood nor validated by her therapist, and even felt condescended, as if because she was not an adult her emotions weren't taken seriously. So, on top of her own invalidation (towards herself) she was also experiencing invalidation of her suffering from the person who was supposed to be supporting her. She also explains how in school self-harm was not addressed or talked about collectively, and how this was unhelpful and perhaps detrimental as it "*bred secrecy*".

"People can become sucked into a culture that isn't really explained" (L:40.17)

Megan also refers to the counselling that she received being "*not what she needed at the time*". It was very short, and in hindsight she reflects that she is unsure what she needed, she suggests some more practical guidance.

As in Lily and Megan's accounts Beth expressed how the counselling she received at the time of her self-harming was unhelpful. Beth explained how the counsellor created a conditional

relationship whereby Beth was to stop self-harming if she wanted to attend therapy. This was extremely unsupportive and ineffective at creating a trusting and useful relationship.

“after my parents found out, I started seeing a counsellor who told me that I-I had to not self-harm while I was with her otherwise she couldn't see me anymore. Which, just seems like a really twisted way of approaching it...I just felt like I wasn't being taken seriously...if you think that I am going to stop just because you have asked me to stop, then you don't understand what is going on here. And clearly, like, I said, 'oh yeah, fine', and in my head, I was like, 'I just won't tell you then'. It just seemed a really bizarre kind of contract that she was trying to enter into. It's basically like saying, if you feel awful enough that you will self-harm, then there will be no help for you, it just seems completely the wrong way around.” (B:22.12)

Beth emphasises how the actions of the counsellor demonstrated that she did not “understand”.

The participants emphasise how anger as a response to self-harm is unconstructive. Beth explains how anger was her father's first response and that this was really “unhelpful”, especially as it caused her only to feel worse. Megan speaks about experiencing anger/upset from her boyfriend, which then leads to her feeling worse.

“he can get quite upset if I self-harm so it can kind of add to the guilt, like even though I don't self-harm now, I have done a couple of times since we've been going out in the last like, five years. Um and I think it's just he doesn't know how to manage it when I do

that... but it makes me feel really guilty and probably worse about myself because...he says why have you done this? Why are you doing this again? You shouldn't have done that. When actually I'm already probably self-harming because I feel bad about myself."

(M:28.1)

She accentuates that his words only serve to make her feel worse about herself, which is the reason she is self-harming in the first place. Imitating his voice, as if he were speaking, gives her statement more power, and signifies that these words resonate with her. In a similar vein, Alice conveys the message that:

"people aren't going to get better if you get angry at them for self-destructive behaviours, they are probably going to get worse." (A:40:20)

Katia's account diverges from others in this theme as she recounts how she received helpful and "*supportive*" responses from her two friends and her therapist.

"I think I was lucky enough that I had friends around me that were very supportive..."

(K:1.12)

"they were really receptive. They-they looked at me and were like 'this is too vicious, you can't do this to yourself anymore. I know you think this about yourself but, like, everyone thinks like this. Like no one thinks you're-you're boring or you're super ugly or whatever... look at the good characteristics you have'...they put everything into

perspective. So every time I felt that way I would think about that...okay Katia, maybe you can't see it... but this is not what people are receiving about you...that really helped.” (K:17.19)

The response she receives from her friends helps her onto the path to recovery. Interestingly their responses could have been perceived by Katia as invalidating as they are disagreeing with the negative beliefs she holds about herself. However, Katia expresses that their reaction allowed her to begin to question her “*perspective*” of herself. That she is worth more than she believes so she does not need to hurt herself. Katia’s depiction of her friends’ voices clearly displays a tone of love and care, conveying that this is what she experienced from them at the time.

Despite this supportive reaction from her friends in regard to her self-harm, Katia does portray that her parents’ response to ‘negative’ emotions was unhelpful. Feeling “*sad*” was not allowed in her household.

“Feeling sad, feeling anything that wasn’t happiness was wrong. If I got upset when I was little, if I was anything but happy then my dad would be-be really mad. And then I would be really upset and he was, like, why are you upset? And well, I would think, well you’re really mad because I’m sad” (K:40.18)

Her words hint at the adverse impact this had on her psychological wellbeing and the part it potentially played in the suppression of, or reaction to ‘negative’ emotions and subsequent self-harm. The response to her sadness was anger potentially leading to a reinforced belief that sadness is something bad/to be punished. She thus internalized invalidation of her emotional experiences.

3.5 Superordinate Theme: Rejection and Acceptance

This theme depicts how during their adolescent years, these individuals felt a strong sense of rejection which caused deep emotional pain and was connected to the desire to hurt themselves. However, they also describe accounts of beginning to find acceptance, from others, and also from within, and they link this to their process of stopping self-harm.

3.5.1 Subtheme: Rejection

“they hate me, so I hate me too”

Predominant across all transcripts was a dialogue centred on rejection. The participants in the study explicitly described being rejected in some form, whether that be from one person, such as a relationship break up, or rejected from a social group. Participants communicate how the experience of rejection is in some way connected to self-harm. A rejection from others equalled a rejection of themselves.

In Francis’ account she describes how she felt rejected and abandoned by two men in her life: her father and later her boyfriend at the time. Her father left the family home when she was very young; this description was woven into her account of self-harm from early on, indicating a significant connection.

“During a break-up with that guy, I wanted to cut myself again...My dad left because he had someone else and my ex-boyfriend cheated on me. Someone leaving me...for someone else. There’s a sense of being inadequate...not enough. And then a self-attack because what did I do to make him leave?” (F:18.27)

Francis describes how her boyfriend cheating on her was a trigger for self-harm. She notes similarities between this cheating and consequent break-up, and her father who “*left*” her and her mother for someone else. She implies that these people leaving were directly related to her, “*what did I do to make him leave*”, and her worth, that she was not good enough for them, “*inadequate*”. It could be interpreted that these feelings of low self-worth were a motivator for self-harm, or that the reduction in self-worth reduced Francis’s protection from acts of self-harm.

Similarly to Francis, Alice describes rejection she experienced as a child via the abandonment from her father. This detail seemed of great importance to Alice in defining her adolescence and experiences of self-harm and her adolescence. She also spoke about her experience of a break-up with her boyfriend, and how these two endings of relationships impacted on her psychological wellbeing and thus were related to her self-harm behaviour. Her words suggest that one of the reasons she felt bad about herself and self-harmed was in relation to these two men who had left her, or as she puts it “*rid [themselves] of [her]*”, as if she was something bad; something to be rejected.

“I had met with him [her dad] to try to re-kindle the relationship which never really worked out ...but I had been very hurt that he’d sort of, I guess, rid himself of me because I didn’t seem like I was in a bad place he didn’t have anything to worry about... so that coupled with the time I broke-up with my boyfriend at the time. It was not good” (A:14.4)

In Lily's account, she describes experiences during adolescence of being put down and belittled by others, including her sister. She gives a descriptive account of very obvious overt physical signs of rejection from others, how she was "edge[ed] out of the group".

"I sort of gravitated towards a kind of group of queen bees who gradually rejected me. Just like being very clear that I wasn't welcome and sometimes like phys-like you know, when they were standing round in a circle like physically just edging me out of the group."

(L:36.3)

Lily explains how she was bullied by a group of people at school and how this coincided with her self-harming, implying a connection between the two. She directly states that she felt "hated" by this group, a very strong word, conveying the intense feelings she felt directed towards her.

"I was quite badly bullied. The time where I self-harmed, if I remember rightly, was ... it was early on in secondary school, - So I was like 13, - um and a group of girls had just decided that they really hated me ... and were very verbal about that. And um... they would um, undermine me a lot in lessons in the sense of like -I guess because I was quite outspoken and intelligent, I don't know?" (L:3.15)

Lily's choice of words conveys a sense of powerless to her part in this experience. The group had the power. They just "decided" that they did not like her and she did not know why. She attributes the reason to something about herself, her intelligence; something to be valued and

praised was causing her to feel socially rejected. Lily linked this experience of rejection with her self-harming, explaining that she had concluded that other people wanted to hurt her, so therefore, she would hurt herself, in that sense taking back some of the control and power they held. Self-harming seemed to provide some form of protection and control over others' ability to psychologically hurt her.

“These people want me to be hurt. They want to hurt me. So I’ll do it for them. Um yeah, they hate me, so I hate me too. ...I hated myself. Because obviously there was something to hate. ...Uh, I remember explicitly thinking like this is what they would want.” (L:5.11)

Lily further explains how her self-harming was a form of “*punishment*” for her perceived rejection by others:

“She was like slim and pretty and I was a bit chubby and... She was the one that everyone wanted to be friends with and she was the one that all the boys fancied. And because she was like really slim and pretty and that was like obviously the boys just like that. ...I would punish myself for not being that. Feeling fat and yeah...” (M:5.6)

Lily evaluated herself in comparison to others and what she perceived was wanted by society. This extract displays a perceived social rejection, in that there existed social standards she did not fulfil; she was not what other people wanted, and specifically not what the other sex wanted.

Megan also describes how she experienced bullying at school. She connects this to her self-harm. She describes how she was made to feel left out.

“She could make sure there was never enough room for you on the table and be whispering about you and stuff.” (M:2.21)

Her emotional pain as a young child was clearly felt in her account. The reason for the rejection was unknown and not understood by Megan, thus leading to her conclusion that something was “*wrong*” with her.

Throughout her narrative, Megan gives the impression that she believes she is different from others. Firstly, in her physicality following puberty, but also in her introversion and certain personality traits. This difference is portrayed in a somewhat negative light; she describes herself as “*set apart in some way*”.

“it was quite difficult being much taller, much bigger...physically different and quite hormonal compared to all my friends... It kind of set me apart in some way” (M:3.13)

This ‘difference’ seemed more pronounced when recounting her early adolescent days, but also is something that still lingers when talking about the present. Her account suggests that this uniqueness, the quality that makes her who she is, is not something that she fully accepts and embraces. Megan speaks less than other participants about finding acceptance (see next subtheme), which is reflected in her narrative in the way that she talks in a self-deprecating style. This is explored further in the theme: ‘Relationship with the self’.

Yasmine’s account possesses a running theme of rejection and fearing rejection. She describes how she was not part of a “*group*” at school, ostracized by her peers as she was new and

different from others. She states that something about the core of who she was, her “*personality*”, was not liked by others:

“When I moved there, everyone had their group of friends. I couldn’t speak English...I used to think – oh, people are talking about me... I felt like my personality wasn’t really liked by people in school.” (Y:35.8)

She directly states that she felt that others did not like or care about her, and how she carried around a fervent desire to be loved, implying this was something she felt a lack of. She describes seeing others receiving love from their parents and craving it.

“I always wanted to be loved by people. I really wanted to be loved. Like in my house. And when I went to school... ...I felt loved by my parents but I didn’t feel love in the house. They got divorced and I didn’t feel loved feel like no one cared about me.” (Y:35.3)

This extract signifies a conflict between knowing that her parents did love her and yet not feeling the love and care. That her home was a place devoid of love, potentially due to her parents’ relationship in which they decided to separate but stayed living together for the sake of their daughter. Her parents’ divorce seems to have been experienced by Yasmine as some kind of rejection by her parents.

Yasmine explains how she still experiences difficulties related to rejection. She believes that people will reject her due to her problems and perceived flaws. She explains how she believes she can love all aspects of others whereas she doubts whether others can accept and love all parts of herself, as if some of them are so bad they will not be accepted. Therefore, she describes ways

that she tries to avoid rejection, for example, hiding parts of herself, and also how she used to “*compromise*” herself to be accepted by the other: “*Back then- I would bring my standards so low just so people would talk to me*” (Y:26.26).

“I always had the fear of rejection, like people wouldn’t like me to this day I wanna be liked.... It bothers me if someone doesn’t like me. Like what’s wrong with me. I always have insecurity that oh they don’t like me, they are going to do something without me... ..I can’t tell people I’m angry at them ‘cause I don’t want people to see me as someone just nags and whines about stuff. I can’t express myself well because I am scared of people leaving me. ...I always think I can love people more than they can love me. I can love peoples’ shitty stuff, all their problems, but no one can like my problems. So I always get scared if I’m like sad, people will not like me anymore. I still have this.” (Y:35.29)

Yasmine also alludes to a fear of rejection due to her past self-harm. She describes how she believes others might think about her if they were to know about her self-harm, and how they would not want her in their lives.

“maybe she can’t control herself so like I don’t want someone who can’t control themselves in my life” (Y28.12:)

This idea of others thinking she is not able to “*control*” herself is also seen in Katia’s account.

Yasmine's words suggest that, because of this perceived rejection, she has felt anger towards others.

"I felt like I was angry at people, why they don't care about me? Why they don't want to know if I've been self-harming?" (Y:36.27)

She mentions anger often, relating it to her self-harm. She also explains that she finds it difficult to express that she is angry to others due to a fear of rejection (see Y:35:29). Thus, her perceived rejection leads to an anger at others that she cannot express, due to her fear of being rejected by them.

Beth mentions a number of times a "social isolation" amongst her peers at school.

"I was quite socially isolated. Like not particularly popular at school. I wasn't part of the in-crowd kind of thing. I was on the fringes" (B:1.11)

This extract depicts an experience of social rejection. It describes how Beth felt that she did not fully belong within a group, being on the outskirts. She also explains how she felt she was different from others in what she was interested in and her intelligence which segregated her.

"A lot of other girls were, like, getting interested in boys or fashion and that kind of stuff which didn't really appeal to me. I just didn't really feel like I could connect very much with...Like, I was interested in politics and philosophy...and you know...I just didn't really feel like I could connect with my peers very much." (B:27.25)

She elaborates explaining that she lacked connection towards others, portraying a sense of loneliness. Beth describes how this segregation started when she was young, at school, when she was put into an advanced reading class alone.

“I thought I’d done something wrong. Like why am I being put by myself? And it didn’t help me...And like, I mean that’s quite an extreme example, but I think throughout my school life I felt, like, slightly isolated by being, like, academically intelligent.” (B:31.17)

These words portray an experience of a form of rejection from a group, despite it being for a positive reason. As a child Beth does not know why she has been segregated from her peers; she assumes it was something she had done “*wrong*”. Her account paints of a picture of how from early on she internalized society’s segregations, resulting in the conclusion of a flawed self.

Katia refers to rejection when she explains that breaking-up was a trigger for negative thoughts and feelings towards herself. She explains that this took place at the time that her self-harming started. She talks of this period as a whole (“*triggered everything*”), rather than separating the self-harming from the inner processes.

“It was just this break-up that triggered everything...I remember it was the break-up. But I wasn’t sad about the break-up, I was, like finding things [flaws] in... in myself.” (K:7.6)

The break-up, rather about the loss of the person, is more about the rejection of the self, what it means about the self.

“as soon as that relationship ended everything was like, I was, like-. I believed like, not smart at all, not funny, I wouldn’t see my friends. (K:16.21)

She speaks of a self that she rejected. The rejection she experienced from another was internalized, she perceived herself as unlovable, and she began rejecting parts of herself. In particular she projected onto her physical appearance.

“I would spend hours in the mirror finding flaws...How is anyone going to love me if I’m like this? I found myself...I didn’t find myself ugly, I found myself disgusting.” (K:6.22)

Thus, this rejection appears to be twofold: rejection from others and rejection of the self, each of which seem to lead to the other in a cyclical fashion. Participants not only spoke about rejection from others but also about their rejection of themselves, often related to the rejection by others. This will be further explored in subtheme: ‘Self-hatred’.

3.5.2 Subtheme: Finding acceptance

“I can be myself and people don’t hate that self I feel I am”

Connected to the previous theme, participants conveyed a shift from the experience of rejection towards finding acceptance. They spoke of gaining greater levels of acceptance over time. This finding of acceptance was in some cases the finding of a group of people or even one person with whom they felt their whole, true self was accepted. Participants linked this acceptance to an improvement in psychological wellbeing and with the cessation of self-harm. Participants

also spoke about finding acceptance of one's self, which in some cases appeared linked to finding acceptance from others. They described having greater acceptance of their past self-harm.

Lily explains how she found acceptance within a group outside of school and how this was instrumental in the improvement in how she felt which was also connected to the stopping of self-harm. Although accounts of finding acceptance were not explicitly stated as directly relating to the cessation of self-harm, such events were portrayed as important points when speaking about self-harm and its resolution.

“I guess the major change was...so when I was 15, I joined this orchestra outside school...I think finding that group of people who were all kind of outsiders I probably was...given the freedom like, ‘oh you like music too’. Phew, a kind of like oh we can just be geeks together and that’s ok. Finally feeling like oh, I can be myself and people don’t hate that self I feel I am.” (L:29.8)

This extract portrays a new experience of validation found by Lily which she experienced as a relief; she could finally be her true self instead of hiding parts of herself for fear of rejection. She also experienced validation of her experiences and self when she made friends with another person outside of the group at school:

“I just sat down next to her and said this is shit isn’t it and she was like yes it’s shit. Um because I think she was having a similar experience. And again, like being in the orchestra outside of school was like I don’t need these girls, I have a group of people who really like me...” (L:36.27)

Lily's retrospective view towards her past experiences conveys a greater acceptance towards herself now compared to when she was a teenager. She moves away from blaming herself for being rejected due to perceived flaws, towards a more rational reasoning that takes into account other external factors:

"...I think I guess they rejected me because they could tell that I wasn't really into what they were into" (L:37.10)

Alice passionately depicts how she found acceptance and links this to her 'recovery' and cessation of self-harm. She too speaks about finding acceptance and validation within a group of "accepting people". She joined a self-help counselling group specifically for self-harm, that had a buddy system with people who were further along the recovery path.

"And there was no judgment there. There was just understanding...so it was from then um where-when I met up with this group that was when things really started getting better."
(A:16. 25)

Alice's description shows a relief and almost a thrill that she could, after all that time being secretive, be herself and reveal parts of her hidden self. And that rather than them being judged, or rejected, they were accepted. She clearly considers this experience as integral to her improvement in mood and stopping of self-harm:

“Seriously I wouldn’t have got better at all if I hadn’t had that group...I didn’t have to worry or feel bad about what I was doing and who I was...it was just come here and we will listen to you and we won’t judge you and we’ve been there and we can relate and maybe we can help you. But if I can’t I’ll be here for you anyway... Yeah, I just didn’t feel like I had to lie or be too guarded. I could just be honest to these people because they wouldn’t freak out...I can finally express myself and talk about why I am engaging in these behaviours without someone judging me or just trying to get me to stop...you just feel like you don’t really have to explain it. It’s like they just understand” (A:46.14)

This extract conveys the experience of unconditional relationships, with no need for explanation or justifying one’s self and behaviour – something that seems paramount. Alice gives the sense that, as well as the freedom to be oneself, feeling accepted also meant she felt that she “wasn’t alone” any more. Additionally, her account implies that, through other people accepting her, she began to accept herself.

Beth also describes how she found a group where she was accepted and links this to an improvement in her mood. For her it was when she started university.

“I just like went to gigs and talked to people and you know made a group of friends around the music scene there. Yeah, I guess there were just, kind of, one or two people who just, sort of took me under their wing and brought me into their, kind of, social circles.”

(B:28.25)

Her words conjure the image of others actively bringing her in, accepting her into their group, looking after her. She experienced a sense of belonging and inclusion. It seems important that she describes this experience as happening at the same time that she began to reduce self-harming, although she does not attribute a causal relationship directly.

Francis refers to accepting herself which developed over time.

“So growth throughout the years and acceptance in myself as well.” (F:20.10)

She specifically talks about finding an acceptance of her mental health such as her anxiety as well as her past self-harm. Her words suggest a transition, “*growth*”, towards less judgment of her self-harming behaviour and a sense of feeling less shame.

“I’ve come to accept it and I’ve stopped stigmatizing it myself. ...now when you think about it, everyone has a little aspect of mental health issue, so I feel more acc-acceptance to that part of myself.” (F:7.14)

However, she explains how she still fears a lack of acceptance from others due to her past behaviour:

“I don’t speak about [self-harm] as openly as anxiety as it’s not something I suppose that’s as easily understood. I worry others won’t understand. ...I don’t know, I mean I guess there’s always like a fear of not being accepted and just being...looked down on” (F:13.5)

Yasmine describes how she began to write stories online, which helped her express herself, and she speaks of how they would get good feedback. This experience seemed to offer her validation for her emotional expression and a sense of belonging and acceptance within an online community. She also implies how now that she is older her feelings are perceived as more valid by others, highlighting the invalidation she experienced as a teenager:

“now I feel like okay at 24 you’re eligible to have proper feelings and if you have a feeling people validate you because you are not a teenager.” (Y:18.7)

Yasmine’s account refers to a personal development over time and a process of “*self-knowing*” which she indicated led her to become more self-accepting. She declares at one point how now she has “*accepted [her]self*”. Despite still referring to some fears of rejection, her account conveys her levels of self-acceptance increased with maturity.

Katia, also, explains how she found “*belonging*” and acceptance for her ‘self’ online.

“I would go into those, um, forums and I would write like stories. And I don’t know that in a way, gave me a sense of belonging.” (K:23.6)

This “*belonging*” contrasts with her earlier descriptions of feeling alone. Katia also talks about acceptance of undesirable emotions, which previously she rejected or judged.

“I think I’ve learned is that if you’re feeling sad it’s good to feel sad. It’s normal to feel sad” (K:40.30)

Megan, although less than others, makes some indication towards greater self-acceptance compared to when she was a teenager and self-harming, signifying some sort of transition.

“a bit more comfortable with myself being, um, what I am. Like I think, just being a bit more relaxed about the person that I am...feeling a bit more accepted.” (M:21.31)

This extract implies she experiences less tension/ anxieties around her beliefs about herself. It’s not that she has changed but that she has become more comfortable with who she is.

3.6 Superordinate Theme: Relationship with the Self

Across all transcripts were references to how participants related to themselves, noting a shift and improvement in this relationship, over time, coinciding with the reduction in their self-harming behaviour.

3.6.1 Subtheme: Self-hatred

“I found myself disgusting”

All participants’ transcripts made reference to negative attitudes and treatment towards the self, not only behavioural but also psychological. Participants explicitly spoke of self-hatred, disgust, criticism and blame, and hinted at a level of shame. Their words lacked self-acceptance and compassion.

Francis describes a lack in “*self-love*”, which was very marked during her adolescent years but which has remained with her into young adulthood. She speaks of “*self-blame*”. For example, she describes how for a long time she blamed herself for her father leaving.

“I’m definitely lacking in self-love. More so during the time I was self-harming...I feel like, with self-harm, at least for me, there was a lot of self-blame, it was my fault that...things with my family were happening...So in a way it was punishment I suppose” (F:6.17)

She explains that self-harm is a way of punishing the self for perceived wrong-doings.

Lily describes a relationship with herself during the time she was self-harming that was acutely critical and lacking in understanding. She did not believe that she was justified in having low mood or feeling depressed, thus invalidating her own emotional experience. She explains how self-harm was a way for her to have something concrete as a reason for her suffering, thus it acted as a form of emotional validation.

“I was annoyed at myself...because I was like sort of like I don’t really have any problems. I didn’t have a leg to stand on to feel shit because so many other people were having a shitter time...I was basically having massive privilege guilt. And not letting myself just feel shit and stressed and upset. Because I didn’t feel like I had a reason to. ...But I think because I bottled it up so much it came out in this really extreme way which was like, now I’ve got a reason. Like look – that I’ve done this to myself...I have a reason to feel something because I’ve done something pretty terrible to myself.” (L:12.17)

She describes “*guilt*”, or potentially shame, which she experienced from being born into a certain amount of privilege, and how this led to her not “*letting*” herself feel certain emotions, a form of experiential avoidance. She would compare her life with other people’s and their suffering, displaying a lack of compassion towards herself and her own emotions, as she states a lack of self-respect:

“I didn’t have enough respect for myself and my emotions to like deal with them properly.”

(L:16.25)

She suggests this lack of respect for herself impacted upon her ability to manage her emotions successfully. Lily also explains how she can still be “*very self-critical*”, in her work, making comparisons to others and not being able to praise her own work.

Yasmine explains how when she was an adolescent and self-harming she “*was self-critical*” and “*didn’t feel that good about [her]self*”. Yasmine compares physical self-harm with a “*mental self-harm*” that she engaged in, including the process of self-blame. This mental self-harm continued beyond the cessation of the self-harming behaviour.

“When I was 18 and stopped the physical stuff, I started to do like mentally self-harming myself. Like not talking about my feelings, blaming myself.” (Y:15.7)

Alice, too, states that she was very “*self-critical*” and had very “*low self-esteem*”. She blamed herself for events out of her control, such as her father leaving. She also blamed and shamed herself with regards to her self-harm and other difficulties.

“It was kind of all my fault, I was doing these bad things.” (A:24.21)

All participants express that they disliked themselves. Megan describes a shift from childhood to adolescence where she started to feel self-disappointment; these feelings coincided with the beginning of her self-harm.

“I just didn’t like myself when I was that age. Like, just...yeah. There wasn’t a lot that I could find about myself that I liked, I guess...I think it was when I started self-harming that I those feelings of being disappointed in myself started. And maybe it was that when I was younger I don’t think I’d ever felt disappointed in myself.” (M:18.3)

Megan explains how this disappointment has continued to this present day, although it is less pronounced. She still berates herself for not working harder and “*achieving*”. Megan adopts a self-critical tone and uses self-deprecating language throughout her account (e.g., “*not good at coping*”, “*disappointed*” in self). Similar to Lily, she also conveys a sense of invalidation of her own suffering:

“it feels like it wasn’t serious enough. Sort of em-embarrassed that I couldn’t have managed things differently and embarrassed about sort of the reasons why I did it because in the grand scheme of things any problems I had weren’t that bad.” (M:9.22)

She refers to embarrassment, again, I wonder if this is a verbal expression for the feeling of shame. Participants don’t seem to verbally recognise shame explicitly, perhaps as the acknowledgement of shame is difficult.

Katia speaks of an “*attacking*” self that was present during the period when she self-harmed. She describes being extremely self-critical, and spending vast amounts of time obsessing over her flaws.

“This other side of you...a new side and it’s really, kind of, um...I don’t know how to say it, like a mean side of you. And it’s like attacking you. You don’t know how to control it.” (K:2.17)

Katia refers to herself in the second person, highlighting two sides of herself – one is the punisher, one is the victim, illustrating a lack of an integrated self.

“I started having these like, really, um bad thoughts about myself...And then I started having all these self-esteem issues...I remember I would spend hours and hours just looking in the mirror, like um trying to find flaws in what I saw.” (K:3.14)

She actively tries to “*find flaws*” in herself. Her account speaks of an abusive “*voice*” that she describes as almost separate to her other self:

“I would look in the mirror and I would have this voice that would tell me, like, you’re super ugly. No-one’s ever gonna want –gonna be with you. You’re gonna be alone your whole life and like, people look at you in the streets and they think, like, you’re-you’re disgusting” (K:13.3)

She considered herself unlovable:

“How is anyone going to love me if I’m like this?” (K:6.22)

By speaking her thoughts in the first-person Katia brings to life the vicious tone and creates an image of an abuser. Katia’s apparent disdain for herself was projected onto her body and its perceived flaws; self-harm, then, was potentially a way of attacking this flawed body.

“I didn’t find myself ugly, I found myself disgusting” (K)

This phrase serves to highlight Katia’s level of disgust towards herself and the intense self-hatred and shame she experienced. She gives the impression that it was this level of self-hatred that allowed her to physically hurt herself.

3.6.2 Subtheme: Towards self-compassion

“no one’s gonna take better care of you than yourself”

Participants' accounts tell of an improvement in their treatment of themselves, displaying a more self-compassionate side, demonstrating more kindness and self-acceptance. Katia describes how her critical voice still surfaces sometimes, especially in times of stress: *"It still happens sometimes"* (K.18.14). However, she mentions that she now has the ability to reassure herself, with the introduction of a new compassionate voice that empathises and encourages rather than blames:

"...Sometimes I am aware of it and I can think, Katia, no one's perfect...just relax. It's gonna be ok. And sometimes it really stops me...um but most of the time I'm aware of it, and I'm like ok you do what you have to do and if that doesn't work, don't worry about it..." (K:25.28)

Katia describes how there has been a *"real change"* in how she relates to herself, repeating this phrase for emphasis. Her account suggests that she is now more compassionate and understanding towards herself.

"I have come to a point in my life where...I-I know who I am. I'm comfortable with who I am, and if I feel like I've been in a situation when someone doesn't like me, or I don't make an instant click with anyone...I don't blame it on me anymore. And that's really exhilarating. That feels amazing. It's been a real change from like, when um-yeah, I was a teenager. A real change. And I don't blame it on me anymore. I'm like, okay, I-I can't like, control people...if this person doesn't like me or I don't like this group or whatever- it's not my fault. I know who I am." (K:26.5)

Her words speak of a greater level of self-acceptance. She emphasises with repetition that she no longer blames herself and describes experiencing almost a sense of liberation from this, which she finds “*really exhilarating*”. She does not attribute causes internally thus no longer experiences the same sense of ‘rejection’:

“I mean, if I break up with someone, of course I’m gonna feel bad, but I...I never blame it on myself anymore.” (K:44.17)

Katia additionally speaks about paying attention to oneself and ones’ emotion, demonstrating self-compassion in her mindful attention to herself.

“Now I know like if-if you’re feeling something, it’s good to identify what you’re feeling and then let-let you feel it. Because if you’re sad, you’re gonna be sad.” (K:40.8)

She has an improved relationship with her emotional experience, instead of an invalidation and criticism of her feelings.

Yasmine describes a shift in her attitude towards her body and relationship with herself. She describes the initially novel concept of self-care she now experiences, and her acknowledgment that hurting oneself is a form of self-abuse. Her words indicate a newfound respect for the self, that it does not deserve to be treated in such a way.

“I just think like I love my body so much so I shouldn’t hurt it. Like this is me, I will hurt myself...it’s wrong to do that, it’s not- it’s not a nice way to treat yourself. I feel like if you are sad okay, go through the sadness but actually take care of yourself. Because if I don’t take care of this who is going to take care of this?” (Y:21.24)

Yasmine speaks of accepting her emotional experience, *“if you are sad okay...”*, which closely reflects Katia’s words, *“because if you’re sad...be sad”*. Yasmine describes the realisation that she has to take care of herself, rather than relying on others to, that the relationship with herself is important. The idea of dependence and independence relates to the next subtheme, ‘Autonomy’. Yasmine uses persuasive language to convey her message, highlighting the significance of this realisation. She uses the second person as if directly conveying a message to others, perhaps to herself. Her words *“Like this is me”* underline the connection of her body and her ‘self’, and imply that she now has a more integrated, embodied sense of self.

Yasmine also refers to gaining greater self-awareness:

“I’m not as scared to like think about myself. Um-that [self-harm] changed me a lot. Like a self-knowing. I have more idea about myself than before” (Y:20.22)

She reasons that her self-harming was fundamental in her process of *“knowing”* herself. She also states that she *“like[s] [her]self more now”* and that she *“hated [her]self back then”*. It seems as if this self-awareness came with a greater liking of herself; perhaps through self-acceptance.

Megan, also, conveys that she likes herself more now as a young adult. She relates her feelings towards herself to her urge to hurt herself, explaining that the two must be linked.

“I suppose, me liking myself more must be related to me having the urge to harm myself less...I don’t dislike myself as much anymore.” (M:30.17)

It makes sense that an improvement in how one feels about the self will impact on the desire to hurt oneself, especially if the function of self-harm is self-punishment. It may also impact on one’s ability to carry out the desire – i.e. self-esteem is a form of self-protection.

Alice speaks explicitly about the change she experienced in how she feels about and relates to herself. She conveys that she has greater awareness now and no longer blames herself as much. Her words point to a shift in her thinking over the years.

“I’ve allowed myself to actually go like hey you actually, you did good. Whereas before, negative things were amplified and positive things were negligible.” (A:48.10)

Again, we see the use of the second person “*you did good*”, giving direct insight into her internal dialogue, accentuating the change in this area. She acquired the ability to praise herself and acknowledge the positives, as well as, attributing them internally, thus improving the relationship with herself. This signifies a shift from a negative to more positive and compassionate cognitive style.

Beth reflects that she feels compassion towards her younger self, which contrasts with her descriptions of dislike that she experienced when she was self-harming.

“I guess I feel more compassion towards my younger self in a way I didn’t back then.”

(B:4.21)

Her words imply she was unable to feel compassion towards herself during that time but now can. Katia also describes a moving desire “*to go back and help*” her younger self, displaying a compassion towards her younger self that she points out she didn’t feel “*back then*”.

“I wanna go back and help myself, like my 16-year-old self. Like I don’t know, ‘life is much more than that, it’s like gonna get better.’” (K:5.7)

Her words convey a hopeful message and looking to the future, suggesting that hope was something she lacked during that time.

Throughout Francis’s account she refers to a change in her relationship with herself, from self-blame towards more “*self-love*”. She also, like Yasmine, connects this with a process of self-awareness and learning about herself.

“I’ve learnt a lot about myself. I’ve learned to deal with stressful and emotional situations better.” (F:22.17)

Lily describes a process relating to self-awareness and identity that took place for her during adolescence.

“You become more self-aware. I think that’s like- a fundamental part of teenagehood is like becoming aware of like your place in the world.” (L:26.13)

The fact that she speaks about this in an account of her self-harming indicates a connection between this self-awareness and her self-harm. Her word choice of *“place in the world”* suggests identity processes.

Lily demonstrates a self-awareness when she talks about her tendency to be self-critical and how she has realised that this is not constructive for her personal wellbeing and professional success.

“like shit, yeah that’s really bad, and actually it doesn’t it just doesn’t help...like professionally, musically, psychologically.” (L:21.2)

This statement of acknowledgement seems to demonstrate a shift in how she relates to herself.

Katia repeatedly refers to her increase in self-awareness in her account of her self-harm. She suggests that self-harm helped her to achieve this greater awareness and knowledge of self.

“it helped me to learn a lot about myself” (K:11.10)

“I learned a lot about myself...up to that point I wasn’t really comfortable with myself. And I-I don’t know if that makes any sense- but I was a stranger to myself. I had no idea who I

was....it helped me to know myself and to know what I wanted and what I didn't want. And how I wanted to be and the person I wanted to become” (K:12.1)

Interestingly, these words imply that she had experienced almost a loss of self/identify: “*I had no idea who I was*”, and that self-harm was part of a process of identity development and reforming the self.

She conveys the sense that she has got to know herself better and accept her limitations, and that as she is in tune with herself and her needs, she does things that make her more content.

“I know my flaws I know what I'm good at. ...Like now, my goal in life, like, is to be happy. To do things that make me happy.” (K:27.16)

Katia states that the most “*important thing [she] has learnt about herself*” is the importance of the relationship with herself.

“I think the most important thing I've learnt about myself...It doesn't matter how much you want someone to like you or love you or to approve you. Like no one's gonna take better care of you than yourself...You can't expect people to care more about you than you care about yourself.” (K:15.32)

These words highlight the realisation of the importance of self-care, and no longer relying on others to care for her, which mirrors Yasmine's account.

It is important to note that participants convey that the adverse relationship with the self remains to an extent. Lily speaks of her self-critical nature in her work, Katia her perfectionist streak: *“because I-I think I still have this -this thing on my mind that kind of tells me I have to be perfect”* (K:34.9). Francis states that she is *“definitely still lacking in self-love”*, however she finishes the sentence with *“but less so”* (F:5.3). Despite these references, the overall overriding message of participants’ accounts was a significant improvement in how they relate to themselves.

Katia sums it up when she says:

“I have like two-two different stories. Like I feel really good about myself but, yeah there’re still things-I-I don’t know. I think...I don’t know if I am ever, ever going to be, like, a hundred percent, like, comfortable.” (K:35.8)

She conveys a slight tension and contradiction within the self, seen in a number of participants’ accounts, reminiscent of the abusive self. She implies that the difficulty in how she relates to herself might always remain.

3.7 Superordinate Theme: Autonomy

A theme that appeared in a number of transcripts was the divide between adults and adolescents, a sense of ‘us and them’ and references towards dependence and independence. Participants reported feeling a lack of independence whilst growing up and thus a lack of control over their lives. Participants recounted experiences of gaining greater independence due to the change in conditions around them, for example leaving school and going to university. They depict a shift from a focus on the expectations of others to making decisions based on their desires.

3.7.1 Subtheme: Lack of autonomy

“I had always been told what to do, even what to feel”

Alice alludes to a lack of choice a number of times throughout her account. She portrays a world where she is reliant on adults, yet they often do not provide her with what she needs. She conveys feeling helpless and powerless, not only towards her emotions but also towards her situation. She links this feeling to her self-harm, that this was a way of giving her some form of control.

“I just kind of got fed up with feeling so helpless and...I felt like the only way I could cope with this was self-harm” (A:23.2)

Participants recount a frustration at adults’ control over their lives leaving them feeling powerless. For example, Yasmine asks: *“Why did you do that to our lives? Why did you move?”* (Y:38.27), when talking about her parents and their decision to relocate. The use of direct questions, as if she were speaking to them, highlights the exasperation she experienced at not having control over this choice concerning her life. There is some resonance of anger at her parents for their choices which affected her. She mentions numerous times in her account that she was an *“angry teenager”* and angry at her parents. She connects this anger with her parents’ control, explaining she was *“not as free”* as other teenagers, suggesting her anger stemmed from a lack of feeling autonomous.

Lily also demonstrates the exasperation felt by herself as an adolescent wanting to have independence and *“do what [she] want[ed]”*.

“You’re not being nurtured in like the same way as you are as a child...you’re becoming more independent...but also like you’re like, as a teenager I was like, just let me do what I want! <laughs>” (L:24.25)

This extract is illuminating as it speaks about a change in nurturing during adolescence. In the absence of this nurturing one needs to learn to nurture oneself, Lily’s self-harm indicating she was unable to do this adequately.

Katia depicts a sense of a lack of autonomy from “controlling” parents.

“My parents are very nice but they’re- they have been, they were really controlling when I was growing up. So-And I never really questioned what they said...My parents would tell Katia sit here and I would sit there. Do this and I would do it.” (K:11.24)

This extract describes how she was very obedient. Katia links her parents’ control and high expectations with the period when she self-harmed. She portrays an accumulation of pressure building up due to mounting expectations until it became too much, the use of ‘explosion’ indicating the extremity and destructiveness of her emotions, self-criticism and self-harm.

“My parents set out goals for myself that were unreachable. And I think that maybe got me to the point where I just exploded and everything like...I don’t know.” (K:20.30)

Participants convey that adolescents’ lack of choice and autonomy isn’t something that is acknowledged or validated. Instead, teenagers are confined to doing what their parents ask/want,

yet are also expected to become more independent in taking care of themselves. Katia explains this contradictory dilemma:

“I had no idea who I was or what I wanted in life or anything because, uh, I had always been told what to do, even what to feel. So, like without that I was lost. I was totally lost. I remember it was a year before I finished school, I had to decide what I wanted to study, where I wanted to go to university...I remember at that point my parents were like, well you should know what you want to do...I felt like they were really disappointed because I had no idea what I wanted to do, because I was-was never mature enough. I remember I was thinking like why don't you tell me where I should go to university, what I should study? Please.” (K:41.24)

Katia's words “*I had no idea who I was*” acutely highlight her loss of self and sense of identity. She states that she was “*lost...totally lost*” further emphasises this. Her loss of self seems in part related to her reliance on her parents for direction and lack of opportunity for autonomy.

“It was like, you can't- you can't expect a person to act like a grown up...if you're never given the chance. And from one day to another I had to like, become a person/adult that I had never been. So that's really frustrating.” (K:42.31)

These extracts convey Katia's confusion, and the underlying question: ‘am I a child or an adult?’ and with that, ‘who takes care of me?’ She explains how adults expected her to act “*like a*

grown up” yet, at the same time, she was not given the freedom that comes with being an adult. Katia highlights the frustration that arose from this conflict of expectations.

Beth also describes her retrospective reflection about how it is difficult “*when you are growing up to deal with, like adult situations and emotions*” (B:32.29). Her words portray a clear distinction between child and adult and suggest that they even have distinct emotions. Her words seem to suggest that she felt expected to deal with adult situations without really knowing how.

3.7.2 Subtheme: Gaining independence

“I was given the chance to live an independent life”

Participants refer to gaining independence and feeling a greater sense of autonomy, and the impact this had on their wellbeing. When speaking about stopping self-harming, Alice pinpoints turning 18 and going to university. She then proceeds to discuss establishing her independence and taking responsibility for herself:

“About 18, so when I went to uni...you’re looking after yourself, you’re getting your independence. I didn’t really think that way anymore. Because you’re-you’re on your own and it’s very different at uni. You’re not in these classes, where you are sort of competing against each other. You’re just... adults trying to study to the best of your abilities. Also earn a living. All sorts of things.” (A:11.27)

This extract highlights the significance of the reduction of peer comparison and competition with an improvement in well-being and the cessation of self-harm, as if this new environment allowed her to create a more independent, individual self.

“I think I was able to define, you know, who I was and what I did... ‘cause when you’re at school you do these classes you have only an option of these things and that’s it... you only see the people around you in class. But when you’re at uni it’s-it’s life. It’s not as...structured.” (A:13.1)

These words suggest there is more variety around her which seems to impact on her identity process. Allowing her a wider range of reference points to help define herself.

“I was given the change to live an independent life...I can actually do this myself...I came to a realisation at uni that...only I could get what I want and do well...the only way I’m going to get where I want to be is if I put in the work myself. Because before then it was just you get everything from your parents or the school.” (A:22)

This extract marks a shift from relying on others, authority figures, to relying on oneself. She demonstrates a new belief in herself and sense of capability.

“great, I’ve got freedom...I had to organise where I lived, I was the only one who ... if I didn’t get my work in that was my fault and no one’s gonna-gonna chase you to make you do the work...it’s all up to me. So, like uni teaches you, that independence. So that kind of made me feel more empowered you know, kind of take control of my circumstances and...there’s choice. As an adult now I can complain and get this sorted.” (A:23.24)

Alice's use of the words "*freedom*", "*empowered*", "*control*" and "*choice*" highlights her newfound sense of liberation and independence. She describes being much more self-sufficient, in practical ways which seems to transfer into the emotional domain too.

Beth, when discussing cessation of her self-harm, also describes taking more responsibility for herself when she went to university.

"I suppose when I went to uni...I didn't know anyone. Um, and I-I think I felt slightly, like, I have to make friends, it's kind of sink or swim at this point and the next three years are going to be miserable if I don't make some friends. So, at some point...I just like went to gigs and talked to people and you know made a group of friends" (B:28.17)

This extract communicates a sense of transition from childhood to adulthood, "*sink or swim*", a turning-point. It seems as if having more independence lead to a realisation that she was an active agent in her life.

Yasmine uses a powerful metaphor to highlight her shift from dependence to independence.

"when I can finally take the reins on where my life is going...I could voice my dissatisfaction...by that point I had a choice." (Y:18.13)

By "*tak[ing] the reins*" she has control on her life direction. She too uses the word "*choice*" which illustrates autonomy. She contrasts this with "*just being young and not seeing everything in life*" (Y:19.15) highlighting a new-found wider perspective.

Katia highlights a change from doing what she was told to taking charge of her life. The expectations of others meant less.

“I thought what they told me I had to do... Yeah I just kind of tried to put the direction on my life. I tried to direct it rather than just allow it to be determined by other people.”

(K:27.5)

Her use of active verbs highlights her active role in taking control. She explains how she has *“been able to detach from my parents’ expectations.”* (K:27.31)

“They have all these expectations for me, um but I realise at some point it is not the same expectations I have in life. Their idea of happiness and my idea of happiness. What makes them happy, like really doesn’t make me happy at all.” (K:28.3)

This extract indicates a process of psychological separation from her parents, a *“realis[ation]”*.

Lily also states how she is doing things for herself and that *“interest [her]”*, implying, perhaps, previously she did things based on the expectations/needs of others.

“I feel like I’m doing the right thing for myself. Like my work is fulfilling. Now I’m doing all the things that I love to do and that interest me.” (L:35.22)

The repeated use of *“I”* highlighting her independence and autonomy.

Yasmine delivers a message to adolescents who are self-harming: *“You will have the power to change and your voice will be heard” (Y:20.3)*. This extract brings to mind someone giving a motivational speech, bringing hope to a group of repressed people, which gives deeper insight into her experiences as a teenager. Interestingly, her words imply the change is inevitable, and thus will happen with maturation.

3.8 Summary

To summarise, the superordinate themes that emerged from participants’ transcripts were: ‘Isolation’, ‘Others don’t understand’, ‘Rejection and Acceptance’, ‘Relationship with the self’, and ‘Autonomy’. The theme ‘Isolation’ captures participants’ experiences of loneliness and of hiding/secretcy during the period that they self-harmed. A focus throughout participants’ accounts was the negative judgements and unhelpful responses from others, which is captured in the theme “Others don’t understand”, as the overall message conveyed was that participants did not feel understood by others. The last three superordinate themes depict shifts described by participants related to their cessation of self-harm. Firstly, from experiencing rejection to finding acceptance, from others and themselves. Secondly, in their relationship with themselves, from self-hatred towards self-compassion, and lastly, from lacking autonomy to gaining independence. The findings will be discussed further in the next chapter.

4. Discussion Chapter

4.1 Chapter Overview

This chapter reviews the findings of the present study in relation to the existing literature. It considers the theoretical insights obtained from the study and the implications these may have for clinical practice, whilst additionally presenting limitations of the study, including a critique of the methodology as well as recommendations for future research.

This study aimed to shed light on the lived experience of individuals who began repetitive self-harming in adolescence and subsequently stopped. It aspired to illuminate the experience of self-harm for these particular individuals. Results produced a number of themes that captured prominent features of participants' experiences. Whilst the focus of the study was on how individuals understand their experiences of repetitive self-harm, this came to include their experience of the resolution of self-harm.

4.2 Overview of Findings in Relation to the Literature

Most of the findings observed within the present study support the existing self-harm literature, including various conceptualisations of self-harm. They are also in line with previous accounts of the lived experience of those who engage in self-harm. In addition, the analysis brought to light new themes within the realm of lived experience, which are supported by findings in the broader existing research. The findings shed light specifically on the experiences of young women who ceased self-harming, and illuminate some of the shifts/changes they experienced. This study cannot directly highlight factors that contribute to the cessation of self-harm in adolescence, but findings that have emerged from the data add an additional dimension to the

existing literature in revealing the processes that might occur during the resolution of self-harm, coinciding with the transition from teenager to young adult.

All participants reported stopping engagement in repetitive self-harm around the end of adolescence. The majority of participants reported isolated incidents (5) or isolated urges (6) since ceasing regular self-harm, at times of crisis or intense stress. Interestingly, these incidents often seemed to involve an interpersonal relationship or loss of a relationship. Most participants claimed that they would not now self-harm, and some were not even certain that they would physically be able to do so, although interestingly they could not definitely rule it out. Participants alluded to changes (in their lives and themselves) but did not give explicit reasons that they attributed to the cessation of the behaviour.

This supports Moran and colleagues' (2012) conclusion that repetitive self-injury that begins in adolescence resolves spontaneously. Participants spoke more about the progression of their self-harm in the context of maturation and the personal development that took place towards the end of adolescence and into young adulthood. Cessation of self-harm thus seemed to be linked, in some part, to resolving issues that existed at the time. This supports previous findings by Sinclair and Green (2005). The present study's participants related their cessation of self-harm to an improvement in their overall psychological well-being, although some reported difficulties beyond self-harm that translated into other destructive behaviours, such as disordered eating. Overall, the findings would appear to imply an association between the developmental process of adolescence and self-harm. This lends support to authors who suggest self-harm is a reflection of adolescent turmoil and developmental processes (e.g., Conterio et al., 1998; Moran et al., 2012).

The five superordinate themes to emerge from the data were: ‘Isolation’, ‘Others don’t understand’, ‘Rejection and Acceptance’, ‘Relationship with the self’, and ‘Autonomy’. The theme of ‘Isolation’ connects with previous research that highlights the hidden nature of self-harm as well as its association with loneliness (Armiento, Hamza, & Willoughby, 2014; Evans et al., 2005; Rönkä, Taanila, Koiranen, Sunnari, & Rautio, 2013). ‘Others don’t understand’ supports previous findings that report individuals who self-harm experience feeling misunderstood, as well as stigma and negative attitudes towards their behaviour (Lindgren et al., 2004; Brown & Kimball, 2013; Stration et al., 2013). The theme ‘Rejection and Acceptance’ is reflected in the literature with regard to the association between bullying and peer alienation with self-harm (Baldry & Winkel, 2003; Brunstein Klomek et al., 2016; Hawton et al., 2002), as well as acceptance acting as a component in self-harm therapeutic interventions. The theme ‘Relationship with the self’ contributes to the body of evidence on the role of self-hatred and self-criticism in self-harm (see Adams et al., 2005; Sim et al., 2009; Gilbert et al., 2010; St. Germain & Hooley, 2012; Chapman & Dixon-Gordon, 2007; Xavier et al., 2016). It also lends support to the use of compassion-based interventions in self-harm intervention, as well as promoting self-acceptance. This theme captures participants’ processes of knowing themselves, corroborating the role of identity processes in adolescent self-harm. Additionally, this study expands the existing understanding of self-harm in adolescence via the observations seen under the theme ‘Autonomy’, by revealing that adolescents who self-harm may experience a lack of autonomy and struggle with the dialectic of their dependence and independence. This theme potentially implicates the importance of the separation/individuation process in adolescents who self-harm. These theoretical insights are explored in further detail below.

4.2.1 Isolation. Throughout the accounts, participants shared their experiences of feeling significant social isolation and loneliness. Laursen and Hartl (2013) claim that developmental changes that occur in adolescence may increase the risk for physical isolation as well as perceived social isolation. The social world of an adolescent shifts rapidly; the nature and frequency of social experiences and social expectations change (Laursen & Burowski, 1997). Adolescents begin to spend more time with peers and less with family (Larson & Richards, 1991), thus their social reference groups change. Adolescents' desire for autonomy may lead to loneliness, as needs that were once fulfilled by family relationships may not be readily met elsewhere (Laursen & Hartl, 2013).

Accounts of pervasive isolation and loneliness in those who self-harm can be seen in certain phenomenological accounts and sufferers' memoirs (e.g. Adler & Alder, 2011). Adler and Adler (2011) reported that a common reason why participants of their study self-injured was loneliness, yet ironically the self-harm could in fact exacerbate this experience. They also noted that feelings of loneliness and social isolation were common for many of the participants in high school (ages 13/14-18) surmising this was because "peoples relationships, identities, and ability to understand themselves and peers were particularly challenging at this age" (p.98).

A quantitative research study in Finland found an association between loneliness and deliberate self-harm in adolescence (Rönkä et al., 2013). Another study using content analysis found that isolation played an important role in the reasons why a group of South Asian women in the UK self-harmed (Chew-Graham et al., 2002). The authors related this specifically to culture, however it may be a wider feature shared by individuals who self-harm. Additionally, it is clear that self-harm is something that a significant proportion of individuals tend to keep concealed (Evans et al., 2005; Armiento et al., 2014). The present study goes further in illuminating a part

of the self that is also hidden, as the individuals' accounts shared an overall sense of hiding one's inner self and experiences.

Participants gave accounts describing hiding and secrecy, thus contributing to their isolation. Participants reported concealing their self-harm for a substantial period of time, often years, before they disclosed to others or "let them find out" (L:16.21). Participants' accounts portrayed a world of secrecy and an underlying impression of shame associated with this. This shame was not explicitly identified by participants but interpreted from their transcripts. This interpretation arose from participants' depictions of their flawed selves, the negative judgements of themselves in the eyes of others, and how their self-harm was something that was not spoken about.

This analysis is in line with findings that highlight the importance of shame in self-harm. Hiding, and secrecy often come hand in hand with shame. Proneness to shame is a risk factor for self-injury (VanDerhei, Rojahn, Stuewig, McKnight, 2014), moreover, "shame-proneness" has been associated with self-injury when controlling for internalizing disorders (i.e., anxiety and depression), and in fact has shown more of a relationship to NSSI than internalizing disorders themselves, suggesting shame is of high importance in self-injury (VanDerhei et al., 2014). VanDerhei et al. (2014) also found that proneness to guilt is a protective factor. Guilt, unlike shame is often related to behaviour and the impact on others. Shame conversely refers to feelings about the self. It is common for shame and guilt to be present at the same time. Shame, however, by its nature, is difficult to vocalise, recognise, and admit, which is seen in the participants' accounts. For example, Alice states that she felt "guilty a lot of the time" because she was hiding her injuries, her language and other indicators suggest that she also felt ashamed, yet she herself does not identify the emotion. VanDerhei et al. (2014) suggest that therapeutic intervention for self-harm

should focus on encouraging “constructive, reparative actions in response to [an individual’s] NSSI instead of extrapolating blame to their entire self” (p.328). They reason that this would lower the individual’s proneness to shame and develop the protective outcome of guilt, i.e. guilt can be a useful emotion that helps evoke change in behaviour and prevent future harm to the self.

Participants in this study described an absence of communication about their problems and distress with others, leaving them feeling alone and misunderstood. Their isolation, which seems to, in some part, stem from their difficulty finding intimacy and seeking help, was often related to their experiences of being encouraged to hide or suppress problems, therefore promoting the idea that problems should be kept to oneself. Fortune et al. (2008) suggest different societal groups may have implicit or explicit attitudes and/or social norms surrounding the disclosure of personal issues or distress, and that these influence help-seeking behaviours in adolescents who self-harm.

A theme emerged depicting the difficult relationship participants had to help. Participants recounted having nobody to communicate their problems to, as well as not knowing how to communicate and express distress. One barrier to accessing help was participants’ tendency to refrain from opening up and reaching out to others. Relationship to help, according to systemic theorists Reder and Fredman, is defined as the “complex collection of beliefs about the helping process, these include ideas about the meaning of turning to someone else for help” (1996, p.457). They maintain the idea that the route to help can be difficult due to personal beliefs about help. Relationship to help also considers others and their ability to offer help. It seems that participants experienced difficulty in accessing help, as well as the inability of others to offer appropriate/helpful help.

These findings are in line with research indicating that people who engage in self-harm report having poorer communication skills compared to those who do not (Abrams & Gordon,

2003). Correspondingly, it has been found that having a better quality of communication with peers decreases the chances of engaging in NSSI, especially in adolescent females (Hilt et al., 2008; Turner et al., 2012). Additionally, the theme reflects previous findings that people who self-harm are less likely to seek help from others (Berger, Hasking, & Martin, 2013), and that adolescents who self-harm find it difficult to access help (Evans et al., 2005). Furthermore, the majority of individuals who participate in self-injury do not seek out psychological or mental health treatment (Wester & Trepal, 2010; Deliberto & Nock, 2008). Research has indicated that adolescents who self-harm feel they can cope alone, managing things themselves, and not wanting to be a burden on their families (Evans et al., 2005; Fortune et al., 2008; Hume & Platt, 2007). This echoes Francis's descriptions of wanting to be in control and sort things out herself. Beth described how she did not know how others could help her, which is reflected in Berger et al.'s (2013) finding that a substantial number of teenagers were uncertain as to whether teachers and parents could do anything to help.

Based on clinical descriptions of self-harm, authors have suggested that the act may be a form of communication and seeking help when language and other methods are ineffectual (Conterio et al., 1998; Favazza, 1996; Walsh & Rosen, 1998). The social signalling hypothesis (see Nock, 2010) states that self-harm is used as a way of communicating or signalling distress, as it is "more effective at eliciting help from others than milder forms of communication such as speaking, yelling or crying" (Nock, 2010, p.353). Although the theme 'Relationship to help' identified in this study does not specifically represent a social function of self-harm, and it is pertinent to note that none of the participants stated that they were self-harming for social or communication reasons, the social signalling hypothesis does in some way align with the difficulty participants experienced in seeking help and not knowing how to communicate their distress.

Interestingly, a previous study found that individuals who reported using NSSI to socially signal appeared to feel a sense of isolation or alienation from others (Wester & McKibben, 2016), something also reported by participants in the present study. The authors suggest that isolation possibly results in the need to use self-harm for communication purposes. Although none of the participants explicitly stated that they were self-harming as a call for help, a few alluded to this and on reflection questioned if this might have been a motivating factor behind their actions. It could be that individuals were not conscious of this motivation, or perhaps an element of social motivation is difficult to admit to due to the stigma already attached to self-harm and the shame experienced. Nock (2010) suspects this is why limited research has been done in the area of social signalling – for fear of “invalidating or further stigmatizing those who engage in the behaviour” (p.353). Admitting to a social function would also contradict participants’ strong desire for keeping their self-harm private. The fact that this study’s findings support, in various ways, a number of different conceptualisations and models of self-harm suggests to the researcher that self-harm has multiple functions; it is a complex issue with different layers and levels, which ultimately supports an integrated model of self-harm (see Introduction).

The present study’s findings also highlight individuals’ experience of a lack of available help. This is perhaps due to people’s tendency to shy away from self-harm because of the uncomfortable feelings that it gives rise to (see Babiker & Arnold, 1997, Favazza, 1996; Law, Rostill-Brookes, & Goodman, 2009). Fortune et al. (2008) explored the perspectives of 2,954 adolescents, aged 15-16 years, in anonymous, self-report questionnaires. The overriding theme that arose conveyed participants’ belief in the importance of communication with adolescents, for instance, listening to, giving advice, or talking with the person engaging in self-harm, thus highlighting the importance of opening communication channels. A similar message is conveyed

in the results of the present study, with participants highlighting the absence of open communication around self-harm. Correspondingly, the themes of communication as well as comfort and hope emerged from research exploring descriptions of what helps stop engagement in acts of self-harm in BPD clients (Weber, 2002), highlighting the role of communication in refraining from hurting oneself.

4.2.2 Others don't understand. Throughout their accounts, the importance of the reactions, responses, and opinions of others was echoed by all of the participants as they described how they received unhelpful reactions to their self-harm, as well as negative judgements, imagined or observed. The overriding message was that they felt others lacked an understanding of their self-harm, as well as their difficulties and needs. A significant amount of recent literature emphasises the importance of people's perceptions and attitudes towards self-harm. The present study's findings add weight to previous research that reports that those who self-harm feel misunderstood (e.g., Lindgren et al., 2004; Brown & Kimball, 2013) and experience significant negative stigma (Cello & YoungMinds, 2012; Lindgren et al., 2004; Stration et al., 2013). It also provides insight into how the negative perceptions of others have a substantial impact on the individual and may perpetuate the behaviour (some participants expressed that their concern about being judged and thus feeling invalidated, was a contributing factor in why they did not divulge their self-harm to others). The majority of participants described how they desperately tried to avoid negative judgements, although some seemingly sought to anticipate the judgements of others by judging themselves, for example Megan classifies herself as an "attention seeking little girl".

Participants' fear of being stigmatized and judged continued once they had ceased regular self-harming behaviour. They appeared to believe their past engagement in self-harm might cast aspersions on their value as a responsible, stable person. This appears to be a novel finding, as no

research, to my knowledge, has been conducted on the lived experience of those who formerly self-harmed and how they perceive themselves in the context of their past self-harm. It is important to note that participants' perceived negative judgements might be related to their own negative self-concept. It is unclear as to whether the perceived negative judgements of others are grounded in reality or are assumed or exaggerated. However, what is important in this research is that participants experienced such negative judgements.

The emergence of a theme depicting 'unhelpful help' is enlightening and corresponds with previous research that reports that individuals who seek support for self-harm are dissatisfied with mental health professionals (e.g., Brown & Kimball, 2013; Warm, Murray, & Fox, 2002). Whether this relates to the quality of the help that is offered, the nature of the problem and/or the characteristics of the individual who is self-harming (i.e., a reluctance, whether conscious or unconscious, to accept help, or a tendency to perceive the judgements/actions of others as negative), or a combination of both is unclear. Given the existing research indicating stigma and ingrained negative attitudes towards self-harm, it follows that responses to the behaviour from both professionals and non-professionals might be less than ideal. Mangnall and Yurkovich (2008) advised that "withholding negative judgement and avoiding the mind-set that these behaviours [self-harm] are manipulative is imperative to maintaining an open line of communication" (p.182). Additionally, the fact that self-harm tends to engender uncomfortable feelings in people, including those who work therapeutically with individuals who self-harm (see Babiker & Arnold, 1997, Favazza, 1996; Law, Rostill-Brookes, & Goodman, 2009; Shepherd & McAllister, 2003; Walsh & Rosen, 1988), might contribute to explaining inappropriate approaches towards the behaviour. Many researchers, as well as individuals who have engaged in self-harm, have suggested the need for greater awareness surrounding the behaviour, in order to help others respond better and offer

appropriate help (e.g., Cello & YoungMinds, 2012; Brown & Kimball, 2013). The past decade has seen gradually shifting attitudes and better training for those working with individuals who self-harm.

4.2.3 Rejection and Acceptance. Experiences of not only isolation, but also exclusion and abandonment were observed in the participants' accounts. Their sense of loneliness was considered to be further strengthened by the experience of feeling rejected, as well as not fitting in with social standards. Participants conveyed experiences of being rejected and feeling rejected by individuals as well as groups of people, for example school peers. According to Gilbert and Irons (2009), adolescence is a time of preoccupation with the "in-group and out-group", fitting in, and being accepted (p.209). It is suggested that physical changes relating to puberty may heighten segregation/exclusion due to observed or perceived differences, especially in girls (Laursen & Hartl, 2013).

The explicit descriptions of experiencing rejection appear to be a novel finding in the lived experience literature of self-harm, however, current literature does indicate that difficulties in peer relationships are associated with self-injurious behaviour (e.g., Giletta et al., 2012). It has been suggested that peer relationships can have an important influence on development in adolescence (Harter, 2012). During adolescence, there is an increase in peer intimacy, with adolescents tending to depend more on friends than families. It has been observed that positive friendships can result in improved psychological well-being in teenagers (Viner et al., 2012), and that adverse peer relations friendships can lead to problematic behaviours (Antonishak et al., 2005). Corresponding with this, it was found that peer alienation predicted self-injury in a large sample (1,153) of university students (Yurkowski et al., 2015).

Additionally, the theme of ‘Rejection’ is supported by the association between bullying and self-harm. Being a target of bullying and victimization has been associated with self-harm in community-based studies (Baldry & Winkel, 2003; Brunstein Klomek et al., 2016; Hawton et al., 2002). The majority of participants in the present study described experiencing bullying-like behaviour from others, even if they did not explicitly label it as such. Megan and Lily specifically named their experience as bullying. Participants gave descriptions of feeling like an outsider, feeling different, and feeling as though they did not belong, which their self-harm consequently exacerbated. This was often in reference to a group of people in their lives whom they felt excluded from. This resonates with a previous finding that individuals who experience less affirmation from, and a reduced sense of belonging to, their ethnic group are at greater risk for engagement in self-injury (Wester & Trepal, 2015). In their recent narrative literature review focusing on systemic factors relating to adolescent self-harm, Fortune, Cottrell and Fife (2016) recommend that “therapists should attend to issues of perceived difference and potential victimization” when working with adolescents who self-harm (p.226).

Some participants spoke about rejection and abandonment from a significant other or father figure. In this way, this study provides support to prior researchers who have claimed that abandonment and interpersonal loss are triggers for self-harm (Suyemoto, 1998; Woods, 1988). It also supports the proposed connection between the experience of insecure attachment relationships and self-harm.

Participants in the present study described feeling that their sense of who they were was invalidated by others, which appeared to lead to a rejection of themselves. They described how their emotional suffering was invalidated, which seemed to be a painful and significant experience. The founder of DBT, Marsha Linehan (1993) highlights the connection between invalidating

environments and self-harm in individuals with BPD. She states that invalidating environments play a role in the development of BPD and are detrimental to individuals who engage in self-injury. Further research is needed to investigate the potential role of rejection/invalidation in self-harm during adolescence and young adulthood.

Participants spoke of a progression from feeling rejected to finding acceptance, primarily within groups. They explained how they found a place where they felt their true selves would be accepted and validated. As limited research has been carried out on the course of repetitive self-harm and its resolution, this finding regarding the significance of acceptance provides an additional insight into the phenomenon and signifies an area for further exploration. Interestingly, evidence from a review of 10 studies, including clinical and randomised control trials, discovered group therapy to be the only therapy associated with a significant decrease in rates of repetition of self-injury (Burns, Dudley, Hazell, & Patton, 2005). This is in line with Alice's experience of a therapeutic group that she attributed to improvement in her well-being and cessation of self-harm. She explained that this was due to having a place where she experienced acceptance from others and did not feel the need to hide parts of herself. She was one of only two participants who spoke positively about therapy experiences during the period that they self-harmed.

Just as participants demonstrated how rejection from others led to rejection of the self, acceptance from others appears to have acted as an instigator in the process of accepting themselves. Participants spoke of how they have come to accept who they are and their emotional experiences, as well as accepting their past self-harm. This finding lends support to DBT and other therapies that promote self-acceptance. The key principle of DBT is to cultivate a balance between advocating change within the client while simultaneously fostering their awareness and acceptance

of themselves (Muehlenkamp, 2006). This study's finding regarding the importance of self-acceptance in self-harm resolution has implications for informing treatment plans for self-harm.

Some participants also described finding acceptance within the online community. This topic is one that is documented within the existing self-harm literature with several studies suggesting individuals who self-harm find connection, a sense of community and self-exploration/identification in online support forums (Baker & fortune, 2007; Coulson, Bullock & Rodham, 2017; Whitlock, Powers & Eckenrode, 2006). Adler and Adler (2011) make specific reference to this area in their sociological research concluding that "cyber self-injury communities" provide a context within which self-awareness can grow and personal identities can be formed. They also suggest that such arenas provide opposition to the "dominant psycho-medical discourses, giving space to people to define the meaning of this behaviour on their own terms" (p.205).

4.2.4 Relationship with the self. The theme most supported by the existing self-harm literature is 'Relationship with the self', specifically the subtheme of 'Self-hatred'. There is less direct evidence for the subtheme 'Towards self-compassion', as limited studies have been carried out involving individuals who have ceased self-harming. However, therapeutic interventions that focus on this area of self-to-self relating have been advocated in managing self-injurious behaviour. For instance, various authors have advocated the teaching of Compassion Focused Therapy (CFT; Gilbert, 2009) with those who self-harm (see Van Vliet & Kalnins, 2011), as well as the acceptance components present in DBT and Acceptance and Commitment Therapy (ACT: Hayes, 2005).

A common thread running through participants' narratives was their lack of self-worth and feelings of inadequacy during adolescence. More extreme than inadequacy, participants portrayed feelings of self-hatred, dislike, and even self-disgust during the period that they were self-harming. Their relationship towards themselves reflected this degraded opinion, with self-deprecating and

self-critical conduct amounting to psychological abuse. Adolescence is a time of increased proneness to feelings of shame and when individuals begin to engage in internal self-regulation, i.e., self-criticism or self-recognition (Gilbert & Irons, 2009).

The concept of self-hatred is thoroughly documented within the research on self-harm. “Self-hatred” and “anger at the self” were reported as the thoughts/feelings preceding almost half of all self-injurious acts in ecological momentary assessment (EMA) studies (Nock et al., 2009). Non-suicidal self-injury has been associated with negative feelings about the self, negative self-concept, self-doubt, self-hatred, feelings of worthlessness, and a sense of inadequacy (Adams et al., 2005; Sim et al., 2009; Gilbert et al., 2010; St. Germain & Hooley, 2012; Chapman & Dixon-Gordon, 2007; Xavier et al., 2016).

Self-harming behaviours have also been correlated with self-derogation (Klonsky et al., 2003) and self-criticism (Gilbert et al., 2010; St. Germain & Hooley, 2012). Individuals who self-injure report significantly more self-criticism than those who do not (Glassman, Weierich, Hooley, Deliberto, & Nock, 2007). Glassman et al. (2007) proposed that the existence of a self-punitive or self-critical demeanour may be the consequence of major depression and and/or of prior criticism or abuse from others, resulting in a learned behaviour whereby perceived flaws or failures are responded to with self-criticism and self-punishment manifesting as self-harm. A self-critical cognitive style, as reported by participants, has been shown to mediate the relationship between childhood abuse and self-injury, and to predict self-injury even when controlling for the effect of depression (Glassman et al., 2007). Furthermore, research has shown that self-criticism moderates the relationship between parental criticism and self-injury (Wedig & Nock, 2007).

St. Germain and Hooley (2012) found that having a cognitive style that inspires pronounced negative feelings towards the self was a risk factor for self-injury. They conclude that

this is because an extremely negative attitude towards the self “removes a potential barrier to self-injury” (Hooley & St. Germain, 2014b, p.302). The present study lends support to the proposed self-punishment model of self-injury (Klonsky, 2007b), which views self-injury as a representation of anger towards the self and thus as a form of punishment. Punishment of the self for perceived flaws could be described as a rejection of the self, which is clearly observed in participants’ accounts. Although significantly reduced, this self-critical feature has continued into participants’ present lives, suggesting perhaps the remnants of a once deeply ingrained cognitive style.

Participants described becoming more compassionate towards themselves over time and the association this change had with their cessation of self-harm. They depict a kinder, more accepting attitude towards themselves, with less judgement even the ability to commend and praise the self as opposed to criticising. The role of self-compassion in self-harm has been documented in the literature. Fear of self-compassion, along with external shame and a “hated self”, have all been associated with NSSI (Xavier, Gouveia, & Cunha (2016). Xavier et al. (2016) found that self-compassion moderated the relationship between depressive symptoms and self-injury. The authors concluded that self-compassion could be a protective factor, acting as a safeguard against the effect of depressive symptoms on self-injury (Xavier et al., 2016). They promote interventions that address the self-to-self relationship, as well as interpersonal difficulties. Self-talk and internal dialogue are techniques that Shaw (2006) identified within her participants’ accounts as helpful and valuable strategies in the resolution of self-injury.

Kirsten Neff (2017) describes lack of self-compassion as including “an irrational but pervasive sense of isolation – as if ‘I’ were the only person suffering or making mistakes” (Three elements of self-compassion section, para. 2). She states that, in fact, all human beings suffer and that “the very definition of being ‘human’ means that one is mortal, vulnerable and imperfect”.

She explains, therefore, that self-compassion includes appreciating that to suffer and have personal limitations is a part of “the shared human experience” (Neff, 2017, Three elements of self-compassion section, para. 2). This explanation reflects the present study’s interpretation of participants’ experiences. During the period when they self-harmed, participants described feeling alone and disliking themselves profoundly. Over time, they became more understanding and accepting of themselves and their own human suffering, allowing them to feel less alone and share themselves with others. This transformation appears to coincide with the reduction and cessation of their self-harming behaviour.

Participants additionally described engaging in less self-blame. They described how they stopped blaming themselves for their personal limitations and demonstrated greater understanding towards who they are and their actions. This reduction in self-blame appears to correspond with a reduction in shame. Gilbert (2010) states that compassion acts as an antidote to shame. Participants’ accounts, however, do portray remnants of some shame regarding their past behaviour, specifically it would seem, “external shame” – shame that arises “from what one thinks is in the minds of others about the self” (Gilbert, 1998, p.16). Gilbert proposes two types of shame that are undoubtedly connected. These are external shame as described above, and internal shame, which relates to negative shameful perceptions and feelings towards oneself. Gilbert’s conceptualisation might explain participants’ depictions of an improvement in their overall experience of how they feel about themselves, yet retaining an element of shame regarding their self-harm in relation to others. They are “not ashamed” (Y:27:22) of their self-harm, yet they do experience some external shame.

Another domain of self-compassion that surfaced was the acceptance of one’s emotions. Participants described learning to acknowledge and accept their own limitations and negative

emotions, letting themselves feel sadness and even self-soothe. This represents another element of self-compassion described by Neff (2017): “the willingness to observe our negative thoughts and emotions with openness and clarity, so that they are held in mindful awareness”, i.e., relating to our emotional experiences without judgement and allowing them to exist, as opposed to trying to suppress, reject, or fight them (Three elements of self-compassion section, para. 3). Research has shown that individuals who had ceased self-harming displayed significantly greater acceptance of their emotions and significantly better ability at controlling impulses compared to those who were still self-harming (Anderson & Crowther, 2012). Researchers have suggested that acceptance-based interventions that help individuals become aware of and accept their emotions, so that emotions are approached and tolerated rather than avoided, may be important in the treatment of self-injury (Gratz, 2007; Nock et al., 2006). The findings of the present study support this notion.

The analysis revealed participants’ portrayals of their experiences of self-harm as, in some way, a process of “self-knowing” (Y:20:23). They described an increase in self-awareness and how they transitioned from not knowing who they were to becoming clearer about themselves. This finding corroborates the role of identity processes in self-harm as suggested by other researchers (Breen et al., 2012; Claes et al., 2014). According to Erikson, identity formation in adolescence is a crucial psychosocial developmental process that involves the resolution of identity confusion and identity synthesis (Erikson, 1968). Identity synthesis involves the reformation of childhood identifications into a cohesive self-representation that includes values, ideas, and goals. Identity confusion, conversely, represents the inability to resolve conflicting self-representations and thus form a stable, secure, self-definition (Schwartz, 2001).

There is increasing evidence to suggest that self-harm may be linked to disturbances in identity formation. Claes and colleagues (2014) found that self-injury is positively associated with identity confusion and negatively associated with identity synthesis in adolescents (using a sample of 532 U.S. high school students). Luyckx et al. (2015) also observed similar results in an adolescent sample of 568 high school students. Lear and Pepper (2006) found that “identity instability” (i.e., confusion) was a factor that impacted the relationship between emotional dysregulation and self-injury severity. They concluded that their findings emphasise the importance of “self-concept clarity” (a measure of identity stability) in the presentation of self-injury. Breen and colleagues (2013) conducted a qualitative analysis of 52 websites with online narratives of adolescents engaging in self-harm. They concluded that adolescents may use self-harm as a way of counteracting a loss of self, and that self-harm may provide “a basic sense of a coherent self who persists across time” (20, p.60).

Erikson (1968) asserted that identity confusion “may lead to isolation or at best to only formalized and stereotyped relationships”, which connects to participants’ accounts of perceived social isolation (p.52). As identity begins to form, new identities may not align with those endorsed by peer groups, leading to an internal conflict between companionship and personal development (Kiuru et al., 2010).

Participants’ descriptions of experiencing not knowing who they were, as well as connecting the process of knowing oneself with the recovery from self-harm, gives some support to the notion that self-harm is used to establish the boundaries of the self by marking the skin, thus separating individuals from both their environment and other people (see Klonsky, 2007b). Perhaps as participants began to know themselves better, define their identity, and see themselves

independent of others around them, they no longer felt the need to mark the boundaries of their 'self'.

4.2.5 Autonomy. Participants reported experiences of feeling a lack of autonomy, control, and choice. This sense of powerlessness echoes previous research that has found an association between depression and poor mental health, and experiences of subordination and entrapment (Gilbert & Sanghera, 2004; Gilbert & Allan, 1998). Additionally, self-harm is particularly common in prison populations (Dixon-Gordon et al., 2012), lending support to the potential role of disempowerment and lack of life control and choice in self-harm.

Hoffman and Kress (2008), in their paper advocating narrative therapy for NSSI, remark on disempowerment of the client as a limitation of traditional treatment approaches for self-harm, whereby the therapist frequently assumes the role of expert. Johnson (1997) argues that the philosophy of the medical psychiatric approach has the potential to invalidate the feelings of the individual who self-harms and overlook the personal meaning behind the acts of harm. He notes that individuals who self-harm likely experience high levels of invalidation from themselves as well as others, which may in actuality be a contributing factor to their self-harm. It has been suggested that creating an “environment in which self-expression and individualism is accepted and encouraged may help to decrease the prevalence of self-mutilation” (Zila & Kiselica, 2001, p.52). Hoffman and Kress (2008) advocate “externalizing the problem and internalizing personal agency” (p.157). The present study supports adopting this approach in the treatment of adolescents who self-harm.

The emergence of the subtheme ‘Gaining independence’, which captures participants’ accounts of gaining greater independence with age and linking this with their reduction in self-harm, indirectly supports the proposal that self-harm resolves spontaneously with age as young

people become more independent (Hawton & O'Connor, 2012). Hawton and O'Connor (2012) suggest this may be due to the decreasing impact of family problems. Participants in the present study attributed their transformation to discovering a sense of autonomy, responsibility, and choice over their lives. However, there was the implication that this was connected with detachment from the family system and the issues associated with it, such as authority and expectations. Family dynamics inevitably play a role in an adolescent's sense of autonomy and their struggles between dependence and independence, and thus perhaps both factors are implicated in the cessation process.

The theme of 'Autonomy' relates to literature regarding the process of separation-individuation in adolescence. Blos (1967) postulated that in addition to the initial process in infancy, a further process of separation-individuation occurs in adolescence, whereby individuals disengage from internal, childhood representations of parents as omnipotent authoritative figures. Freud (1905) asserted that this detachment from parental authority was an important, but also painful psychic experience of adolescence. Blos (1967) and others explain the process as a lessening of dependence on parents and increased autonomy. Adolescents' capability for independent self-regulation increases, and they become prepared to take responsibility for themselves and their actions. This is necessary in order for them to develop a true sense of individuality and more sophisticated relationships with parental figures and others (Erikson, 1968; Smollar & Youniss, 1989). Contemporary literature also regards separation-individuation as involving the interaction between the endeavour for self-definition and interpersonal relatedness (Allison & Sabatelli, 1988). That is, the need to determine a clear, differentiated, secure, genuine, and positive sense of self, as well as the need to establish intimate, stable, supportive and protective relationships (Blatt & Blass, 1996;). Individuation can be a difficult process due to the competing

needs for both separateness and closeness (Reis & Buhl, 2008). In Erikson's stages of development, identity cohesion precedes/is followed by intimacy.

The concept of the process of separation-individuation in adolescence appears to reflect the present study's participant accounts of becoming more independent and responsible for the self, and of knowing oneself. Interestingly, this process is depicted as happening alongside the cessation of self-harm. Participants' experiences of dependency confusion, isolation, and social exclusion during the period that they engaged in self-harm suggests difficulties within this process. Although no known research has been conducted on separation-individuation and self-harm, it has been observed that adolescents who have attempted suicide, frequently appear to be involved in a struggle for parental separation (Orbach, 2007).

Taken together, the present study's themes complement the research conducted by Kool et al. (2009), who investigated the process of, and the factors that contribute to, cessation of self-harm. They identified six stages in the recovery process. The stages of "increase in self-esteem," "increase in self-understanding," and "increase in autonomy," (which was followed by the stopping of the physical behaviour of self-harm) resonate with the present study's findings. The present study offers further insight with regard to the difficulties related to self-harm and thus why these processes might be significant, as well as highlighting the important dimensions of acceptance and self-compassion in 'recovery'. It should be noted that Kool et al. conducted their study with participants who were receiving treatment.

4.3. Evaluation of the Study

The study achieved its aim of exploring the lived experience of repetitive self-harm for individuals who began self-harming in adolescence and subsequently stopped with age. The

themes produced were rich, meaningful, and illuminating, and helped gain deeper insight into the participants' lives and how they understand their experiences of self-harm. As opposed to assessing validity and reliability, this research endeavoured to meet Yardley's (2000) four principles used to assess the "quality" of qualitative research (see discussion in Methodology chapter). By closely following these principles, the study is considered to have produced a sufficient quality of data. However, it is important to note the limitations of this research and of IPA as a methodology.

4.3.1 Methodological critique.

4.3.1.1 The sample. This study carried out a systematic and rigorous analysis of particular aspects of experience, aiming to capture in detail the understandings and perceptions of this group of individuals (Smith, Flowers, & Larkin, 2009). The willingness, openness, and courage of the participants led to the generation of rich data quality, regardless of the study's relatively small sample size. Ensuring a thorough and in-depth analysis of each transcript meant that quality was not sacrificed. However, due to this idiographic nature of IPA, limitations to this study do exist. Inescapably, striving for depth comes at the cost of obtaining breadth. Thus, whilst the sample was small and homogeneous (the necessary components for detailed, in-depth exploration and analysis of experiences), the study is unable to afford generalizability, i.e., the findings of this study cannot be taken as representative of the entire population of young people who engage in repetitive self-harm during adolescence and then stop.

To improve generalizability in future, a similar research project could be undertaken in numerous cohorts of young people in varying social, educational, ethnic, and economic contexts, so as to investigate the common and differing aspects of their experiences. This would provide a deeper comprehension of the phenomenon as experienced by different groups of individuals, thus

bring us closer to ‘the universal’. However, by continuing to use in-depth qualitative research, a focus on ‘the particular’ would be maintained. Gaining an idea of the shared and divergent experiences within a broader demographic could nonetheless provide a more solid foundation on which to base more general assertions concerning the experience of self-harm amongst those who began self-harming during adolescence.

Furthermore, with regards to the sample, it is necessary to note that some individuals who were invited to take part in the study did not participate. The reasons for this are unknown, but perhaps a busy schedule, apprehension about the procedure or apprehension of openly discussing a sensitive personal topic, may all have been possible factors. Perhaps their accounts would have revealed different prominent experiential features, giving rise to a different collection of themes.

4.3.1.1.1 Homogeneity. According to Smith et al. (2009), a reasonably homogenous sample is required for IPA. The sample in this study was homogenous with regards to the shared experience of self-harm during adolescence, however, participants displayed heterogeneity in many other ways, e.g., their ages, where they grew up, their cultural backgrounds, the length of time since they last self-harmed, and the duration of their self-harm. Despite these differences, the overall aspects of individuals’ self-harm were relatively similar: all participants engaged predominately in self-cutting, all participants began self-harming during adolescence at ages within five years of each other (13-17 years), the period of self-harming was of a similar duration, and all began to stop engaging in repetitive self-harm around the end of adolescence (age 18 years). In addition, all participants were of similar age, between 22-30 years.

Additionally, it is worth considering the homogeneity that existed in the sample that was not intentional or made explicit. The study might have appealed to a certain type of person, such as someone with an interest in the area of self-harm for reasons other than personal. For example,

two participants worked in, or hoped to work in, a mental health setting and another was studying social work. It is interesting to consider what other factors may have drawn participants to the study – it could be suggested that, given many of the participants had not spoken about their experiences of self-harm previously, perhaps they held a heightened desire to share. Additionally, the data suggested some participants had a motivation of reducing stigma, as seen in other self-harm research (Cello & YoungMinds, 2012), perhaps suggesting a bias towards those who experienced stigma.

4.3.1.1.2 Students. All participants (except two) were students, although not all from the same institution and at different levels of study. All participants had attended university, making the research findings specific to a certain demographic. Future research, as suggested above, could widen this demographic. With regards to recruitment bias, individuals who have conducted their own research for their degrees, or are required to, might be more motivated to participate in the university research of others.

4.3.1.1.3 Gender. As the vast majority of research related to this topic has been conducted with female participants, interventions influenced by such research could be ineffective for men. Whilst recruitment might be more challenging, it may be important to replicate this study with male participants. A comparison between the experiences of men and women could then be made. Additionally, a study conducted on a larger scale across a range of demographics, as described above, could deliver access to a broader range of experiences including those of men, thus compensating for such limitations.

4.3.1.1.4 Therapeutic history. Some participants had received psychotherapy during their lives following the cessation of self-harm. It is suggested that this could impact their understanding of their experience. The participants' focus on personal development could be attributed, in some

part, to this history. To the researcher, it was noticeable from the interviews which participants had received psychotherapy, and thus the therapeutic history of the participants is deemed as having at least a slight impact on the analytic findings. Future research could explore comparisons between individuals who have received therapy and those who have not.

4.3.1.2 Interview technique. The utilisation of semi-structured interviews was perceived to be a suitable method for collecting data. I consider that, by experiencing the participants first-hand as individual people, I was able to enhance the quality and detail of the analysis. The richness of the themes would have been lost had I not met participants in person, and I deem that we developed a good rapport during the interviews. Participants, although clearly experiencing some difficult emotions, were observed to be comfortable and forthcoming about their experiences on the whole. I consider that the empathy and compassion I demonstrated, derived from my skills as a counselling psychologist, aided the participants in being able to express themselves, which I consider a strength of the study.

Conversely, one limitation of the interview technique also derived from my role as a practitioner. I found that, as I was used to paraphrasing as a way of conveying a deep level of empathy and understanding, I tended to do this during the first couple interviews. This paraphrasing could to some extent have been leading, and might have influenced participants' responses. IPA calls for researchers to limit their influence during the interview process and for questions to remain open rather than directive, with researchers resisting the urge to interpret while the interview is in progress (Smith et al., 2009). I inhibited this tendency in future interviews. In addition, when listening to and analysing the texts, I ensured I took note and became aware of my input in the transcript and considered any impact I might have had on participant responses. I especially considered words I had used and whether this was a repetition of a participant's word

or my own vocabulary. I thus tried to account for any influence I may have had in the data that was produced. However, as mentioned in the Methodology chapter, the interviews were considered a co-construction by both interviewer and interviewee, and thus there are certain limits to curtailing the researcher's influence on the data.

The interviews were very open-ended so as to be directed by the participant rather than preconceived ideas (this was deemed necessary due to the lack of prior research in the area). However, this meant that the range of experiences was fairly broad. Following this research, future studies could focus on one particular aspect of the repetitive self-harm experience, such as the experience of the self/relationship with the self, in order to gain deeper insight into a particular aspect of the phenomenon.

4.3.1.3 Limitations of the IPA method. Willig (2013) highlights a limitation of IPA methodology stemming from its reliance on language and its demand for the sophisticated use of language by participants. The interpretative findings are restricted by the participants' capability to articulate their inner workings and experiences (Brocki & Wearden, 2006). Willig (2013) deduces that people who are not as skilled/capable in articulating their inner sensations, feelings, and thoughts may be unable to communicate the full scope and quality of their experience. In my role as a trainee counselling psychologist I frequently work with individuals who find it difficult to articulate and/or construct their experiences. This may be due in part to their not having made sense of the experience themselves, and thus part of the therapeutic process involves doing so. This would imply that those who have had therapy may be better equipped to share their experiences. However, I also believe it is sometimes not within certain individuals' capacity to

fully express themselves with words; other methods may be necessary. In addition, differences are seen in the capability for emotional expression across different cultures.

Moreover, Willig (2013) argues that IPA operates on the assumption that language does, in fact, equip individuals with the means to describe and adequately express their true lived experience. There is the argument that the ‘embodied experience’ of participants is not captured in IPA. During the present study, effort was made to take into account body language and the unspoken properties of the interview. These were noted by myself and taken into consideration when analysing the data and producing the findings. More structured techniques of including these aspects would be a helpful addition to the IPA method, especially due to the importance of the body in an experience such as self-harm.

4.3.2 The issue of time. This study explores participants’ present understanding of their experiences. The idea of time and our reality of being in the world over time is a topic that requires consideration when evaluating this research. Our experience of the world is constantly changing day-by-day and moment-to-moment, which is evidenced through participants’ references to how they formerly experienced their self-harm and to how they experience it now. This points to a limitation intrinsic in the present study: the findings are only illustrative of these individuals’ sense-making of their experiences at this specific point in time. This in no way detracts from the significance of the findings or their representation of this sample of individuals at this time, however, it does draw attention to the reality that, had they been asked about their experiences of self-harm a number of years ago, or if they were to be asked again in the future, their understanding of their experience of self-harm might be very different. Consequently, I advocate the undertaking of longitudinal studies, which could locate changes across an individual’s lifespan, thus providing

a more complete understanding of the progression of repetitive self-harm that begins in adolescence and stops with maturity.

4.4 Reflexivity

As a concerted effort was made to adopt the essence of IPA, my role in the research was acknowledged and reflected upon. I attempted to maintain a level of openness and take into consideration the reality of my role as researcher, as well as remain dedicated to the participants' experiential worlds. See Appendix J and the Methodology chapter for personal reflections on my impact on the research process and findings, as well as my reflections on the analytic process.

4.5. Future Research

A large-scale study examining different demographics and both genders would add to the findings of this study. Additionally, it might be worthwhile to replicate the study with individuals who have stopped self-harming more recently, thus getting closer to the experience. Furthermore, longitudinal studies tracking individuals' experiences over time thus providing a deeper appreciation of the behaviour as a whole, rather than at just one point in time, could be carried out. This could provide more focused insight into the experience of stopping self-harm behaviour. Another line of enquiry could be via a narrative methodology, exploring how individuals talk about self-harm in the context of their life stories.

Furthermore, themes emerged in the present study that might warrant further exploration, for instance, the relationship with the self and the shift in this domain. In a similar vein, the relationship of self-harm in adolescence and identity would be a worthwhile area to explore in more detail, especially in light of its relatively limited understanding within the existing literature.

Likewise, the significance of rejection and its impact in relation to self-harm, as well as the finding of acceptance and its relation to the cessation of self-harm, would be another potential avenue for investigation. Given the seeming importance of acceptance within groups, future research could evaluate the efficacy of group therapy for those who self-harm. In addition, the struggle between dependence and independence and the role of autonomy in self-harm during adolescence could be explored in further detail. All of these areas, to my knowledge, are yet to be explored in specific detail.

The findings of the study highlight responses from others as a notable feature of individuals' experiences, with a number of participants depicting experiences of undesired responses to self-harm, as well as insinuating that the help they received at the time (including therapeutic help) was unhelpful. Thus, research that explores, in detail, the experiences of therapy for individuals who engage in self-harm during adolescence, and that potentially identifies factors that are helpful/unhelpful would be beneficial. Such research would have direct implications on therapeutic practice and interventions.

Although IPA is able to produce rich accounts of participants' experience, it does not have the capacity to endeavour to explain the experience (Willig, 2008). This could potentially limit the use of the present study's findings and its impact on informing clinical practice. McCarthy-Jones, Marriott, Knowles, Rowse and Thompson (2013) have proposed that this limitation might be overcome via a meta-synthesis of studies, where findings from separate qualitative studies are integrated. They contend that, in doing this, combined overarching themes would transpire, imparting novel information that could be applied for practical use. This methodology could avoid potential neglect of numerous small-scale qualitative studies.

4.6 Clinical Implications

There is currently no “gold standard” treatment for self-harm, with a lack of empirical evidence for psychological interventions (Stanley, Fineran, & Brodsky, 2014). Current NICE guidelines (2013) recommend considering offering 3-12 psychological sessions that are “specifically structured for people who self-harm, with the aim of reducing self-harm”. This seems relatively vague. Again, we see a focus on the act and behavioural symptom rather than the person and their emotional experience. These guidelines contradict the findings of the present study and previous research, which state that cessation appears to occur when other issues that are contributing to the individuals’ distress are resolved. The guidelines further state that interventions should be tailored to individual needs, and suggest including cognitive-behavioural, psychodynamic, or problem-solving elements. The findings of this study have certain implications for treatment interventions for self-harm and the practice of counselling psychology specifically. These are outlined below.

The various findings of this study could inform treatment in a number of ways. First, the focus on the relationship with the self, highlighted in the findings, promotes an emphasis on this relationship in therapeutic interventions. The results of this study advocate the use of therapies, or therapeutic techniques that focus on and teach self-compassion when working with clients who self-harm as an antidote to their self-criticism, such as CFT (Gilbert, 2009).

Additionally, this study’s findings suggest it would be useful for clinicians to be mindful of the relevance of identity processes in relation to self-harm during adolescence and appreciate the loss of self potentially experienced by adolescents who self-harm. Counselling psychologists, in particular, might consider ways in which they are able to facilitate the individual’s self-awareness and the strengthening of identity.

The participants' accounts of becoming more accepting of their emotional states over time, thus implying prior experiential avoidance, could indicate the use of techniques designed to improve the relationship with one's emotions as part of therapy with individuals who self-harm. This might include, for example, integrating techniques from ACT (Hayes, 2005). More research is needed in order to better determine the association between experiential avoidance and self-harm, and establish an evidence base for therapeutic techniques that teach acceptance of emotions.

The analysis revealed that self-harm appears to be very private and unique to the individual, which is in line with previous findings. This has implications for the importance of tailoring therapy to the individual client. Counselling psychologists as practitioners trained in integration are suitably equipped for this. This study informs practitioners of the potentially intensely private nature of their client's self-harm and their reluctance to share, and illuminates possible reasons for this.

4.6.1 Approach to self-harm. Participants conveyed feeling that their distress and difficulties were not adequately addressed and that they did not experience suitable or helpful responses, leading to the continuation of feeling invalidated and thus rejecting themselves. The specific details of what individuals found helpful and unhelpful in responses to their self-harm could be enlightening for counselling psychologists and other professionals working with this client group, as well as for friends and family members.

4.6.2 Awareness of invalidation and shame. Feeling invalidated by others, including helping professionals, in a variety of ways was a theme throughout the participants' accounts. This has also been observed in prior research. This highlights the importance for clinicians of ensuring validation of their client's experiences, including their suffering and the meaning of their self-harm, rather than purely focusing on why the individual self-harms and stopping the behaviour.

Counselling psychologists acknowledge the “importance of clinical diagnosis and trajectories of mental illness”, but also aim to “consider these in relation to the whole person from a positive psychological and strengths-based perspective” (Suzuki, Onoue, Fukui, & Ezrapour, 2012, p.167). Thus, counselling psychology could have much to offer the adolescent who self-harms.

This study’s findings also suggest how clinicians should be aware of potentially working with shame and a hidden self with this client group, and the therapist’s potential for contributing to or maintaining this shame. This research also highlights the potential shame experienced by those who formerly self-harmed, which is an important consideration when working with individuals with a history of self-harm.

4.6.3 The potential role of group therapy. This study highlights the potential importance of group therapy for self-harm treatment. The participants’ portrayals of lacking a sense of belonging but later finding acceptance within a group seemed important with regards to their recovery. One participant specifically related her recovery to attending a therapeutic group. This study thus has implications for the application of group therapy for adolescents who self-harm. Future research is needed in this area – potentially the implementation of therapeutic trials. Investigation into this area seems particularly pertinent given that there is no current treatment of choice for self-harm in young people.

4.6.4 Methods to increase autonomy. The results of the present study suggest that exploring ways to increase a sense of autonomy in adolescents could be useful in interventions for, or the prevention of, self-harming behaviour. Socio-psychological interventions could be used to increase independence and a sense of control over their lives, for example, discovering new activities outside of school and home life and/or taking on individual responsibilities for the self. The reported struggle and confusion between dependence and independence, as well as the

confusing or overbearing expectations of parents, highlights the potential use of family or systemic therapy in addressing self-harm during adolescence.

4.6.5 Access to services: expanding the conversation. The isolation depicted by the participants in this study has implications for the access to services for those who self-harm, including their path to obtaining help. Participants spoke of how self-harm was something that was not spoken about by others in public, in school, or even by those who formerly self-harmed, perpetuating the idea that it is a source of shame. This suggests that self-harm is a stigmatized and unspoken subject within society. Expanding the conversation about self-harm, and finding ways to encourage people to speak about it, may go some way to help reduce the stigma and shame felt by those who hurt or have hurt themselves.

4.7 Conclusion

As far as I know, no qualitative research has investigated the particular lived experiences of self-harm from the perspective of young people who began self-harming in adolescence and subsequently stopped. Existing self-harm literature is predominantly comprised of quantitative studies that assume a fairly realist standpoint and are possibly directed more by the hypotheses of the researcher than focused on identifying what is significant for the participant. The present study intended to redress this imbalance by endeavouring to investigate the lived experience of the individual participant. Overall, a high quality of data was obtained and enlightening themes were discovered. The findings support the current literature on self-harm, including a range of the conceptualisations/models. They also contribute to the existing literature by providing in-depth, detailed, thought-provoking insights, allowing readers better proximity to particular facets of the lived experience of repetitive self-harm that begins in adolescence, as well as highlighting relevant

areas for important future research. One interesting finding was that the experiences of participants appear to represent a journey from negative self-evaluation and rejection to self-compassion and self-acceptance, as well as from a lack of autonomy to independence.

The results of the study cannot be generalized to the wider population. Nevertheless, the findings have implications for interventions with adolescents who self-harm, as well as providing insight for clinicians and anyone else who may come into contact with those who have experienced self-harm. Participants' accounts highlighted experiences of rejection and stigmatization, and indicated that resolution of their behaviour was dependent on finding validating relationships within which they felt understood and accepted for their true and whole selves. Counselling psychology's emphasis on individual experience, the importance and legitimacy of individual meaning and sense-making, and its focus on the importance of the therapeutic relationship, suggest that counselling psychologists might have much to offer adolescents and young people who are engaging in, or have engaged in, repetitive self-harm

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Appendices

Appendix A: Recruitment Poster



CITY UNIVERSITY
LONDON

Department of Psychology

***Did you self harm during adolescence but
have since stopped?***

***Would you be willing to share your
experience to help improve understanding?***

We are looking for volunteers to take part in a study on
past self harm.

Your participation would involve an informal interview lasting
approximately 50 minutes in which you will have the opportunity to share your
experience.

The process is completely **confidential**.
You must 18 years or older to take part.

As I know life can be busy, payment for your participation will be £15.

If you would like to be involved or wish to know more please contact me,
Emma Punter, at [REDACTED] or on [REDACTED]

This research is part of a doctorate in Counselling Psychology at City University. It is being supervised by
Dr Susan Strauss, Counselling Psychologist: Tel: [REDACTED] Email: [REDACTED]

This study has been reviewed by, and received ethics clearance through the Psychology Department
Research Ethics Committee, City University London. Ethics approval number [PSYETH (P/F) 14/15 250]
If you would like to complain about any aspect of the study, please contact the Secretary to the University's
Senate Research Ethics Committee on [REDACTED] or via email: [REDACTED]

Appendix B: Interview Schedule

- ***What has been your experience of self-harm?***
 - *Can you tell me more about that?*
 - *What was that like?*
 - *What was going on at the time for you?*

- ***When did you stop self-harming? Can you tell me more about that?***
 - *What was that like...?*

- ***What changed?***

- ***How did you make sense of your self-injury at the time?***

- ***How do you make sense of your experience of self-injury now?***

- ***How do you feel about your experience of self-injury?***
 - *What, if any, emotions come up for you when thinking about it?*

- ***Can you tell me about any affects you consider engaging in self injury has had on you?***
 - *Does it influence who you are now, if so how?*

Appendix C: Information sheet



PARTICIPANT INFORMATION SHEET

Title of study: *Experiences of individuals with a history of adolescent self-harm*

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

My name is Emma Punter and as part of my training in counselling psychology at City University, London I am carrying out research exploring the stories people create about their lives.

What is the purpose of this research?

This research aims to explore the experience of individuals who used to engage in self harming behaviour during adolescence but have since stopped. I am interested in how they understand their experiences and how they experience themselves in the present.

Do I have to take part?

Participation in this research is completely voluntary, and you may decide to withdraw at any time, without any consequences. Just let me know at the time that you wish to do this.

What is involved?

You will be asked to sign a Consent Form indicating that your participation is voluntary and that you understand your rights. You will then be interviewed about your experiences. The interview will take place at a location agreed beforehand, and will take approx. 1 hour.

Will what I tell you be confidential?

Yes. The interview will be taped, and listened to only by me, or an examiner if requested. Names and identifying information will be removed. The only time I would have to break this confidentiality is if you disclosed that you were planning to commit an illegal act or one that endangers yourself or another person, which I will discuss with you before we start.

Do I have to answer questions I do not want to answer?

No. It is up to you whether you wish to answer the questions. Mostly it will be you directing what you wish to talk about rather than me asking questions.

What if I find the interview difficult or distressing?

If you find it uncomfortable or difficult to talk about certain things in the interview at any time, please let me know. A list of confidential support services will be given to you after.

What if, during the interview, I want to stop/ I no longer want to take part?

You may request to stop at any time during the interview. As stated above, you may withdraw at any stage of the project- just let me know.

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: *Experiences of individuals with a history of adolescent self-harm*

You could also write to the Secretary at:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?

This study has been approved by City University London Psychology Research Ethics Committee, [14/15 250].

Further information and contact details

If you have any questions or would like any further information about this research, please contact me at [REDACTED], or my research supervisor, Dr Susan Strauss at [REDACTED].

Thank you for taking the time to read this information sheet.

Appendix D: Consent Form



Title of Study: ***Experiences of individuals with a history of adolescent self-harm***

Ethics approval number: [14/15 250]

Please initial box

<p>I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records.</p> <p>I understand this will involve:</p> <ul style="list-style-type: none"> • being interviewed by the researcher • allowing the interview to be videotaped/audiotaped • making myself available for a further interview should that be required • Giving feedback on the research analysis/findings 	
<p>This information will be held and processed for the purpose of answering the research question of this project.</p> <p>I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.</p> <p>AND</p>	

	<p>I understand that I will be given a transcript of data concerning me for my approval before it is included in the write-up of the research.</p>	
	<p>I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.</p>	
	<p>I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.</p>	
	<p>I agree to take part in the above study.</p>	

Name of Researcher

Signature

Date

Name of Participant

Signature

Date

Experiences of individuals with a history of adolescent self-harm

DEBRIEF INFORMATION

Thank you for taking part in this study. Now that it's finished we'd like to explain the rationale behind the work.

The interview in which you participated was designed to explore your experience as someone who used to self-harm. In particular, I was interested in how you understand your experiences currently and your experiences of stopping self-harm.

It is hoped that this research will add depth to the existing knowledge on self-injury, specifically in adolescence. In particular how self-harm is made sense of by the individual retrospectively. A secondary aim is to encourage the overall discussion of self-harm, as it is currently a topic that people tend to shy away from discussing.

By adding to the body of research on self-injurious behaviour in adolescence, it is hoped that this research may help health professionals better understand individuals experience thus aiding them in the care they can provide.

Please let me know if:

- You have any other questions about this research and what it hopes to achieve.
- There is anything that you would like to add to what we discussed during the interview?
- There was anything that you found particularly helpful or unhelpful about the interview?

If anything discussed in this interview has led you to feel any distress, please see the sheet attached for organisations that may be able to offer help and support. These include counselling and support services, and services specifically for self-harm. If taking part in this study has caused you to be worried about potential relapse to past behaviours then please do contact your GP for access to appropriate support.

We hope you found the study interesting. If you have any other questions please do not hesitate to contact us at the following:

Emma Punter, [REDACTED]

Supervisor: Susan Strauss, [REDACTED]

Ethics approval code: 14/15 250

Resources

Samaritans

0845 790 9090

www.samaritans.org

24hr phone service offering emotional support.

MIND

0845 766 0163

www.mind.org.uk

Provides information, advice & publications on all aspects of mental health, and local counselling services in many areas.

Mind Infoline

0300 123 3393

info@mind.org.uk

Text: 86463

Provides information on a range of topics including: types of mental health problem, where to get help and medication and alternative treatments. They will look for details of help and support in your own area. Their lines are open 9am to 6pm, Monday to Friday (except for bank holidays).

Self Injury Support

<http://www.selfinjurysupport.org.uk>

Provides information on support groups in your local area.

Appendix F: Transcript Analysis

Talking about emotions didn't come naturally

1 very naturally to me amongst my friends and my family and
2 stuff.

3 Emma: Mmhmm.

4 Megan: I suppose. — considering. uncertain. (tentative?)

5 Emma: Mmhmm. Mmhmm. So, what was that like, not- not
6 expressing your emotions? At times.

7 Megan: Um, I don't know. It was just, it makes you feel quite
8 separate a lot of the time.

9 Emma: Mmhmm.

10 Megan: Um, and not being able to express your emotions. . . I- there
11 never seemed to be quite the right outlet. Like I'd try. . .

12 Emma: Yeah.

13 Megan: . . . to do things like write a diary, but it never came out
14 right. I didn't seem- when I wrote it it didn't seem, kind of,
15 a bit lame. — self derogatory deprecating language

16 Emma: Mmhmm.

17 Megan: . . . writing it all down, it seemed a bit. . .

18 Emma: Mmhmm.

19 Megan: . . . naff writing it like that.

20 Emma: Mmhmm.

21 Megan: And talking to my friends sometimes – I don't know – it felt
22 like sometimes it was coming out in, sort of, platitudes, like, I
23 was saying, like, oh it's really hard to express your feelings
24 and stuff, but it wasn't. . . I felt a bit detached from it when I
25 was saying those things.

26 Emma: Mmhmm.

27 Megan: Yeah.

28 Emma: Mmhmm. So, how long did, eh, did you self-harm for? How
29 long did that last?

30 Megan: Um, most of the self-harm was probably between 12 and 16,
31 primarily. But then I, kind of, continued to do it until I was
32 maybe 20 . . .

33 Emma: Mmhmm.

explaining and talking about emotions hasn't come naturally to me

separate (different) identity. self.

repetition of word express

repetition of outlet

tried writing diary idea of 'right' way Bored and white thinking.

Self deprecating

derogatory lang towards self

confused. nonsensical?

shallow unifying wisdom over a difficult topic

difficult to understand fully

really hard to express.

difficult to understand fully too general and overused explanations

between ages 12-16 and then tapered off

5

521 Emma: Mmm. Mmhmm. journey: recovery'

522 Alice: ... and either were ahead of me, in terms of progress - they had
 523 stopped or were stopping and they would- and, yeah, still they
 524 were- had jobs or, you know... saw of others progression

Journey

525 Emma: Mmhmm. saw that they moved on. succeeded.

526 Alice: ... they had what I would, in my eyes, see as like a happy or
 527 successful life. - others a point of reference = helpful

528 Emma: Yeah. Yeah.

529 Alice: When, at the time it feels like nothing will ever be OK and... - no hope at the time

530 Emma: Mmm.

531 Alice: ... you'll never be happy... never be happy. - hopeless 'nothing' - finite (all or nothing)

532 Emma: Mmm.

533 Alice: ... and you'll never do anything in life... repetition of never - very final. doom.

534 Emma: Mmhmm.

Judgement from others

535 Alice: ... and there was just no judgement there. - no judgement in the group (compared to other places, eg school)

536 Emma: Mmm. Mmm.

537 Alice: There was just understanding. They did- they didn't, you know, it
 538 wasn't - you have to stop. Obviously there were rules around, um,
 539 the sessions. understanding validation

540 Emma: Yeah. some containment interpersonal relationships

541 Alice: Um, but it, yo- you were there to just sort of talk- talk about it but
 542 also do some therapy together. Activities like craft... talk about it and do therapy communication

543 Emma: Mmhm. part of group - belonging art cap/an-expression

544 Alice: And then there was also a buddy system in place... belonging.

545 Emma: Mmm. Mmm.

546 Alice: ... between each group session. well supported.

547 Emma: Sounds great.

548 Alice: So, it was from then- then, um, where, uh, when I met up with this
 549 group. That was when things really even started to get better. things started to get better and meaning group

550 Emma: Mmm. So t- tell me, you said this non-judgement - can you tell me
 551 more about that?

552 Alice: It's really hard to talk to someone who hasn't self-harmed. getting better linked with acceptance within a group.

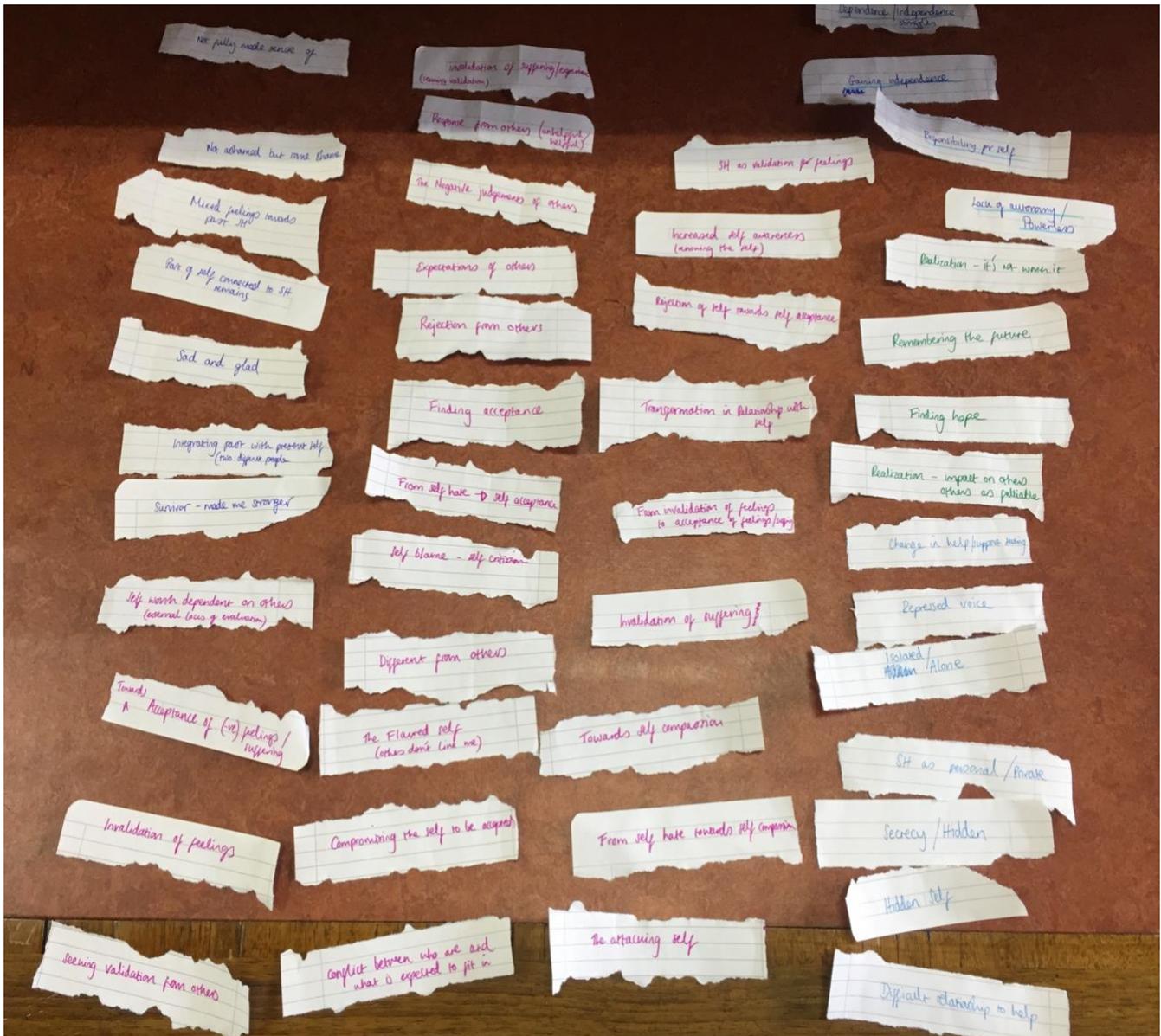
Difficult to talk to others

17 hard to talk to someone who hasn't self harmed relatedness

Appendix G: Emergent Themes

<u>Megan Themes</u>	
Mind - Body relationship	Unbearable
Transition period - child to teen/adult	<u>Ambivalence towards ST (mixed news)</u>
Bullying	self critical
Judgemental others	Awareness of -ve stigma
<u>Different - set apart</u>	<u>Annoyed at self</u>
Not talking to others/adults	Didn't harm self 'properly'
No outlet for talking	Either Normal or Abnormal, no inbetween
Secrecy	Not enough (self)
<u>Shame</u> . Body shame.	My ST not serious enough
Something wrong with self *	<u>Unease / shame</u>
Am I child or adult? .	Lack of compassion for self
Couldn't explain emotions (difficulty expressing emotions?)	<u>Shame</u> at past ST / self that can't cope self that can't cope / manage
Talking about emotions difficult - not natural	Not totally made sense of - unsure
Separate	Dissatisfied in self * -
<u>self deprecating</u>	Not good at coping *
ST difficult to understand fully	self deprecating *
ST as a way to remove self from	Continuation of flawed self *
	ST as <u>private / unique to self</u>
	Lack of compassion for younger self
	<u>ST as individual</u>

Appendix H: Grouping of Themes



Appendix I: Collating of quotes

Isolation

Megan

-Hidden self

4.6 And I remember for like a whole year I didn't tell my mum [re period].

4.25 Just that feeling of not having an outlet for talking about stuff. I haven't felt like explaining my emotions has come very naturally to me...

5.7 It was just, it makes you feel quite separate a lot of the time.

17.25 Um not many people knew about me self-harming and certainly no one ever discussed it out of like people my age. Like my mum and dad knew. Um but it was never spoken about between my friends...like I said some of them self-harmed as well and we never really talked about it.

19.14 Because I was very, very sad... I just think how alone I felt... I guess I just remember a lot of, kind of, hiding

26.31 Like when I was at school I was all fun and light and stuff. And I supposed that's the person that they fancied. Then actually like they'd come round to my house or wed talk and I'd be all somber like... I don't know, depressing.

- Relationship to help

23.14 Like it was never said at school about anything. And actually no one ever asked, no.

24.7 But again, I've always like sort of a slight detached from them I suppose. And, um also I think my reluctance to talk about things that I find difficult, even now can, kind of, create some sort of barrier.

24.24 Like I'm not- I never have my guard fully down, even with them (close friends) a lot of the time.

Beth

1.8 I guess I was quite socially isolated.

7.11 and it just seemed like something that I could do that would like somehow express how I was feelings. But that I could keep hidden. Or I did my best to keep hidden. ...I was always exceptionally careful to hide it. Because I really didn't want the attention.

Appendix J: Reflexivity

Personal Reflexivity

During the analytic process, I encountered a number of challenges and anxieties. I found consolidating the data, as well as letting go of some elements of the data, very difficult. I was initially anxious and uncomfortable in the role of choosing what was significant and what emergent themes might be discarded. I found a great deal of what the participants said interesting. Embracing an interpretative position while simultaneously attempting to stay true to the participants' experiences was particularly challenging. I experienced a continuous tension between attempting to understand the participants' perspective as well as drawing my own interpretations. These interpretations were undoubtedly influenced by my own experiences and preconceptions, and thus I feared losing the essence of the participants' accounts. I was anxious to accurately represent these accounts, which caused the most tension during the write-up of the analysis where I went into interpretative detail.

I believe I placed an enormous amount of pressure on myself to carry out the research 'perfectly' and to 'correctly' portray the participants' experiences. I think, in particular, I had a strong desire to convey the experiences well due to my personal connection with the topic. Consequently, at times this pressure impacted my ability to fully engage in the double hermeneutics cycle. Eventually I came to acknowledge this influence and to observe the process differently, acknowledging that there is no 'correct' way to interpret, relieving some pressure and thus allowing me to be more confident in my interpretations.

In keeping a reflective journal during the analytic process, I was able to reflect on tensions and feelings that arose. I experienced excitement when shared experiences arose and a deep empathy for the person I was interviewing. Similarly, I also experienced unease when something

the participant said perhaps strongly contradicted my own experiences, although this did not happen often and when it did I was careful to take note and reflect. These emotional responses may have impacted my interpretations and compiling of relevant themes, and I might have chosen themes that resonated more with my own experience. However, by being aware of this potential influence and identifying the ways in which participant accounts differed from my own experiences, I was able to limit and account for the potential tendency to favour experiences that corresponded with my own.

The process caused me to reflect intensely on my own experiences and process of resolving my history of self-harm. I wonder if perhaps this research served dual functions for me: a desire to better understand the phenomenon and make sense of my own experiences for personal reasons, as well as to gain professional understanding and enlighten others on the topic.

The sometimes overwhelming feelings I experienced in response to the data and my analysis meant that initially I found it challenging to engage with the data for extensive periods of time, leaving me feeling frustrated. It also made me constantly question my ability to separate, “bracket off”, my own experience when evaluating the experiences of others. However, reflection and personal therapy helped me to become aware of this and manage it effectively. Ultimately, I utilised my experiences and shared experiences to access and achieve a deeper understanding of the participants’ lived experiences, thus strengthening my interpretations. The research process as a whole was an experience that afforded both substantial personal and professional development, and only upon completion have I truly realised this.

PART 2: PROFESSIONAL PRACTICE

Reframing the problem and fostering acceptance:
A client study of OCD

The Professional Practice Component of this thesis has been removed for confidentiality purposes.

It can be consulted by psychology researchers on application at the Library of City, University of London.

PART 3: PUBLISHABLE ARTICLE

Self-harm and the Relationship with the self:

Experiences of young women who engaged in self-harm during adolescence

Emma C. Punter

Supervised by Dr Susan Strauss

Prefix

This article has been written for submission to the Journal of Counselling Psychology. The article has followed the criteria set for submission located on the Journal's website, a copy of which has been attached to the appendix of this section.

Abstract

The aim of this study was to investigate how individuals with a history of adolescent self-harm perceive their experience of repetitive self-harm. This study explores the experiences of young people who previously engaged in repetitive self-harm during adolescence but have subsequently stopped. Due to the lack of qualitative research on this topic and the potential for stigma relating to self-harm, it was considered pertinent to focus on individuals' lived experience. Seven female participants (aged 22 to 30 years old) gave accounts of their experiences via face-to-face semi-structured interviews. The interview transcripts were then analysed using Interpretative Phenomenological Analysis (IPA). Five superordinate themes emerged from the data: 'Isolation', 'Others don't understand', 'Rejection and Acceptance', 'Relationship with the self' and 'Autonomy'. A brief outline of the research is provided and one theme, 'Relationship with the self', is explored in-depth. The findings support previous research and existing theoretical models of self-harm, and are discussed in the context of the developmental stage of adolescence. This study offers concluding thoughts around the implications of the findings in relation to the practice of counselling psychology, specifically when working therapeutically with adolescents who self-harm. Specifically, it advocates a focus on the relationship with the self and one's emotions in therapeutic interventions.

Key words: Self-harm, adolescence, interpretative phenomenological analysis, self-injury, NSSI

The full text of this article has been removed for copyright reasons

Appendix

Guidelines for Submission

Submission

Starting in 2012, the completion of a [Manuscript Submission Checklist \(PDF, 42KB\)](#) that signifies that authors have read this material and agree to adhere to the guidelines is now required. The checklist should follow the cover letter as part of the submission.

Manuscript Details

The *Journal of Counseling Psychology* publishes theoretical, empirical, and methodological articles on multicultural aspects of counseling, counseling interventions, assessment, consultation, prevention, career development, and vocational psychology and features studies on the supervision and training of counselors.

Particular attention is given to empirical studies on the evaluation and application of counseling interventions and the applications of counseling with diverse and underrepresented populations.

Manuscripts should be concisely written in simple, unambiguous language, using bias-free language. Present material in logical order, starting with a statement of purpose and progressing through an analysis of evidence to conclusions and implications. The conclusions should be clearly related to the evidence presented.

Manuscript Title

The manuscript title should be accurate, fully explanatory, and preferably no longer than 12 words.

Abstract

Manuscripts must be accompanied by an abstract of no more than 250 words. The abstract should clearly and concisely describe the hypotheses or research questions, research participants, and procedure. The abstract should not be used to present the rationale for the study, but instead should provide a summary of key research findings.

All results described in the abstract should accurately reflect findings reported in the body of the paper and should not characterize findings in stronger terms than the article. For example, hypotheses described in the body of the paper as having received mixed support should be summarized similarly in the abstract.

One double spaced line below the abstract, please provide up to five key words as an aid to indexing.

Public Significance Statement

Authors submitting manuscripts to the *Journal of Counseling Psychology* are required to provide a short statement of one to two sentences to summarize the article's findings and significance to the educated public (e.g., understanding human thought, feeling, and behavior and/or assisting with solutions to psychological or societal problems). This description should be included within the manuscript on the abstract/keywords page.

Masked Review Policy

This journal has adopted a policy of masked review for all submissions.

The cover letter should include all authors' names and institutional affiliations. Author notes providing this information should also appear at the bottom of the title page, which will be removed before the manuscript is sent for masked review. Make every effort to see that the manuscript itself contains no clues to the authors' identity.

Length and Style of Manuscripts

Full-length manuscripts reporting results of a single quantitative study generally should not exceed 35 pages total (including cover page, abstract, text, references, tables, and figures), with margins of at least 1 inch on all sides and a standard font (e.g., Times New Roman) of 12 points (no smaller). The entire paper (text, references, tables, etc.) must be double spaced.

Reports of qualitative studies generally should not exceed 45 pages. For papers that exceed these page limits, authors must provide a rationale to justify the extended length in their cover letter (e.g., multiple studies are reported). Papers that do not conform to these guidelines may be returned with instructions to revise before a peer review is invited.

Manuscript Preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* (6th edition)

. Manuscripts may be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*).

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the [APA Style website](#).

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

- **Journal Article:**

Hughes, G., Desantis, A., & Waszak, F. (2013). Mechanisms of intentional binding and sensory attenuation: The role of temporal prediction, temporal control, identity prediction, and motor prediction. *Psychological Bulletin*, *139*, 133–151.

<http://dx.doi.org/10.1037/a0028566>

- **Authored Book:**

Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach*. Cambridge, MA: MIT Press.

- **Chapter in an Edited Book:**

Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.

The minimum line weight for line art is 0.5 point for optimal printing.

For more information about acceptable resolutions, fonts, sizing, and other figure issues, [please see the general guidelines](#).

When possible, please place symbol legends below the figure instead of to the side.

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., "the red (dark gray) bars represent") as needed.

Ethical Principles

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

The APA Ethics Office provides the full [Ethical Principles of Psychologists and Code of Conduct](#) electronically on its website in HTML, PDF, and Word format.