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What helps? An exploration of protective factors and self-harm.

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Doctorate in Clinical Psychology
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Chapter 1 – Systematic review

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Systematic Review 5,482

Journal Article 9,942

Research Portfolio Abstract

Background: Self-harm is important considering the demand it places on health services and its strong association as a risk factor for suicide. Research regarding protective factors for self-harm is limited, protective factors can be personal or social resources that reduce the impact of negative consequences, in the face of stressors. Identifying protective factors is important, provided they can be enhanced and utilised to inform intervention.

Aims: This thesis had two aims; to systematically review the literature investigating the relationship between social support and suicidality, and to use Interpretative Phenomenological Analysis to explore the factors that support desistance from self-harm.

Methods: Quantitative studies, exploring the relationship between social support and suicidality were reviewed systematically. The empirical study employed Interpretative Phenomenological Analysis to investigate self-harm behaviour in context, identify potential protective factors and explore what participants have found to be helpful to desist from self-harm behaviour. Semi structured interviews were conducted with nine participants (18-61years) recruited from the Adult Community Mental Health Team.

Results: Findings of the systematic review indicate that there is an association between poor social support and increased suicidality in adulthood. In the empirical study four main themes emerged from the data: Self-harm provided Relief from Psychological Distress, Difficulties Communicating, Social support and Gradual desistance.

Conclusions: Social support may be an important factor that protects against suicidality; however further research is required to investigate this association. Findings from the empirical study suggest that treatment providers must be sensitive to the context and function of self-harm behaviour for the individual, and be willing to work to reduce the self-harm

behaviour, while being cognisant that self-harm may be protective for the individual and prevent more severe self-harm or even suicide.

Key words: Self-harm, suicide, adult, protective factors, social support, systematic review, desistance, qualitative, IPA.

Research Portfolio Introduction

Suicide is a sensitive topic that has received much attention in recent years, as a result, there has been a considerable increase in research is this domain. The Scottish Government and governments worldwide are backing research and policy in this area and see it as a priority (O'Connor, Platt & Gordon, 2011). Suicide is a leading cause of mortality in people under 35 years of age with a worldwide estimated one million deaths by suicide each year (Hawton & Heeringen, 2009). The Office for National Statistics (2014) reported that in 2012, 5,981 people committed suicide in the UK, 830 people committed suicide in Scotland and out of these, 718 people were aged 20 – 65 years (General Register Office for Scotland, 2014). The suicide rate for males is greater than three times that for females, while suicides in the most deprived areas of Scotland are significantly higher than the Scottish average (Russell, Lardner, Griesback & Johnston, 2010).

Not all people who attempt suicide come to the attention of healthcare services. However, patients attending hospital after a suicide attempt or a self-harm incident are frequent enough to present a significant clinical challenge to hospitals and their staff (Crandall, Fullerton-Gleason, Aguero & LaValley, 2006). Self-harm has the strongest association of all risk factors for suicide (Owens, Horrocks & House 2002; Cooper, Kapur, Webb, Lawlor, Guthrie, Mackway-Jones & Applyby, 2005) and can include a broad range of behaviours, such as cutting, poisoning, biting, picking and burning. It is a common feature across a variety of diagnostic conditions and is often associated with personality disorder (Brooke & Horn, 2010; Hooley, 2008). Self-harm is an increasingly common presentation at general hospitals (Hawton, Zahl & Weatherall, 2003) and a rise in rates of self-harm referrals to general hospitals has increased the pressure on services to respond. Further, this may result in an inadequate response to self-harm (Kerkhof, 2000; Taylor, Hawton, Fortune & Kapur, 2009). Repetition of self-harm is an important research focus given its frequent occurrence and

association with completed suicide (Olfson, Marcus & Bridge, 2012). A clearer understanding of the factors that promote desistance from repeated self-harm episodes is necessary to provide appropriate and effective after care, and inform intervention approaches (McLean, Maxwell, Platt, Harris & Jepson, 2008). It would be helpful to explore what prevents repetition of self-harm and identify the possible protective factors for those with risk factors who don't commit suicide. McClean and colleagues (2008) suggest that a "stock-take" of knowledge concerning resilience and health survival would be valuable, to gain insight into adaptive coping and recovery.

Patients' perceptions of healthcare services and post discharge management are important to inform the development of improved services and implement better quality of care (Taylor et al., 2009). A review of patients' attitudes toward clinical services following self-harm revealed that poor communication between patients and staff, and a perceived lack of staff knowledge with regard to self-harm were common (Taylor et al., 2009). The quality of care patients receive seems to be partly dependent on how staff understand self-harm behaviour, and how they react toward it (The National Institute for Clinical Excellence [NICE], 2004). Self-harm is commonly encountered and managed by Community Psychiatric Nurses (CPNs). A study exploring CPNs' experiences of working with people who self-harm revealed that staff found working with this population stressful; in particular managing the emotional impact on themselves and the responsibility of managing risk. This study highlighted the difficulties faced by community staff working with this population (Thompson, Powis & Carradice, 2008).

While there have been studies from the perspective of healthcare staff, there are fewer from the perspective of the patient. Numerous studies have looked at suicide and self-harm in relation to psychiatric diagnoses however many people who present at general hospitals following self-harm or attempted suicide do not have a diagnosis, and O'Conner et al. (2011)

have suggested that we need to look beyond 'mental disorders' if we want to understand what suicidal behaviour is about. To date research has been focused on explaining suicidality rather than understanding it and have generally employed quantitative methodology. It is imperative that further research includes qualitative methodology to increase our understanding of suicidal behaviour and to account for the complexity of self-harm as a phenomenon (Hjelmeland & Loa Knizek, 2011).

A large amount of research have investigated risk factors for suicide; however there is considerably less exploring protective factors and resilience (Fliege, Lee, Grimm & Klapp, 2009; Skegg, 2005). O'Connor and colleagues (2011) argue that a qualitative approach may be best suited to capturing data on complex issues such as the multi-faceted nature of resilience and risk. A literature review by Scottish Government social research advised that future research should explore resilience and protective factors within the context of the interaction of protective factors, adversity and risk factors, rather than assume that protective factors can be identified as simply the inverse of risk. It recommended that qualitative research designs provide further in-depth and personal insights into the complexities of the interaction between risk and protective factors for suicide and suicidal behaviour across the life course (McLean et al., 2008).

Whilst suicide research is essential, it can be ethically challenging (Lakeman & Fitzgerald, 2009). Recent research investigated the experiences of 63 participants across four qualitative studies concerning suicide or self-harm. Participants completed a visual analogue scale measuring their emotional state pre and post interview. Results revealed 57% of participants reported increased well-being and 21% reported no change in their emotional state. Although 22% of participants reported a lowering of mood, overall these findings suggest that there is a greater likelihood individuals will derive benefit from participation than experience harm. There was no follow-up in this study which would be necessary to corroborate these findings.

However, the study concluded that over-protective gate-keeping could preclude some individuals from experiencing the benefits gained from research participation (Biddle, Cooper, Owen-Smith, Klineberg, Bennewith et al., 2013).

Definitions of self-harm and suicidality

There is significant disagreement in the literature regarding the terms used to describe self-harm and suicide. Literature from the United States tends to exclude self-harm in the absence of suicidal intent. However, self-harm in the United Kingdom literature generally includes all behaviours irrespective of suicidal ideation or intent, as intent is complex and multifaceted (Skegg, 2005). This discrepancy across definitions limits study comparability (Fliege et al., 2009). This thesis proceeds on the assumption that there is considerable overlap between suicidality and self-harm, it has been suggested that suicide and self-harm exist on a continuum (O'Connor & Sheehy, 2000). Regardless of definition, having engaged in an act of self-harm is the strongest predictor of suicidal behaviour both fatal and non-fatal, thus, if we can intervene with those who have a history of self-harm, it should be possible to prevent at least some further deaths by suicide (O'Connor et al., 2011).

Current study

There is an absence of research with individuals who repeatedly self-harm (Skegg, 2005), this is surprising considering that repeated self-harm is a significant problem for front-line staff and is a major risk factor for suicide (Taylor et al., 2009). The studies that have looked at repetition of self-harm have tended to focus on risk factors, specific disorders, or have recruited from adolescent or population based samples. In response to this apparent gap in the research literature, the empirical study reported in Chapter 2 of this research portfolio, employed Interpretative Phenomenological Analysis (IPA) to investigate self-harm behaviour in context, identify potential protective factors and explore what patients have found to be

helpful to decrease self-harm behaviour in an adult mental health sample. A systematic review was conducted to investigate the relationship between social support and suicidality; this is reported in Chapter 1.

Chapter 1: Systematic Review

Title: A Systematic Review of the Relationship between Social Support and Suicidality.

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Abbreviated Title for Running Head: Relationship between Social Support and Suicidality

Word Count: 5,433 (excluding references and appendices).

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[1] Produced according to submission guidelines of ***Archives of Suicide Research*** (see Appendix A)
[2] Tables and figures are included within text as per instructions in the *University of Edinburgh/ NHS (Scotland) Clinical Psychology Training Programme 3 year Full Time and Specialist Training Handbook.*

Abstract

Objectives: To systematically review published quantitative studies that investigated suicidal behaviour and social support, to inform clinical practice, and consider recommendations for future research.

Methods: Published studies were identified by searching the following databases; PsychINFO, Medline, Embase and CINAHL. Participants were adults and the outcome measure was self-harm or suicidality. Methodological quality was assessed using the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement.

Results: Twelve studies met the inclusion criteria and findings suggest that low levels of social support are associated with increased suicidality. Heterogeneity of studies and lack of consensus over definitions and measures were identified.

Conclusion: There is an apparent association between social support and suicidality in adulthood; however this association requires further research. Future studies would benefit from a longitudinal design, large sample sizes and standardised psychometric measures of suicidality.

Introduction

It is estimated that worldwide there are one million deaths by suicide each year (Hawton & Heeringen, 2009). There is significant disagreement in the research literature regarding the terms used to describe self-harm behaviour, and definitions of suicide and self-harm are inconsistent. Literature from the United States tends to exclude self-harm behaviour in the absence of suicidal intent. However, self-harm in the United Kingdom literature generally includes all self-harm behaviours, irrespective of suicidal ideation or intent, as intent is complex and multifaceted. A significant difficulty in conducting research in this area is the lack of consensus about definitions which results in research studies that are often not comparable. There is some comorbidity between suicidality and self-harm and self-harm is prognostic for suicide attempts (Cooper, Kapur, Webb et al., 2005). The distinction between suicidal behaviour and self-harm is based upon the construct of intent, which is challenging to define and measure, intention is more difficult to measure than observable self-harm behaviour (Cooper et al., 2005). Skegg (2005) suggests assessing the self-harm behaviour descriptively irrespective of the apparent purpose of the act. Self-harm has the strongest association of all risk factors for suicide (Owens, Horrocks, & House, 2002; Skegg, 2005). Self-harm, suicidal thoughts and behaviours exist on a continuum of suicidality and self-harm increases the risk of completed suicide (Hooley, 2008). Suicide attempt and self-harm are often used interchangeably in clinical practice and in research literature; however for the purpose of this review suicidal behaviour can be defined as self-harm behaviour regardless of suicidal intent. Given the lack of consensus about definitions, and the comorbidity between suicidal behaviour and self-harm, self-harm and suicidal behaviour will be investigated as a single variable in this review. The broad term suicidality will be used which is widely accepted (O'Connor, Platt & Gordon, 2011), to ensure accuracy of reporting and consistency with the included studies.

Social support

There is a growing interest in the factors that may protect against self-harm and suicide. A body of research in recent years has focused on the role of social support in maintaining mental health and moderating the effects of life events and risk factors (King & Merchant, 2008). It is important to consider psychosocial variables that may protect or reduce the risk of suicidal behaviour. Although recent research has provided valuable information about prevalence, risk factors and functions of self-harm (Fliege, Lee, Grimm et al., 2009; Skegg, 2005) less is known about what factors prevent individuals from engaging in self-harm behaviour. It has been argued that protective factors should be viewed as a separate dimension to risk factors and moderate the impact of suicidal risk (Johnson, Wood, Gooding, et al., 2011) and that a clearer understanding of the protective factors that reduce self-harm and suicidality is necessary to provide the appropriate and effective after care, and inform intervention approaches (McLean, Maxwell, Platt et al., 2008). Identifying protective factors is important, provided they can be modified and enhanced by interventions (Fliege et al., 2009). Social support has been reported as a key factor in protecting individuals from the negative consequences of unfortunate life experiences (Uchino, Uno & Holt-Lunstad, 1999), it has been studied extensively in health psychology and broadly refers to the extent to which people are available and accessible to assist in times of need and distress (Gottlieb & Bergen, 2010). Social support can be defined as an exchange of resources between individuals intended to enhance the positive well-being of the recipient, it conveys the message of being loved, cared for, esteemed, valued and bestows a sense of belonging (Shumaker & Brownell, 1984). Social support is a widely investigated variable in relation to suicidality; a negative association was reported in a systematic review of adolescent studies, with social variables such as perceptions of family and peer support and social integration considered important protective factors for suicidal behaviour (King & Merchant, 2008).

Social and interpersonal variables are deemed important to our understanding of suicide (King & Merchant, 2008), the Interpersonal Theory of Suicide (Van Orden, Witte, Cukrowicz et al., 2010) proposes that three factors characterise individuals at an elevated risk for suicide; feelings of burdensomeness, a sense of isolation and a learned ability to engage in self-harm behaviour. The theory suggests that individuals have a need to feel connected to and cared about by others, which is considered to be a need to belong, and when people feel they are a burden on others thoughts of suicide may develop. Moreover, when the need to belong is unmet and perceptions of burdensomeness are present, the suicidal thoughts will transform into active thoughts of committing suicide. The Interpersonal Theory suggests that social factors are not sufficient to explain why, only a small number of individuals who experience suicidal ideation complete suicide (Fassberg, van Orden, Duberstein et al., 2012).

Rationale for current review

Research has tended to focus on risk factors for suicidal behaviour; however recently there has been an increase in studies exploring protective factors (King & Merchant, 2008). A body of research in recent years has focused on the role of social support in maintaining mental health and moderating the effects of life events and risk factors (Suresh Kumar & George, 2013). Assessment of suicide risk is essential and carried out by clinicians in a number of different settings. This comprises an assessment of risk factors and protective factors; however the evidence base for protective factors is inadequate. The role of social support in our understanding of self-harm is of interest, considering the high levels of self-harm, the strong association between self-harm and suicide, and the need for effective and low-cost interventions.

A review of older adult literature explored social factors and suicidal behaviour and reported that limited social support is associated with suicidality; however they highlighted the need for further research (Fassberg et al., 2012). In addition, a recent review of all age groups

investigated a wide variety of factors that may confer resilience to suicidality and proposed a buffering hypothesis (Johnson et al., 2011). Although there have been reviews of suicidality and protective factors, no review has focused specifically on social support and suicidal behaviour in adults. In contrast to earlier reviews that examine multiple factors, this review focuses on adult populations and specifically looks at one protective factor; social support. It is important to explore literature related to adult populations in isolation, as the social support variable is likely to be different than for older adults or adolescents, and rates of suicidal behaviour and social support vary widely across these different populations (Fassberg et al., 2012). While this review examined the relationship between social support and self-harm, there were no assumptions made about the direction of this relationship.

Aims

1. To conduct a systematic review of studies that examine the association between social support and self-harm among adults.
2. To summarise the research findings of social support and self-harm taking into account the methodological quality of the studies retrieved.
3. To inform clinical practice and identify areas for further research.

Method

Population

Studies included were based solely on adult participants (18 – 65 years) from both clinical and population based samples. Studies with a learning disability, adolescent or older adult sample were excluded.

Eligibility criteria of the studies included in the review

Studies that used quantitative methods and analysis, which focused on adult samples, published in peer-reviewed journals and examining both social support and self-harm were

eligible for inclusion. Only articles available in the English language were considered due to a lack of translation resources. Case control studies were preferred; however in order not to omit relevant evidence, cross sectional studies were eligible, provided that data from a comparison group was reported, and data was analysed by comparing social supports between groups with and without self-harm. The review considered all empirical primary research studies which included a measurement of social support (either a scale or questionnaire) and self-harm (a scale, questionnaire or proxy measure). Theoretical or review studies were excluded. This review omitted studies of suicidal ideation only, with the aim of reviewing specific studies of self-harm behaviour.

Search Strategy

Literature searches were undertaken in January 2014 and involved database searching and hand searching of selected journals. The following databases were used to identify suitable studies: Medline (from 1950), PsycINFO (from 1987), EMBASE (from 1980) and CINAHL (from 1982). They were searched using the following search terms [suicid*] OR [self-harm] OR [self-injur*] AND [social support] OR [protective factor]. The Journal of Suicide and Life-Threatening Behaviour and Archives of Suicide Research were hand-searched.

The search of the four databases yielded 1839 articles, which following de-duplication left 1046. Of these 904 were excluded during a review of the titles; titles containing terms related to suicide or self-harm and social support were retained. These articles were assessed by examining their abstracts, 93 were excluded and a further 37 were found not to meet the inclusion criteria on reading the full article, leaving a total of 12 papers to include in the systematic review (see *Figure 1*).

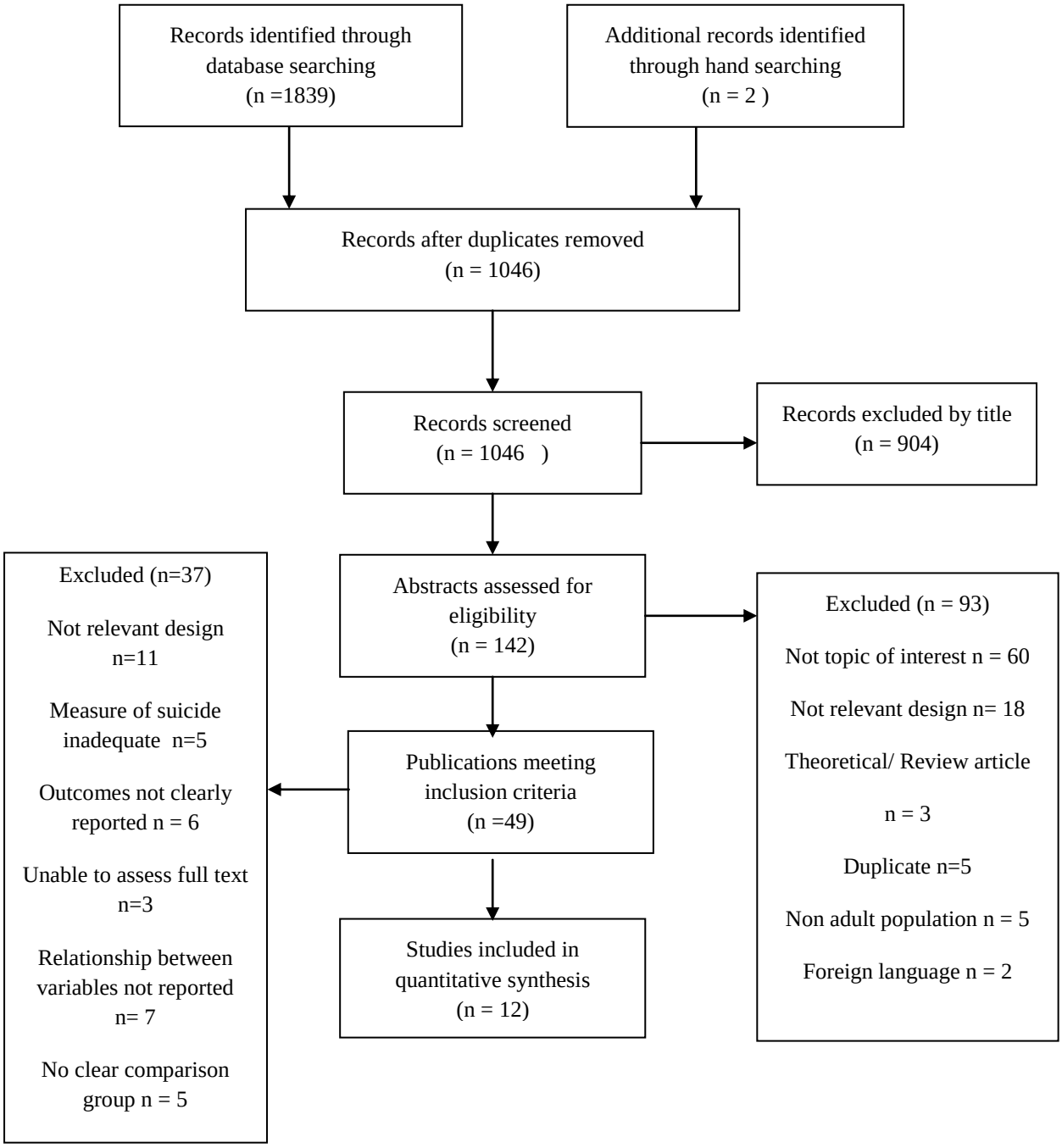

Figure 1. Flow chart of the study selection process

A total of 12 original papers met the inclusion criteria. Table 1 gives an overview of included studies, sample characteristics, assessment methods of suicidality and social support and main findings.

Table1. Summary of studies included in review.

Author, Country, year	Number of participants	Participants /Sample	Design	Measure of suicidality	Measure of social support	Main findings
Chou, Ko, Wu et al. 2013 Taiwan	Total 2835 N =299 suicide attempt in past year N = 2836 Non attempters	College students	CS	ASIQ-R 1 Question assessed previous suicide attempts	Social Support Questionnaire	No significant differences between groups.
Compton, Thompson & Kaslow 2005 United States	Total 200 N=100 suicide attempters 50 male /50 female N=100 controls 50 male /50 female	African American men and women	CC	Suicide attempt presented at A&E Risk-rescue rating Suicide Intent Scale	MOS Social Support Survey Social Embeddedness Scale	Lower levels of social support increased the risk of suicide attempt
Kotler, Finkelstein, Molcho et al. 1993 Israel	Total 90 N=46 Suicidal inpatients N=44 Non=suicidal inpatients	Psychiatric Inpatients	CC	Suicide Risk Scale (SRS)	Social Support Scale (Cohen et al., 1985)	A negative correlation was found between social support and suicide risk No significant differences on social support between the groups
Jenkins, Bhugra, Meltzer et al. 2005 United Kingdom	Total 12025 N=3139 Prisoners N=8886 Community sample	Prison population vs adults living at home	CS	National survey of psychiatric morbidity 5 Items assessing suicidality	National survey of psychiatric morbidity Subscale: Health and Lifestyle survey	Poor social support is an important risk factor for suicide attempts in prison sample
Jeglic, Pepper, Vanderhoff et al. 2007 United States	Total 97 N= 48 Suicide attempters N=49 Controls	University students	CC	SHI SBQ SIS BSS	SNL MSPSS	Lower social support was correlated with previous suicide

Author, Country, year	Number of participants	Participants /Sample	Design	Measure of suicidality	Measure of social support	Main findings
						attempts supporting a mediating model
Suresh Kumar & George 2013 India	Total 100 N=50 suicide attempters N=50 controls	Inpatient Controls = community sample	CC	Suicide attempt presented at hospital No psychometric measure	Social Support Scale (Asha, 1996; Nehra, Kulhara & Verma, 1996)	Social support was significantly lower in attempters. Good social support was protective against suicide
Kaslow, Thompson, Okun et al. 2002 United States	Total 200 N=100 suicide attempters N=100 controls	Abused African American women attending trauma centre Controls presenting to the hospital (non-emergency)	CC	Suicide attempt presented at hospital Risk-Rescue ratio	SSB	Social support is a protective factor associated with non-attempters
Wu, Chang, Huang et al. 2013 Taiwan	Total 248 N=124 self-harm cases N=124 controls	Patients attending hospital following self-harm Controls presenting to outpatient clinic at same hospital.	CC	Self-harm presented at A&E	CPQ	Higher levels of social isolation significantly associated with self-harm
Kaslow, Thompson, Meadows et al. 1998 United States	Total 285 N=148 suicide attempters N=137 controls	Abused African American women attending trauma centre Controls other hospital patients, no reported history of suicidal behaviour	CC	Suicide attempt presented at A&E	PSS	Social support moderated the link between partner abuse and suicidality

Author, Country, year	Number of participants	Participants /Sample	Design	Measure of suicidality	Measure of social support	Main findings
You, Van Orden & Conner 2011 United States	Total N=814 N=207 History of suicide attempt N=168 No history of suicide attempt but history of ideation N=439 No history of ideation or attempt	Participants in a substance use treatment programme	CS	3 items assessed suicidality	KPSS The Interpersonal Needs Questionnaire TENSE	Perceived social support is a significant predictor of suicide attempt
Cheung, Law, Chan et al. 2006 China	Total = 2219 N=149 suicidal ideation N= 39suicidal attempts N= 2031 No ideation and no attempt	Population based	CS	2 Questions	MSPSS	Social support appeared to play little role as a buffer to suicidality
Benda 2005 United States	Total 625 N=315 Male Nonsuicidal N= 91 Comtemplating suicide N=140 Attempted suicide N=84 N=310 female Nonsuicidal N = 46 Comtemplating suicide N=151 Attempted suicide N=113	Homeless military veterans	CS	Multi problem screening Inventory (MPSI)11 item subscale	MSPSS	Limited social support associated with suicide attempts; more so for women than for men

Note. Social support measures: Social Support Questionnaire (Sarason, Levin, Basham et al, 1983); MOS = The Medical Outcomes Social Support Survey (Sherbourne and Stewart, 1991); Social Embededdness Scale (Norris & Murrell, 1987); Social Support Scale (Cohen, Mermelstein, Kararck et al., 1985); Social Support Scale (Asha, 1996;Nehra, Kulmera & Verma, 1996); National survey of psychiatric morbidity (Jenkins, Bebbington, Brugha et al., 1997)**;** SNL = Social Network List (Hirsch, 1980); MSPSS = The Multidimensional Scale of Perceived Social Support (Zimet, Dahlem et al., 1988); SSB = Social Support Behaviours Scale (Vauz, Riedel & Stewart, 1987); CPQ = Close Persons Questionnaire (CPQ; Wu, Stewart, Huang et al., 2011); PSS = Perceived Social Support (Cohen & Hoberman, 1983)**;** KPSS = Kessler Perceived Support Scale (Kessler, Kendler, Heath et al., 1992); The Interpersonal Needs Questionnaire (Van Orden, Witte, Gordon et al., 2008); TENSE = Test of Negative Social Exchange (Ruehlam & Karoly, 1991). **Suicidality measures:** ASIQ – R = The Adult Suicidal Ideation Questionnaire- Revised (Reynolds, 1991); SRS = Suicide risk scale (Plutchick, van Praag & Conte, 1989); SHI = Self harm Inventory (Samsone, Wiederman & Sansone, 1998); SBQ = Suicidal Behaviours Questionnaire (Linehan & Neilson, 1982); SIS = Suicide Intent Scale (Beck, Schyler & Herman, 1974); BSS = Beck Scale of Suicidal Ideation (Beck, Steer & Ranieri, 1988); Risk-Rescue Ratio (Weissman & Worden, 1972); MPSI = Multi problem screening Inventory (Hudson, 1990). **Design:** CS = Cross sectional; CC = Case control.

Assessment of Quality of Included studies

The evaluation of the methodological quality of studies included in systematic reviews is important to predict the reliability and validity of the results (Jarde, Losilla & Vives, 2012). Current guidelines and check-lists have predominantly been developed to evaluate the effectiveness of treatment interventions based on randomised controlled trial methodologies, for example, the Centre for Reviews and Dissemination (CRD; 2008). Quality assessment of observational studies is still in development, and methodological quality was assessed in this review using the Strengthening the Reporting of Observational Studies in Epidemiology Statement (STROBE; von Elm, Altman, Egger et al., 2007; Vandenbroucke, von Elm, Altman et al., 2007). This instrument was developed by an international collaboration of experts and is supported by the Cochrane Collaboration (Jarde et al., 2012). It contains recommendations of items to be included in reports of observational studies in epidemiology, it is a combined checklist for cohort; case-control and cross sectional studies (see Appendix B). Studies were rated on 22 items in five main areas; title and abstract, introduction, methods, results and discussion, yielding a maximum total score of 22. Each paper's total score was converted to a percentage. Three categories for quality assessment were established arbitrarily. 'Good'—when the study fulfilled more than 80% criteria stated in STROBE; 'Moderate'—when 50–79% of STROBE criteria were fulfilled; and 'poor'—if less than 50% criteria could be achieved (Olmos, Antelo, Vazquez et al., 2008). An independent rater used the same quality rating to review four papers to ensure inter-rater reliability. There was good overall agreement of 82 % between the reviewers. Disagreements between raters were resolved through discussion. The quality ratings calculated for each study are summarised in Appendix C.

Results

This review investigated the association between social support and self-harm, given the wide-range of populations, a narrative synthesis is presented rather than a meta-analysis, as the included studies were not sufficiently homogeneous to provide a meaningful summary. The results are summarised in terms of research findings and methodological quality. The STROBE checklist identified two studies (Kaslow et al., 1998; Kaslow et al., 2002) as 'good,' and the remaining studies as 'moderate.' Scores ranged between 82% - 68% (Appendix C).

Setting

Eight of the included studies were in an inpatient setting, with half (n=6) of the studies conducted during hospitalisation for a non-fatal suicide attempt (Suresh Kumar & George, 2013; Wu et al., 2013; Kaslow et all, 1998; Kaslow et al., 2002; Compton et al., 2005; Kotler et al., 1993). Two samples were recruited from an inpatient substance misuse treatment programme (You et al., 2011; Benda, 2005); One study utilised a prison sample (Jenkins et al., 2004), two studies (Chou et al., 2013; Jeglic et al., 2007) used a college sample and one study was population based (Cheung et al., 2006).

Study design

Seven of the 12 studies utilised a case control design, the remaining five studies were cross sectional (Chou et al., 2013; You et al., 2011; Cheung et al., 2006; Jenkins et al., 2004; Benda, 2005) but did separate participants into groups according to measures of suicidality post hoc. In all of the studies participants were administered a battery of questionnaires at one time point.

Sample characteristics

The majority of studies were recruited from vulnerable groups (e.g. homeless, abuse victims, substance misuse). Two studies (Chou et al., 2013 and Jeglic et al., 2007) used students in a college sample hence the mean age of their samples were 19.75 years and 18.6 years respectively. Not all studies reported mean age of samples. Gender composition of samples was reported across all studies. Gender differences were examined in two studies (Jenkins et al., 2004; Benda, 2005). Two studies were composed of female participants only with a history of abuse (Kaslow et al., 1998; Kaslow et al., 2002). Three of the studies' samples were composed of African American men and women (Kaslow et al., 1998; Kaslow et al., 2002; Compton et al., 2005).

Measures of suicidality

Half of the studies employed psychometric measures of suicidality (Chou et al., 2013; Compton et al., 2005; Kotler, 1993; Jeglic et al., 2007, Kaslow et al., 2002; Benda, 2005). Two studies (Compton et al., 2005 & Jeglic et al., 2007) used two or more psychometric measures of suicidality. Three studies used a proxy measure of suicidality only, which was attendance at hospital following an incident of self-harm (Suresh Kumar & George, 2013; Wu et al., 2013; Kaslow et al., 1998). Three studies (Jenkins et al., 2004; You et al., 2011 & Cheung et al., 2006) used specific questions to assess suicidality. You et al. (2011) reported high rest-retest reliability for one item, but did not report reliability for the other items, nor did the other studies that used single items to assess suicidality (Jenkins et al., 2004; Cheung et al., 2006) . As attempted suicide or incident of self-harm was the reason for hospital admittance in half of the studies, the primary outcome was self-harm with hospital presentation. Of these studies two (Kaslow et al., 2002; Compton et al., 2005) used a risk-rescue rating scale (Weissman & Worden, 1972) to assess suicide attempt lethality, good

inter-rater reliability and validity was reported for this measure, but they did not report a value. Similarly, Compton et al. (1995) administered the Suicide Intent Scale but did not report the reliability of the measure. Overall, outcome measures of self-harm were highly heterogeneous across studies.

Measures of social support

Social support was measured across all studies using a variety (n=13) of psychometric measures. Good reliability of measures was reported using Cronbach's alpha co-efficient of internal consistency by 75% (n=9) of the studies. The MSPSS (Zimet et al., 1988) was administered in 25% (n=3) of the studies (Cheung et al., 2006; Benda, 2005; Jeglic et al., 2007) which was reported to have good internal consistency (α =.87).

Main findings

All seven case control studies reported appropriate matching of groups. A variety of statistical analyses were conducted across studies, and multivariate and logistical regressions were the prominent statistical techniques to examine social support amongst a number of psychosocial variables. Social support was found to be protective in 10 of the included studies (Kotler et al., 1993; Suresh Kumar & George, 2013; You et al., 2011; Jenkins et al., 2005; Wu et al., 2013; Kaslow et al., 1998; Kaslow et al., 2002; Compton et al., 2005; Jeglic et al., 2007; Benda, 2005) and showed positive effects on indicators of suicidal behaviour. Social support was significantly lower in suicide attempters and was protective in the presence of risk factors. All studies, with the exception of Wu et al. (2013), investigated the relationship between suicidality and a number of psychosocial variables, and the authors (Kotler et al., 1993; Suresh Kumar & George, 2013; You et al., 2011; Jenkins et al., 2005; Kaslow et al., 1998; Kaslow et al., 2002; Compton et al., 2005; Jeglic et al., 2007; Benda,

2005;) concluded that it is the complex interplay of various factors which protects the individual against suicidality.

Social support was significantly lower in attempters and was protective in the presence risk factors (Suresh Kumar & George, 2013). In this study, all factors which were significant in one-to-one comparison were entered into a stepwise conditioned logistic regression analysis and revealed that social support, amongst other factors, protects the individual against suicidality (Suresh Kumar & George, 2013). However, this study received one of the lowest quality ratings (68%), and the validity of this result is compromised by small sample size of the groups (n=50, n=50) therefore a stepwise analysis is unlikely to be reliable (Tabachanick & Fiddell, 2001). In addition, a common criticism of this technique is the large influence of random variation in the data, with variables being included or excluded from the model on purely statistical grounds. In this case, only statistically significant factors were included for analysis. Kotler et al., (1993) reported a significant negative correlation between social support and suicide risk ($p<.05$). Multiple regression analysis revealed that social support amongst other variables was a predictor of suicide risk, and greater social support reduced the risk of suicide. This study received a moderate quality rating of 77%, however the sample size of the groups was also small (n=44, n=46) therefore multiple regression may not be a reliable predictor (Tabachanick & Fiddell, 2001) considering that 11 independent variables were included in the correlation matrix. Significant results were compromised by small samples, and a lack of statistical power to support findings (Suresh & Kumar, 2013; Kotler et al., 1993; Jeglic et al., 2007).

Benda (2005) reported gender differences, with limited social support significantly associated with suicidality for women than for men ($p<.01$), in a sample of homeless war veterans, who misuse substances. Multivariate results revealed that lower levels of perceived social support were associated with greater probability of suicidality, ($p < .05$) in a sample of individuals

who misuse substances (You et al, 2011). Jenkins et al. (2005) reported that suicidal thoughts and attempted suicide in prisoners were associated with small primary support groups and a lack of social support. Poor social support was a correlate of lifetime suicidal attempts, using a stepwise analysis. Adjusted odds ratio found that social support makes a significant ($p<.05$) contribution to suicidal attempts. This study also investigated psychiatric disorders which were found to be highly correlated with suicidal behaviour. Among male remand prisoners, the odds of suicidal behaviour in the last year was increased by 2.75 for those who had no contact with family or friends compared with those who had received letters, telephone calls or visits from both groups.

Two large population based cross sectional studies were conducted in China (Chou et al., 2013 and Cheung et al., 2006) and did not report significant differences between groups on measures of social support. This is of interest considering that both studies were cross sectional in design and used a college sample and a population based sample respectively. Comparison of means revealed that 10% of the college sample (Chou et al., 2013) reported suicide attempts in contrast to 1.7% of the population-based group (Cheung et al., 2006). The college sample consisted of younger adults, so this may be a factor in the significant findings. Indeed, the authors discuss that young adults are likely to experience increased stress and transition during these years. Other reasons explored include; extensive exposure to media coverage of suicide, gender distribution of participants, as more female participants reported suicide attempts, and finally a false-positive effect may have occurred due to the possibility that participants may not have differentiated between self-harm and attempted suicide. Levels of social support were not found to be significantly different between attempters and non-attempters in the college sample, however Cheung and colleagues (2006) revealed that the odds ratio for social support was associated with a higher risk of suicide attempts ($p<.01$) but the population attributable risk fraction (PAF) was small. Multiple regression analysis did not

reveal significant findings. Therefore when covariates were accounted for, social support was not associated with suicide risk. The main limitation of this study was the small number of suicide attempters, which is likely to have impacted the results; this study received one of the lowest quality ratings (68%), which compromises the validity of results. In general, the high level of heterogeneity amongst outcome measures, diversity of samples and variation of sample size increased the difficulty interpreting the findings.

Discussion

This review found preliminary evidence that social support protects against suicidality, however, there are methodological limitations to this conclusion. Although the evidence in favour of social support was not consistent, non-significant findings may be due to studies lacking the large samples and effect sizes necessary to detect significance. Retrospective assessment is limited by various factors, such as recall bias which may result in an inaccurate reflection of social support. In studies that were not case control, comparison was limited by small groups with suicidality (Chou et al., 2013; Cheng et al., 2006). Regression analysis was conducted using very small groups, therefore may not be a reliable predictor considering that a number of independent variables were in the correlation matrix. In addition, a common criticism of this technique is the large influence of random variation in the data, with variables being included or excluded from the model on statistical grounds (Tabachanick & Fiddell, 2001). This review focused on one specific factor; social support, however studies frequently explored a broad range of potential protective factors. This approach may not be the most appropriate as it may result in participant fatigue, with participants completing large batteries of questionnaires (Johnson et al., 2011). Moreover, it possibly will result in Type I error by increasing the likelihood of false positives. A small number of studies (e.g. Jeglic et al., 2007) controlled for this by using adjustments to the criteria for significance such as the

Bonferroni correction. However, this could then increase the likelihood of Type II error (Perneger, 1998); a preferable alternative would be to investigate a smaller number of factors.

A particular difficulty was the variability of measurements of both self-harm and to a lesser extent, social support. Half of the studies included investigated social support in individuals who were recently admitted to hospital following a suicide attempt, and compared these individuals to a control group recruited within the hospital, with no reported history of suicide attempts. These studies rarely used a psychometric measure of suicidality as the participants were recruited immediately after a suicide attempt; the primary outcome measure of self-harm was hospital presentation. Psychometric measures of social support varied; hence clear comparison of studies is restricted, however the majority of studies used reliable measures. Results would be more robust if reliable psychometric measures of suicidality were used; this would also enable greater comparability between studies. The variation of outcome measures also poses questions about definitions of suicidality, for example, the studies included in this review largely recruited participants that had attended hospital for Emergency medical treatment following an incident of self-harm and were deemed "suicide attempters," in the absence of a reliable measure of suicidality. Compton et al. (2005) and Kaslow et al. (2002) used a psychometric measure of suicidality and were deemed the best quality studies (82%).

Conclusions for research

Knowledge of protective factors, such as social support is important in order to better predict, understand and treat self-harm, and the limited number of studies published suggests further research is required. Future research should consider a longitudinal design, given that in most cases in this review, social support was assessed immediately after a suicide attempt. A longitudinal study post discharge may potentially reveal different results, and may provide

more reliable information about social support, than measurement at one time point. Further case-control studies would benefit from larger samples, recruited from the community to increase the generalisability of findings. Intervention studies may provide more information on the role of enhanced social support and its impact on suicidality. The studies in this review used self-report and retrospective accounts of participants' experiences, which raises questions about response validity. A prospective study design in which data is collected from multiple informants would strengthen the conclusions that could be drawn (Kaslow et al., 1998). There is a marked variability of assessment of suicidality across studies, therefore the use of a standardised psychometric measure is recommended, that makes reference to suicidal ideation and previous self-harm, in addition to current suicidality. Qualitative studies with a focus on experiences of social support reported by individuals who have made a suicide attempt could provide a greater understanding of the protective influence of social support that a quantitative design cannot afford. In summary, it appears that perceived social support may represent a potential protective factor against suicidality, this association requires further investigation and future research would benefit from examining the particular risk factors which social support can confer resilience against (Johnson et al., 2011).

Clinical implications: Implications for suicide prevention

These findings suggest that social support should be considered when assessing patients for suicide risk. Further investigation of social support is important, as it is thought that support networks provide social support that helps to maintain emotional well-being and buffer the effect of adverse life events (Sumar Kumar & George, 2013). This review provides evidence from comparative studies that social support systems are reduced among suicide attempters compared with non-suicidal individuals. Social support may be protective against suicide; however, social support in isolation does not explain the aetiology of suicidal behaviour. Moreover, it may be the interaction between social support, the individual and other factors

which may escalate the risk of suicidal behaviour (Fassberg et al., 2012). However, as social support is a potential protective factor, it is important that it be included as a component in treatment programmes for effective intervention for suicidal behaviour.

Limitations of the review

There are a number of limitations of the present review that must be taken into consideration. This review afforded a narrative synthesis due to the small number of studies and heterogeneity of results. Despite efforts to do so in a rigorous and unbiased way, a meta-analysis would be preferable to reduce the risk of subjective bias. The inter-rater reliability of the quality of included studies was based on only four of the included studies thus reducing reliability somewhat. To ensure quality this review included only published studies. However, this may increase bias and an overestimation of effect. Including data from "grey literature" is advisable to reduce bias; however this may reduce other quality criteria. The small number of included studies and the variability in design and quality requires that any conclusions should be treated with caution. Due to the heterogeneity of the studies, it is difficult to compare findings and as such this review can only perhaps suggest the feasibility of social support as a protective factor and recommend that efficacy is yet to be established through further research.

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2. Journal Article

Title *"Life isn't about waiting for the storm to pass it's about learning to dance in the rain:"* An Interpretative Phenomenological Analysis of factors that promote desistance from self- harm.

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2.1 Abstract

Self-harm is a complex problem and is a significant risk factor for suicide. The current study explored the factors that contribute to desistance from self-harm and reduce repetition, using Interpretative Phenomenological Analysis. Semi structured interviews were conducted with nine participants (18-61years) recruited from an Adult Community Mental Health Team. Four main themes emerged from the data: Relief from psychological distress, Difficulties communicating, Social support and Gradual desistance. Results suggest that treatment providers must be sensitive to the context and function of self-harm behaviour. Harm reduction strategies are preferable to harm cessation, as self-harm is a coping strategy that may prevent suicide. This study provides further support for the use of qualitative methods with individuals who self-harm.

Key words: Self-harm, suicide, adult, protective factors, desistance, qualitative, IPA.

2.2 Introduction

Self-harm is significant problem considering the demands it places on health services, high rates of repetition and the increased risk of suicide (Klonsky, 2007). Self-harm is a prominent presentation for Adult Community Mental Health teams (Taylor, Hawton, Fortune & Kapur, 2009). While there is a relationship between self-harm and increased risk of suicide, many individuals engage in self-harm to avoid killing themselves (Brown & Kimball, 2013). Suicide attempt and self-harm are often used interchangeably in clinical practice and in research literature; for the purpose of this study self-harm behaviours are investigated regardless of intent, in accordance with NICE (2004) guidelines. Self-harm has been described as a coping mechanism, a distraction from emotionally painful situations and a way of taking control (Skegg, 2005; Klonsky, 2007). There is consensus within the research literature that self-harm serves a role in emotion regulation by relieving negative emotions (Klonsky, 2007; Rotolone & Martin, 2012; Brown & Kimball, 2013). Other common functions include anti-dissociation, suicide prevention, self-punishment, an externalised way of representing internal distress and sensation seeking (Klonsky & Muehlenkamp, 2007). Explanations of self-harm are poorly understood as many individuals who self-harm do so in secret and never attend health services (Warm, Murray & Fox, 2002).

2.2.1 Interventions for self-harm

There is limited empirical evidence to understand the resolution of self-harm. This is due to the significant difficulty in ceasing self-harm behaviour (Sinclair & Green, 2005) and the lack of evidence of effective interventions. A recent Cochrane review of interventions for self-harm concluded that there is sparse evidence to indicate effective treatments for self-harm (Hawton, Townsend, Arensman, Gunnell, Haxell, House & Heeringen, 2009). Research in the area of self-harm is predominantly quantitative and focuses on general population

samples rather than clinical samples, with a large body of evidence relating to adolescent self-harm behaviour. Patients' descriptions of self-harm, and the treatment received, are important to evaluate experiences of care but also to inform the development and implementation of effective management strategies (Sinclair & Green, 2005). Furthermore, there is a likelihood participants will derive some benefit from participation in qualitative studies of self-harm (Biddle, Cooper, Owen-Smith, Klineberg, Bennewith et al., 2013).

The National Institute for Clinical Excellence (NICE, 2004) noted the limited evidence of effective interventions for self-harm, and recommended that more research with service users be conducted, to gain first-hand accounts and insights into their understanding of self-harm, and experience of services (NICE, 2004). Indeed, two focus groups of patients (n=17) hospitalised following a suicide attempt, highlighted the importance of service user involvement to improve the quality of health care (Ghio, Zanelli, Gotell, Rossid, Natta & Gabrielli, 2011). The Royal College of Psychiatrists' report on self-harm, suicide and risk (2010) noted that people who self-harm require health professionals who are empathetic, and able to listen in a non-judgmental way, to reduce the stigma associated with self-harm, as individuals often do not disclose self-harm behaviour for fear of being judged, labelled, detained or dismissed. This is in contrast to the treatment commonly offered, which deems the reduction of self-harm behaviour a priority (Warm, Murray & Fox, 2002). Intervention with treatment to decrease or eliminate self-harm behaviour may be detrimental (Arnold, 1995), the most recent NICE (2011) guidelines for longer term management of self-harm, propose that harm-reduction rather than prevention of self-harm may be beneficial, with consideration given to self-harm as a coping mechanism that may prevent suicide (Kendall, Taylor, Bhatti, Chan & Kapur, 2011).

2.2.2 Resolution of self-harm

Knowledge of how individuals cease self-harm behaviours and what they experience as helpful and unhelpful to this process is important to increase understanding and enhance treatment efficacy. A case-control study compared current individuals who self-harm with a control group of people who have ceased self-harming to identify social and personal characteristics that promote desistance (Rotolone & Martin, 2012). Significantly lower levels of perceived social support, social connectedness, resilience, self-esteem, and life satisfaction were reported by participants who self-harm, compared to controls. Family support, self-esteem, resilience, and satisfaction with life were significantly better ($p<.01$) for past, compared to current self-injurers (Rotolone & Martin, 2012).

A mixed methods study of university students (n=54) with a past history of self-harm explored their reasons for engaging in self-harm and explanations of cessation (Gelinas & Wright, 2013). Six themes emerged as reasons for cessation; futility of self-harm; concern about scarring and negative attention; interpersonal reasons; receipt of help; desire for wellness and development of alternative coping strategies. Strategies employed by the participants to cease self-harm included positive coping behaviours, professional help, negative coping behaviour, social support and rational self-talk (Gelinas & Wright, 2013). Positive coping behaviour included creative alternatives such as keeping a diary or poetry or other distractions such as going for a walk. Negative coping included pulling hair out, taking drugs and vomiting after meals. In some instances cessation of one form of self-harm was only possible by using another form. Professional and social support was deemed helpful and emphasised the importance of having someone to talk to and the central role of family and friends. Rational self-talk was an intrapersonal method used in the absence of help-seeking or behaviour substitution (Gelinas & Wright, 2013). Reported barriers to cessation included;

mental health difficulties, interpersonal issues, the functional and addictive role of self-harm and ongoing stress (Gelinas & Wright, 2013).

A qualitative study explored resolution of self-harm with individuals who had not had an episode of self-harm in two years (Sinclair & Green, 2005). Three themes were identified; the resolution of adolescent distress, the recognition of the role of alcohol as a trigger and maintaining factor, and the understanding that self-harm was a consequence of an illness that was unidentified and untreated. Participants discussed that their experiences of self-harm related to lack of control over their lives due to alcohol misuse, untreated depression or, if self-harm occurred during adolescence, uncertainty within family relationships (Sinclair & Green, 2005).

2.2.3 Gender differences

There are potential gender differences in self-harm and suicidal behaviour, there is evidence that women are more likely to self-harm, whereas men are more likely to complete suicide (Russell, Moss & Miller, 2010). Russell and colleagues (2010) conducted qualitative interviews with four male participants (37 – 58 years) to gain an understanding of their self-harm. Outcomes yielded similar results to previous studies, such as the comfort and relief afforded by self-harm, features of dissociation, self-harm as communication and ambivalence among participants. Results were in agreement with previous studies suggesting that self-harm was both "appalling" and "appealing" to participants however, results are tentative due to the small sample (Russell et al., 2010, Gardner, 2001).

A qualitative study of six female college students who had previously repeatedly self-harmed but ceased for at least 10 months revealed that multiple factors contributed to cessation (Shaw, 2006). These included the subjective meaning of the behaviour, a decrease in psychological triggers and self-motivation to stop self-harming. Other themes considered

developmental processes, engagement in therapy, and acceptance following disclosure of difficulties to others which alleviated shame. Interestingly, although participants had not self-harmed over the past 10 months or more, they did not all express a desire to cease self-harm or a conscious decision to do so. This suggests that a conscious decision to stop self-harming may not be required for self-harm resolution. The study reported that cessation seemed to be on a continuum, with some participants having a clear desire to stop, others expressing little or no aspirations to stop, and the remainder affirming ambivalence toward stopping. For some, it would appear cessation can be an absence of self-harm behaviour, rather than an adjustment process or development of alternative coping skills. Therefore cessation of self-injury is not a reliable indicator of improved mental health, unless it is accompanied by shifts in other areas of people's lives. Shaw (2006) concluded that giving up self-harm may be temporary as the underlying issues, which contributed to it, may be unresolved. All six participants noted that the research interviews provided a useful opportunity to reflect on their self-injury (Shaw, 2006).

Current Study

The aim of the current study is to build on the existing research by exploring the factors that promote desistance from self-harm, in an adult sample recruited from a Community Mental Health Team.

2.3 Method

2.3.1 Design

Interpretative Phenomenological Analysis (IPA) was employed in this study to enable detailed exploration of the individual's personal account of their experience. IPA has roots in hermeneutics, which involves making sense of the lived experience and symbolic interactionism, and suggests that the meanings assigned to events by individuals are of central

concern, but are only assessed through an interpretative process (Olfson, Marcus & Bridge, 2012). Therefore the IPA approach acknowledges that the researcher's engagement with the individual's account has an interpretative element, yet takes a phenomenological stance that it is possible to access an individual's internal world, and in this case reveal something of the nature of what factors play a role in desistance from self-harm. IPA was used in this study as recent reviews (e.g. Smith, 2011; Shaw, 2011; Pringle, Drummond, McLafferty & Hendry, 2011) have demonstrated that IPA has a sound research base. In addition IPA is widely used in the domains of clinical, health and social psychology and is particularly suitable to investigating unexplored territory where a theoretical or empirical pretext may be lacking (Reid, Flowers & Larkin, 2005). This approach is particularly pertinent in the current study given the aim of identifying protective factors for individuals, who self-harm, an area which has little empirical support. Additionally, it had been noted that a qualitative approach would be required to analyse the protective factors amongst individuals who self-harm (Mclean et al., 2008).

2.3.2 Ethics

The study was carried out in accordance with the British Psychological Society's (BPS) Code of Ethics and Conduct (2009). Submission was made to the Integrated Research Application System (IRAS) and complied with the University of Edinburgh and local health boards' ethics process (see Appendix E for ethical documentation).

2.3.3 Participants

A purposive sample was recruited, participants were considered eligible to participate in the study if they were aged 18 to 65 years, following a recent episode (within past 12 months) of self-harm and were being supported in the community by the CMHT. Participants with cognitive impairment, eating disorder or drug or alcohol addiction were not eligible to participate, as they are explicit symptoms or meet the classification criteria of a specific

disorder (Fliege, Lee, Grimm & Klapp, 2009). Suicidality was assessed by their keyworker (CPN or OT) prior to participation in the study, and people who were an active suicide risk were not invited to participate. As recommended by Smith, Flowers and Larkin (2009), the participants in this study represented a reasonably homogenous, purposive sample. Potential participants (n=14) were identified and were given an information sheet (Appendix F) inviting them to take part and explaining what this would entail. Of the 14 participants invited to participate, nine agreed to be interviewed for the study. This sample size is in line with previous studies of self-harm which used IPA methodology (e.g. Thompson et al., 2008; Wood, 2011, Brown & Beail, 2009). Participants were six females and three males, aged between 18 and 61 years. All patients had harmed themselves at least twice previously, many on several occasions. They reported engaging in a variety of self-harming behaviours, including cutting, burning and overdose. The majority (n=7) engaged in more than one form of self-harm. Previous suicidal intent was reported by six participants. Two participants were college students; the remaining seven were unemployed, three were former nurses. Six participants reported their sexual orientation to be heterosexual, one homosexual, one bisexual and one participant did not disclose her sexual orientation.

2.3.4 Procedure

Community Mental Health Team (CMHT) meetings were used to inform Community Psychiatric Nurses (CPNs) and Occupational Therapists (OTs) about the study (see Appendix G for information sheet for CMHT). The CMHT were requested to invite patients on their caseload who have engaged in self-harm in the past 12 months, to participate in the study and to provide a participant information sheet. Patients were given the opportunity to opt-in or find out more by notifying their CPN or OT. These patients were then contacted by the researcher and invited to participate; written consent (Appendix H) was obtained before the interview commenced. All interviews were digitally-recorded and the length of each

interview was approximately 50 minutes. Participants were encouraged to talk as widely as possible about their experiences of self-harm, active listening and empathy were employed to ensure the interview was participant-led as much as possible. After the interview a debrief sheet was provided (Appendix I), this contained telephone numbers of internal and external support lines should the interview evoke thoughts or feelings which they would benefit from talking through with a professional. Additionally, the appropriate key worker in the CMHT was aware of their participation in the study, to provide support after the interview if the participant deemed it necessary. All nine transcripts were transcribed verbatim and included non-linguistic elements for analysis.

2.3.5 Interview Schedule

The interview schedule (Appendix J) was developed based on a review of the relevant literature and guidance provided in Smith, Flowers and Larkin (2009). The interview schedule was not adhered to rigidly but rather used as a guide to help prompt deeper exploration of issues. This enabled participants to give direction to the interview while the researcher implemented non-directive prompts to aid exploration of relevant topics as they emerged (Brown & Beail, 2009).

2.3.6 Analysis

Analysis of the data was conducted according to the guidelines outlined by Smith, Flowers and Larkin (2009), which emphasises rigour. This process was idiographic whereby one transcript was examined in detail before going on to examine others. Transcripts were read in detail several times, initially listening to the audio recording simultaneously. The second stage involved producing a comprehensive and detailed set of notes to identify prominent points; associations and contradictions. These were written on the right hand margin of the transcript. Thereafter, these notes were used to establish potential emergent themes. These themes were recorded on the left hand side of the margin in the form of phrases attempting to

capture the essence of what was being discussed and what sense the participant was making of their world (see Appendix K for coding extract). This process was repeated for each individual transcript; a full set of emergent themes was constructed and grounded in extracts from the text. The last stage involved searching for patterns and both convergence and divergence across cases, and emergent themes were then clustered together to produce a master list of superordinate themes (Appendix L). At this stage, measuring recurrence across cases is important. In accordance with Smith (2011) recurrence of an emergent theme is defined as being present in at least three of the participants' interviews.

2.3.7 Quality Assurance

Established quality controls procedures were used including audit of the analysis process (Smith, 2011). To ensure validity of interpretations an independent researcher audited the final master themes to ensure that they were an accurate reflection of the data set. As the transcripts of nine participants were included in the current study, a measure of prevalence of each subtheme is included as a quality assurance measure (Appendix L). In order to minimise interpretative bias, three transcripts were analysed by two experienced qualitative researchers. This process found a high level of agreement with the same emergent themes from the data. Furthermore, emergent themes presented are supported by interview extracts so that the reader can assess the reliability and validity of the interpretations.

2.3.8 Reflexivity

In qualitative research, the data emerges from an interaction between the participant and the researcher at a specific time point. It would be reasonable to assume that this may have an impact on what the participant says and how that is interpreted by the researcher. Personal reflexivity is important when conducting IPA studies due to the potential for interpretative bias. In this study, a reflective diary was kept throughout data collection and analysis, to consider personal experiences and preconceptions that may influence interpretation, and

supervision was used to reflect on this process. One of the issues encountered, was the challenge of adapting to the role of researcher during the interviews, rather than the more familiar role of clinician. It was important to be mindful of this during data analysis, where it was endeavoured to retain a balanced and open-minded approach to the data.

2.4 Results

This study was interested in the accounts provided by participants about the subjective meaning of self-harm and their perception of protective factors. All participants discussed the individual meaning of self-harm, the context in which it occurs, and the factors associated with desistance. Four superordinate themes were identified within the data; Relief from psychological distress, Difficulties communicating, Social support and Gradual desistance. These will be discussed in relation to subordinate themes and illustrated using extracts from the interviews.

2.4.1 Relief from psychological distress

Participants described how they struggled to express their emotions, and how self-harming was a method of coping with, and regulating, difficult emotions. They articulated self-harm is a long-standing, effective coping strategy, which was difficult to desist from in times of stress:

> "*I could draw blood from myself constantly I would and it's just because I'm used to it and it's how I deal with things now cause it's the only thing I know, it's been 11 years I've been doing it for"* P4

At times participants seemed ambivalent about the physical impact of harming when it seemed that self-harm was so effective in relieving psychological distress, with, for some, the "benefits" of self-harm offsetting physical injury. Participants explained that they had not learnt to express their emotions in healthy ways and they felt as though their family relationships did not allow space for emotional expression. As they did not know how to cope

with their emotions, self-harm became their reliable coping strategy, and sometimes the only option which was effective and immediate. All participants spoke of the role self-harm played in relieving psychological distress. They noted the effective relief it provided from a range of feelings such as anger, frustration, anxiety, pain, shame and self-loathing. They described it as an immediate way to manage uncontrollable, unbearable emotions and a way of releasing emotional pain:

> *"It's a relief for me, if I'm feeling sad or worried and I get to that point that I can't take it anymore, for me it's not that I want to end my life, it's just that's why I don't do it on my arm, I find it more private and other people don't know about it"* P2

Feeling alone: Feeling isolated and alone was expressed by all participants. For some this was also a precedent to self-harm. In addition, it may be viewed as a maintaining factor:

> *"So when I'm by myself that's when things start to get really bad cause I don't like being on my own"* P2

Participant 7 describes poignantly a sense of isolation, and her language conveys the emptiness she feels and the longing for company and support:

> *"Last time I self-harmed was a month ago, and I really, really think that I was lonely and I wanted someone to talk to, somebody to come and see me chat to me yeah I think I was lonely, I was hurting I had this emptiness inside and I really wanted human contact, you know somebody just to chat to about normal things."* P7

Part of the psychological distress participants encountered related to low self-esteem and all expressed a painful self-loathing and sense of being worthless. Acknowledgement of difficulties was experienced as shameful. The language used is a powerful communication of the disgust this participant felt about herself and her sense of failure:

> *"I don't accept a lot of help from my family, my sisters and things because my house has been left go because I can't do too much, em and I'm ashamed to have anybody up, I've not kept in touch with anybody from work it's the shame of being fatter, the shame of what I done today the same as yesterday, the last five years I've done nothing, em I've got nothing to talk about, nothing to say to people, I can't do anything"* P7

Underlying Participant 7' comments appears to be an uncertainty about whether her self-harm and her current depression are worthy of care. Her low self-worth is particularly salient and she appears to interpret the apparent absence of her family as further evidence of her non-significance.

Loss: There was a theme of loss in seven of the participants' narratives and indeed a struggle to reconcile losses. These unresolved losses were described as both a trigger and maintaining factor for self-harm. These included loss of family due to death, ending of relationships and loss of role. For example, three of the participants were former nurses who were used to caring for others and being knowledgeable about a wide variety of physical health presentations. It was difficult for them to adjust to being in the role of patient rather than carer:

"I was the one that everybody turned to before all this nonsense started and carry on and all that, so going back say 10 - 15 years I was the one that sorted all the problems… and now … I'm the one that's got all the problems and that's hard, hard to take, sometimes I sit and think how did this all go wrong?" P9

Participant 7 reported the various losses were like a "catalyst" for deterioration of her mental health and commencing self-harm to cope:

> "*I lost my mum …she took a sudden heart attack, I lost my brother 11 weeks later and then I had my injury which I coped with for a year but then I lost my career as well which meant I nearly lost my house and different things like that. And that seemed to be a catalyst then, I just had had enough."* P7

Self-harm as Control: An important aspect of self-harm is that it is generally done in secret, it is a private behaviour that the participant has ownership of. Self-harm provided a sense of control, participants (n=6) were able to take control of stressful situations by using self-harm to cope:

> "*…even sometimes when someone's talking to me, I burn myself with a cigarette on my arm and that keeps me okay*" P5

> *"Everything's been so manic and I feel like my self-harm is just one thing that I can do, I'm in control of how bad it is, when I do it, I do it in a specific place and I get that relief"* P2

Self-harm protects against suicide: Five participants articulated that self-harm was a protective factor against suicide. They noted that self-harm kept their mental health from deteriorating to a point where they would consider taking their own lives. Participant 4 described times that he had suicidal thoughts and had attempted suicide, but now he illustrated that self-harm prevented suicidal behaviour, by providing enough relief so that he does not do anything more damaging:

> *"Well there's been times when I've wanted to just end my life and I've tried cutting myself, tried overdosing, em but it's just, it's not worked so instead of going the full way I'll just harm myself enough, just to make sure that I don't do anything worse…"* P4

Similarly, Participant 7 indicated that self-harm prevented her from taking her own life. On the other hand she acknowledged that self-harm was harmful, however it had the benefit of providing relief in the moment, which in turn had defused the situation and prevented suicide, which others found difficult to understand:

> *"I went back to cutting myself, my arms, my legs em but I don't know, I don't know if it sounds right or not, but I feel that everybody else acted as if I was harming myself. And I know I'm not stupid, I know I was harming myself but nobody would listen to my point of view, that though I was harming myself what I was actually doing was saving myself. Because when my harming gets worse it's usually because my mental health is getting worse, and when I cut myself and get release it stops my from killing myself you know, it really does"* P7

Participants made a differentiation between self-harm and suicide attempts, and highlighted the role self-harm plays in preventing suicide, this suggests that suicide and self-harm may be on a continuum, and participants believed that if they did not self-harm more serious consequences would occur.

2.4.2 Difficulties communicating

All participants reported difficulties communicating with others about their self-harm and mental health problems. Participant 3 described feeling unable to express himself, and he also mentioned a trauma history that was too painful to disclose to others:

> *"I wouldn't openly ….divulge what was going on in my mind I would just say "I can't cope" em I didn't actually go into details I just used to say "I can't cope"…. Telling people all the things that had happened to me … I still don't go into great detail about it with anybody, expressing it in words that people will understand"* P3

Participants noted that while they valued communication they found it difficult, and some noted that they would prefer to speak about everyday things to help avoid self-harm. Responses varied whether self-harm served a role in communication. One participant acknowledged that self-harm was an indirect appeal for care:

> *"cause if you're cutting yourself it's like making a statement as well, it's like this is the pain I'm in, you know em …"* P3

Participant 9 noted that there was little contact with his extended family, but after a suicide attempt people got in touch, and that his self-harm initiated contact:

> *"I think I was the one who used to say to people; ' do you need help with this?' and now there's no contact at all unless I've done something stupid …"* P9

In contrast, Participant 4 was adamant that self-harm was not about receiving care or attention and that's why people who self-harm do so in secret. It served to provide relief but not receive attention from others:

> *"… not everybody that does it is looking for attention, I kept it hidden for 11 years so people didn't know. People say that self-harm is for attention but I don't agree that, I don't self-harm for attention it's a relief as such"* P4

This divergence may be related to the experiences of shame described earlier. It may be difficult for some participants to acknowledge that perhaps self-harm may be an indirect appeal for care. This may be a defensive stance considering that this respondent had been accused of "attention seeking" by his friends. However considering that four participants

acknowledged that communication was in part a function of the self-harm it may justify why others were ambivalent about communication, seeking help or receiving care due to fear of judgement and feelings of shame and guilt.

Visible and invisible scarring: There were mixed feelings toward scars. Two participants saw their scars as signs of resilience and coping through difficult times, with their scars seen as a sign of strength. Scars reminded one individual of specific events and the memories associated with them. Looking at scars could also be a reminder of a time when things were much worse than they are now:

> *"It makes me feel like I was in a lot worse place back then I am now, cause I've not got any recent scars as such, like proper with a blade…*[Shows scars on arm] *See that scar there? That there was when I punched my door so I will always remember that one, that's like when my Dad left, that was when my papa died and that one's from getting bullied. I remember all of it, and then it's like I've been in a worse place to where I am now"* P4

Participant 4 noted that scars are powerful and have meaning; he did not deem them to be a negative aspect, rather a sign of strength during difficult times. Five participants noted the embarrassment they felt if an individual commented on their scars. These responses included disliking how the scars looked, being asked about the scars by others, or hiding the scars. This negative attention resulted in participants feeling judged, humiliated and ashamed. While Participant 3 was conscious of his scars, paradoxically, nobody had ever mentioned them:

> *"I'm self-conscious of them now you know em… like I can't wear a short sleeved top or anything like…I would think people were looking at them and stuff like that but nothing was ever mentioned, nothing was ever, ever mentioned I didn't have to explain to anybody or …or anything like that at all, nothing was ever, sort of like mentioned at all"* P3

One participant, who overdosed described memories of his last overdose as painful and humiliating. He reported overwhelming feelings of guilt and shame. It seemed like his scars

were internal and invisible to others, but yet his language indicated overwhelming feelings of guilt and shame:

> "*The thing that's worse for me now is that last one…I started popping all the tablets in front of my daughter and taking them in and that's something that I'd never do, I'd never hurt my wee-one like that and that's what hurts the most that I've done that to her…I'm starting to get annoyed with myself and getting emotional, wish I hadn't done that…I feel embarrassed and ashamed that I done it… I've got nothing else to say… It'll not happen again*" P9

Mental health stigma: Participants illustrated that they always felt inadequate:

> *"There's a lot of attitudes towards it people see it a stigma, you're weak, you're a failure, you don't think you're adequate enough"* P8

Coping with the challenges of mental illness and self-harm led to a greater awareness of themselves and others. This promoted recognition that a large number of people have mental health issues, but the symptoms are invisible and often go unnoticed. At times this left participants feeling unseen, unheard and misunderstood. Six participants stated that people's attitudes to mental health issues and self-harm are still uninformed, judgemental and fraught with inaccurate assumptions:

> *"You'd actually feel guilty telling people because there's a stigma so I wouldn't tell anybody at all"* P8

Three participants highlighted that they felt their mental health problems are often unseen, while physical health problems are more tangible and as a result are treated empathically:

> *"If you've a visible injury you get sympathy…if you don't have a visible injury you don't, people need to understand that"* P3

2.4.3 Social support

Most participants shared the view that they valued the support they received from their friends, families and health professionals to cope with their self-harm behaviour and mental

health difficulties. Some participants described social support as a factor mediating their ability to cope and playing a protective role in desistance from self-harm. Although variation existed across accounts, social support was described as protecting various aspects of wellbeing, and thus negating the need to self-harm. One characteristic of helpful social support related to a sense of acceptance of the self-harm behavior and a non-judgmental stance. In general, participants described valuing having their family there throughout their recovery, to help them cope both practically and emotionally. Participant 4 described the way having his family helped his motivation to keep fighting through the difficult times, in particular when friends were not supportive:

> *"Just my family have helped me really the most…I've lost a lot of my friends… people don't realise that depression can lead to losing friends and things like that and people just think of depression…when I told someone about it he said there's no such thing as depression, depression's just an excuse to be lazy and that's their attitude, that's their opinion"* P4

In addition, participants reported that their family gave them a reason to live, and those who had children (n=5) described it as a protective factor and a reason for living.

> *"If you see my house it's surrounded by photos of my girls and my granddaughter because I have to see why I'm still fighting so hard to be here"* P7

However, some participants (n=4) reported little support from their family and friends as they struggled to understand self-harm:

> *"it took a long time for my Mum to understand my illness … a long, long time, em at that time she didn't' understand my illness dya know? So to her it just seemed … 'there's no need for you to be doing that'"* P3

> *"I found some of my closest friends weren't really my friends, and when I've told them about it they've stopped talking to me and said I'm being stupid, and I'm just looking for attention by self-harming"* P4

There was some conflict expressed about receiving social support, as this inferred that self-harm was no longer private; an aspect that some participants valued. It would seem that social

support was desired by all participants in the context of how alone they felt, but yet risky as it exposed the participant to potential judgment and shame:

> *"You're not as low if you've someone to talk to – I'm a very how can I say it …a deep individual, it's personal, it's private"* P8

Participants also acknowledged that it was difficult for others to understand self-harm, and that it was an uncomfortable topic to raise as they sensed the discomfort of others:

> "*Self-harming to me it's a natural thing but it's not …. I think people find that hard to understand; how do you hurt yourself to help yourself? And to be quite honest with you, five or six years ago I would have probably thought the same"* P8

Some reported receiving a critical, angry response from people close to them who made assumptions about the self-harm and appeared to show little insight and understanding. In addition, the loss of people who provided support through death or ending of a relationship escalated the need to self-harm:

> *"My sister came up and I had my housecoat on and she saw the state of my legs and she said 'I'll support you in anything, but I'll not support you in this' She said if you're cutting yourself 'That's just daft' She said 'Don't, cause I won't have anything to do with ya if you're cutting yourself, how's it going to feel if you die and we're all left without yeah you know …' guilt-trip you know …I felt guilty but I felt she was possible taking away the only thing that made me feel better"* P7

<u>Support provided by health service:</u> Overall participants provided positive accounts of healthcare received; they noted that the community support was helpful and a wide range of supports were offered, such as social groups. Three participants spoke of the importance of communication among health professionals involved in their care, which made them feel well supported:

> *"When Mary* [CPN] *started coming out it was a great relief. It's great because Mary tells me things and I know she feeds back to my Psychiatrist and so I don't feel as if I'm speaking to someone and then I see someone else and it's not connected, I feel as if it is connected"* P5

Four participants reported benefitting from previous engagement with psychological therapy, which addressed the issues which may be underlying the self-harm, such as, trauma, depression and adjustment to physical health difficulties. However, two participants also noted that therapy was difficult and resorted to self-harm to cope with the emotions elicited:

> *"I think therapy is an incredibly wonderful thing, but it's not as easy thing and em… I had a big hard look at myself and I think the emotions that that brought out because I'd spend all my lifetime with these feelings and hadn't shared them, then all of sudden it was out of control and I started using the self-harm which make me feel better again before I got to extremes"* P5

Experience of taking part in this research: Three participants expressed surprise at how much they had disclosed during their interviews and six participants noted it was helpful and cathartic to have the space to speak and think about their self-harm:

> *"I've told you more there then what I've told anyone…you know more than any member of my family does…hmm"* P7

Participant 9 reported that he found the environment of the interview and the space to explore issues enabled him to remember and articulate things he had been unable to:

> *"you see the way I'm talking to you? There's thing that'll come out and I explain everything better because of the way you ask my something… things with my psychological therapist were like that too …it just shows things are clearer sitting talking to someone from a different aspect"* P9

Three participants described wanting to give something back to society and to help others who engage in self-harm by sharing their experiences. The language used by Participant 3 suggested that he would like to use his experiences to contribute to research:

> *"I suffered from it quite badly for a long time and if there's anything I can do to help anybody on the way you know, what's why I've done it* [the interview], *this isn't the first time I've done a research thing em… it's something I feel strongly about"* P3

Participant's experience of taking part in this research is significant, especially considering they reported rarely going out due to social anxiety. It may have provided them with a sense

of purpose which is important in view of the feelings of worthlessness, shame and low self-esteem described earlier.

2.4.4 Gradual desistance

Six participants noted a pattern of replacing or substituting self-harm with other potentially problematic coping strategies such as, drink, drugs, restricted eating, or a less severe form of self-harm. Although these coping strategies may be perceived as harmful, they were seen by participants as useful in the short term:

> *"I've used a lot of negative things to manage…to stop feeling I think."* P5

For some, the cessation of one form of self-harm was achieved through the beginning of another; however the harm was to a lesser degree and thus helpful as a gradual, phased reduction of self-harm. For example, one participant described cutting as his most severe form of self-harm. He now no longer cuts but occasionally would pick at his skin, or burn himself with a hairdryer, which he deemed to be a lesser form of self-harm. Participant accounts gave the impression that self-harm is on a continuum and consisted of a spectrum of behaviours, and that the form of self-harm changed over time for some participants leading to gradual desistance.

<u>Alternative coping strategies:</u> There were varying views about the role of medication, with three participants finding medication particularly helpful during difficult times. However, two participants were uncertain about its utility, with Participant 9 left feeling like a "guinea pig" as a result of the range of medication he received:

> *"I want to get rid of the medication or cut it down as much as possible, because I feel like a guinea pig now with so many different tablets."* P9

Some participants noted that what helped was increased involvement in academic and recreational activities. The development of interests and skills was associated with gradual

desistance from self-harm. Participants (n=6) described other forms of alternative activities to distract from self-harm behaviour, and to cope without self-harming. These included music, art, painting, exercise, gaming and writing in a diary. Participant 4 described the meaningful lyrics in some songs that he could relate to and he imagined himself screaming the lyrics as a way of expression of his pain:

> "*I know a lot of people resort to music, my mum calls it the screaming music but the screaming music helps so it does….and if you're listening to somebody else doing it you can just picture yourself and that being you if that makes sense ….you can listen to someone screaming at the top of their lungs and you can relate to it so it just helps you"* P4

Three participants noted that art, in the form of drawing or doodling, was a helpful coping strategy and an alternative to self-harm. This would seem to serve as distraction but also a creative way to relieve distress:

> *"I'd rather paint a picture that shows how I'm feeling, something like that em …"* P2

Similarly being able to express difficulties was important for participants. Participant 2 noted that keeping a diary was helpful as a way of releasing some of the thoughts she experienced as an alternative to self-harm: however she noted that this may not be adequate and that on occasion she needed to self-harm to provide further relief:

> *"It feels too much in my head, I feel like, I can't, I need to get it out, so when I write in my diary it seems to drain the thoughts a little bit, em and it gets to the stage that I can't take that get that anymore and that's when I self-harm"* P2

One participant had found gaming as an alternative to self-harm and spoke of the enjoyment he got from playing games, and particularly connecting with others with similar interests online. He described a supportive on-line environment that was important for him, and promoted desistance from self-harm:

> *"I've met a lot of people on it and it means you get to know somebody and you get to tell them like when I'm playing I talk to people on skype, and I've got people from Sweden and Netherlands places like that have been speaking to me, and if I'm having*

> *a bad day with my depression or anything like that they'll say to me "what's up with ya?" And I've told them I've depression and quite a lot of people I've spoken to have had depression or self-harming, and people resort to playing games, violent games as such to take their mind off it cause it's stopping you from doing it and it's not yours as such"* P4

It may be that computer games and internet forums are 'low risk' activities that can still fulfill, even if in the short term, basic emotional needs and are less threatening than face to face contact. However, other participants described having little alternatives to their routine self-harming behaviour and noted that safer self-harm behaviours such as flicking an elastic band or an ice cube on their skin had little impact. It seemed that the powerful feeling of relief following self-harming was very hard to substitute with an alternative behaviour. As participants had found self-harm to be helpful in the short term, most (n=8) described that it remained an option.

Desistance is time-limited: Although participants described alternatives to self-harm, there were consistent reference to the limitations of these alternatives and that self-harm was always an option in the event that they feel it was required. Desistance was therefore seen to be temporary and time-limited:

> *"I usually resort to self-harming but now I can play games or something like that but if I'm needing to draw blood from myself then I will because it helps me, it's a way of coping"* P4

Participants (n=4) explained that desistance could result in more severe self-harm behaviour and that it seemed inevitable that they will eventually self-harm. For some, a reduction in the frequency of cutting resulted in increased severity when it next happened. Although Participant 2 had attempted to desist from self-harm as she is now a parent, she was also clear that desistance was time limited:

> *"Since I've had my wee boy I've managed to keep it under wraps as much as I can but you can't really cause it's going to come out no matter how much you push it away, cause it pretty much lives with you on a day to day basis…It's probably got worse in the sense I'm a bit more ruthless with myself now… I think because I used to do it*

> *more often and now I'll try to not think about it it'll build up…it might be a couple of days before I do it and it can be a lot worse, more severe, I hurt myself a lot more."* P2

Access to means to self-harm: Participants described the importance of having access to the means to self-harm and the comfort that this provided. This was central to the narratives of the participants, in particular the six women. Having access to ways of self-harming made them feel safe, and gave a way of coping if needed. Being told to cease self-harm had led to engaging in other self-harm behaviours or increased suicidality:

> *"I think I might feel suicidal again if it* [blade] *wasn't there."* P1

> *"If they hide all the razor blades what would I do when things got so bad? … I don't know what I would do"* P7

In contrast, two of the male participants noted they try to control access to the means of self-harming, suggesting a possible gender difference. For example, Participant 3 avoided sharp knives when in the kitchen, and Participant 9 noted that his medication now comes in a blister pack and his wife manages this so he does not have access:

"The only preventative measure would be I've got my wife to deal with the tablets." P9

Ambivalence regarding self-harm and suicide: There was a clear sense of ambivalence about self-harm and suicide across accounts. Despite participants expressing a desire to stop, they expressed doubt as to whether this was feasible. Although alternative coping strategies were described, self-harm remained as an option should levels of stress reach their threshold of tolerance. Self-harm was described as a manifestation of emotional and psychological distress and played a role in self-preservation and the prevention of suicide. Across interviews there was a poignant message of a group of people who were continually struggling with mental health difficulties.

On-going difficulties: On-going difficulties were apparent for all participants, in particular depression, social anxiety and paranoia. Six participants described social anxiety, where the

physiological symptoms of anxiety, and the prospect of speaking to others, were seen as a barrier to relationships. This seemed to be linked with feelings of shame and fear of judgement from others. Most (n=7) required support to go out socially:

> *"I don't really go out and I've been shutting myself away and … I've got into a kind of rut just now where I've shut myself away I've not been going out …"* P3

> *"I go to this group but I can't interact like talking and getting into conversations – I just like to sit and listen, there's a wee lady talks to me, I just feel as if they don't like me, I feel as if nobody likes me."* P6

Resilience: There was a tremendous sense of resilience in the accounts of respondents in spite of adversity, with expressions of hope and a positive outlook toward the future. Participant 1 found support from popular positive sayings:

> *"Life isn't about waiting for the storm to pass it's about learning to dance in the rain" and I've read that a few times and I was just thinking that's actually really good advice, why be negative when you can try to be positive? And that's just really helped me along. Basically emm…if you try… if you try and be positive, it's more likely you'll be happy then just instead of just being depressed to the point where you're going to hurt yourself then when you can find something to bring you up, it might not make you happy but you won't be as sad as you were"* P1

Trying to think positively was used by three participants to help manage the psychological impact of events such as loss of friends or job. They spoke of adapting to their circumstances and the benefits of positive thinking in helping them to cope. Participant 2 chose to protect her wellbeing from any negative impact by focusing on the here and now, rather than ruminating on her losses. Her language also conveyed how her goals have become more present focused and that she had a new appreciation for the joy of daily life experiences:

> *"So I write in my diary and long term I'm not allowing this to consume me, and I try to stay positive, even if it's just 'oh it's sunny today,' something as simple as that can change my frame of mind"* P2

The results have attempted to capture the dominant themes and experiences of the participants as a collective group, whilst striving to retain each individual's unique journey.

Clearly a tension exists in this process and it is recognised that no one account will fully represent the broad spectrum of each participant's experiences. Coping with self-harm seems to be full of inherent contradictions. However it is testament to participants' resilience that they find ways to cope and adapt to ongoing difficulties. It is essential for patients to have access to supports when needed to help reinforce their resilience when required. Perhaps the seemingly paradoxical nature of the results and the journey experienced by many participants is best made sense of by Participant 8:

> *"So what I'm trying to do is stay on the bike and keep going…unless you get a puncture"* P8

2.5 Discussion

This research explored the experiences of patients who self-harm in relation to the expression and function of self-harm, and the factors that play a role in desistance. Four superordinate themes emerged from the data; Relief from psychological distress, Social support, Difficulties communicating and Gradual desistance. Results of this study suggest that self-harm is on a continuum of severity for most participants, being a long-standing, effective strategy for coping with psychological distress. The comfort and relief provided by self-harm is also noted in previous studies (Klonsky, 2007; Rotolone & Martin, 2012). Coping strategies employed as alternatives to self-harm included activities that provide distraction such as art or keeping a diary, factors that support desistance from self-harm included, social support, positive thinking, therapy and are in agreement with previous findings (Gelinas & Wright, 2013). Moreover, the barriers to cessation reported in this study; ongoing stress and mental health difficulties were also reported by Gelinas and Wright (2013). The finding that self-harm was addictive (Gelinas & Wright, 2013) was not supported in the current study.

The factors associated with resolution of self-harm by Sinclair and Green (2005), were not

supported in this study. This disparity may be related to variation of sample characteristics; as their sample consisted of participants who had not self-harmed in two years.

The results pose some interesting questions regarding the cessation of self-harm, with desistance from one form of self-harm often achieved by commencement of another, this was also substantiated in previous research (Gelinas & Wright, 2013). Adaptive coping skills were employed by many, but were not always beneficial in times of increased stress. The psychological difficulties underlying the self-harm may remain unresolved, thus self-harm may be used as a way of avoiding a completed suicide . Therefore cessation of self-harm is not a reliable indicator of improved mental health, unless it is accompanied by shifts in other areas of people's lives (Shaw, 2006).

Although the meaning of self-harm has been covered in various studies, and was not the focus of this research, it was evident across accounts. The context in which the behaviour occurs, and the meaning attributed to it by the individual, is of considerable significance. In agreement with Gardner (2001) and Russell and colleagues (2010) the self-harm encountered in this research was both 'appealing' and 'appalling' to the participants. Participants experienced shame and guilt in relation to their self-harm but also relief and comfort. It appears a dichotomy exists between the "benefits" and the negative consequences of self-harm, such as hostile judgements from others and scarring.

Consistent with previous research (Brown & Kimball, 2013; Cooper, Kapur, Webb, Lawlor, Guthrie, et al., 2005), self-harm was reported to prevent suicide. Self-harm was deemed to be a coping strategy, and therefore, intervention to prevent self-harm may possibly be harmful (Arnold, 1995). This is an important finding, considering that prevention and cessation prevail in treatment approaches (Warm et al., 2002). NICE (2011) guidance of longer term management of self-harm outlines a move toward harm reduction as the primary aim of

intervention. Harm reduction requires further research, however there is evidence supporting this approach in substance misuse (Kendall et al., 2011). Harm reduction focuses on supporting individuals to reduce the risk and the damage of their self-harm (Shaw, 2012). The concept of 'gradual desistance' suggested by results of the current research would support harm reduction as an alternative to preventative approaches, where the aim is to prevent people from self-harming. Interestingly, in contrast to other studies (Taylor et al., 2009; Brown & Kimball, 2013) where participants reported unhelpful support from health professionals, results of this study suggest that help received from health professionals was generally useful.

2.5.1 Clinical Implications

The generalisability of qualitative research is often limited by small sample sizes, but these accounts provided a richness of individual experience that is enlightening for clinical work. Results suggest that the assessment of the function of self-harm must be completed before considering interventions to reduce it. Given the findings of this study and previous studies (Gelinas & Wright, 2013; Arnold, 1995), where self-harm was deemed to be the only method of coping available to some participants, and a protective factor against suicide, work to reduce the self-harm should be gradual, limiting the harm with the goal of the self-harm behaviour occurring at a level that is safe for the participant. Intervening to constrain self-harm behaviour may be detrimental to the patient (Warm et al., 2002). Rather, a therapeutic environment must be created that is non-judgemental and in which the patient can explore the role of self-harm in their lives, prior to attempting to address the self-harm. This may be in contrast to the treatment offered in some services where the primary goal is to reduce the self-harm behaviour (Warm et al., 2002). This is in line with NICE (2011) guidance that recommends harm reduction rather than intervention focussed on cessation for patients who use self-harm as a coping mechanism to prevent suicide. Interventions involving psycho-

education about risk of infection, wound care, safer forms of self-harm, self-harm alternatives and skills building would be appropriate (Shaw, 2012). Participants identified various alternative coping strategies which were often distraction techniques, however, when levels of stress exceed the tolerance of the individual, the alternative coping strategies are redundant and the participant seeks the immediate and effective relief provided by self-harm. The psychological difficulties underneath the self-harm behaviour must also be considered, as they are likely to maintain the behaviour.

The data in this study suggests that communication and social support are required to support desistance from self-harm and this is in line with previous studies (Gelinas & Wright, 2013). In terms of increasing social support, community psycho-education sessions may be helpful for family members, as participants gave varied responses in terms of support from family members and noted their lack of knowledge and understanding. Wider and inclusive support networks would support treatment, and help to ensure that individuals who self-harm do not perceive others to be judgemental, as this may further antagonise their feelings of guilt, shame and humiliation. As a major factor in completed suicide; self-harm can no longer be regarded as a marginal or shameful behaviour (NICE, 2011).

2.5.2 Implications for Research

The qualitative design of the current study accessed more rich detail than could be afforded by a quantitative design. Consistent with the majority of qualitative research, the sample size was small; therefore results are tentative and require further corroboration. Further studies with a clinical sample should be considered in light of the relative absence of research with individuals who repeatedly self-harm (Skegg, 2005). As this study was from the perspective of the patient and highlights the role of social support, the involvement of relatives of patients who self-harm, may produce potentially different accounts which would expand the results of

this study (Hume & Platt, 2007). Future research may also consider a prospective, longitudinal design over the course of self-harm. Furthermore, a more equivalent gender ratio would be preferred for future research in light of the uncertain gender differences between males and females who self-harm. Interestingly, participants were agreeable to taking part in this study, which is consistent with the results of Biddle and colleagues (2013) and Ghio et al. (2011) who reported that participants were comfortable being involved in the analysis of their difficulties and their contribution was informative. This is an important finding considering the perceived ethical issues associated with conducting research with participants who have a history of self-harm or suicidal behaviour. This study provides further support to the utility of qualitative methods with 'high-risk' clinical samples. It is important that the interviewer has some clinical experience and is trained in risk assessment. The availability of follow-up support is essential; one of the strengths of this study was that participants were all being supported by either a CPN or an OT.

2.5.3 Limitations

The results of this research must be viewed alongside its limitations. The sample in this study reflects individuals with mental illness who are receiving community support. Members of the CMHT were gatekeepers during recruitment and used their clinical judgement when referring potential participants, therefore there was potential bias and this sample may not be representative. Although methodological guidelines were followed, one of the limits of this study is the element of interpretation which is an intrinsic component of IPA. The findings may be considered as a co-construction between the participant, researcher and relevant literature (Thomson et al., 2008). Steps were taken to minimise limitations including inter-rater reliability checks during analysis, supervision, use of a reflective journal and internal and external auditing. Although small samples are common in qualitative research (Smith, 2011) the benefit of larger quantitative studies is the increased validity of a large sample.

Further, the participants all resided in the same geographic location, and this limits the generalisability of these findings, future research should consider a more diverse sample.

2.5.4 Conclusion

Despite these limitations, the results of this study are meaningful and relevant to the current discourse on self-harm. This study adds to previous literature providing interpretations of the complex and variable process of desisting from self-harm. Self-harm is a significant challenge for health professionals working in Adult Mental Health services and therefore requires greater awareness, understanding, intervention and future research to reduce the high rates of repetition and eventual suicide. Furthermore, the results support the concept that self-harm and suicide are on a continuum (O'Connor & Sheehy, 2000; Skegg, 2005), with self-harm moderating the risk of suicide. This poses questions around definitions; if self-harm and suicide are on a continuum, a distinction between the two does not seem beneficial, and limits study comparability.

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Appendices

Appendix A. Author guidelines: Archives of Suicide Research

This journal uses ScholarOne Manuscripts (previously Manuscript Central) to peer review manuscript submissions. Please read the guide for ScholarOne authors before making a submission. Complete guidelines for preparing and submitting your manuscript to this journal are provided below.

Please note that ***Archives of Suicide Research*** uses CrossCheck™ software to screen papers for unoriginal material. By submitting your paper to ***Archives of Suicide Research*** you are agreeing to any necessary originality checks your paper may have to undergo during the peer review and production processes.

Archives of Suicide Research , the official journal of the International Academy for Suicide Research, is an international journal in the field devoted to suicide research. The contributions in Archives represent the breadth of suicide erudition in the scientific community featuring original research from diverse disciplines including biology, psychiatry, psychology, and sociology. The journal has become renowned for reporting on the most current and relevant aspects of suicide research, as well as defining the foundations of the field.

Archives of Suicide Research receives all manuscript submissions electronically via its ScholarOne Manuscripts site located at: http://mc.manuscriptcentral.com/usui . ScholarOne Manuscripts allows for rapid submission of original and revised manuscripts, as well as facilitating the review process and internal communication between authors, editors and reviewers via a web-based platform. ScholarOne Manuscripts technical support can be accessed via http://scholarone.com/services/support/ . If you have any other requests please contact the journal's editorial office at archives@nyspi.columbia.edu

Review Process. The Journal Editor and Editorial Staff determine whether the subject matter and content of the manuscripts submitted are pertinent to ASR. The manuscript will be sent out for peer review if it is found to be relevant and important. All reviewers remain anonymous. Authors will be informed of the Editor's decision regarding their manuscript's status of publication when the review process ends.

Manuscript Organization. *Cover Letter.* A cover letter must be included indicating that the material is intended for publication and that all the authors have agreed to the content and submission of the manuscript. *Title page:* The title page should include the following:
- Title of the manuscript: Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 characters and spaces.
- Total word count
-Up to 6 keywords (Please consult our guidance on keywords here .)

- Complete contact information: this includes the corresponding author's full name, title, telephone number, fax number, and e-mail address.

Disclosures and Acknowledgments: authors are required to disclose of all forms of support, including

financial support or involvement in their cover letter. Pharmaceutical company and grant support, as well as any other supportive agency, grant number or contract, and acknowledgments of individuals should all be included here.

Abstract: Each article should be summarized in an abstract of no more that 120 words. Abstract should be separated into Objectives, Methods, Results, Conclusion. Avoid abbreviations, diagrams, and reference to the text.

Text: The contents of the text should adhere to the general structure of scientific papers: introduction, method, results, and discussion. If applicable, it should be made clear in the methods section that informed consent was obtained from subjects who participated in the study.

Illustrations: Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines: 300 dpi or higher; sized to fit on journal page; EPS, TIFF, or PSD format only; submitted as separate files, not embedded in text files.

Color illustrations will be considered for publication; however, the author will be required to bear the full cost involved in their printing and publication. The charge for the first page with color is $900.00. The next three pages with color are $450.00 each. A custom quote will be provided for color art totaling more than 4 journal pages. Good-quality color prints or files should be provided in their final size. The publisher has the right to refuse publication of color prints deemed unacceptable.

Tables and Figures

Tables and figures should be numbered and included as separate sheets or files. Tables and figures should not be embedded in the text. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet.

References

References should be listed on separate pages following the text. They should be listed alphabetically by first author and should not be numbered. Be sure all references have been cited in the text. Provide the last names and first initials of maximum three authors; “et al.” should be used for articles containing more than three authors. Journal names should not be abbreviated. Italicize journal names and book titles. Article references should include the author names, year of publication, title of the article, complete name of the journal, the volume and the page numbers in which the article appears.

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Appendix B. STROBE Statement

	Item No	Recommendation
Title and abstract	1	(*a*) Indicate the study's design with a commonly used term in the title or the abstract
		(*b*) Provide in the abstract an informative and balanced summary of what was done and what was found
Introduction		
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported
Objectives	3	State specific objectives, including any prespecified hypotheses
Methods		
Study design	4	Present key elements of study design early in the paper
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection
Participants	6	(*a*) *Case-control study*—Give the eligibility criteria, and the sources and methods of case ascertainment and control selection. Give the rationale for the choice of cases and controls *Cross-sectional study*—Give the eligibility criteria, and the sources and methods of selection of participants
		(*b*) *Case-control study*—For matched studies, give matching criteria and the number of controls per case
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group
Bias	9	Describe any efforts to address potential sources of bias
Study size	10	Explain how the study size was arrived at
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why
Statistical methods	12	(*a*) Describe all statistical methods, including those used to control for confounding
		(*b*) Describe any methods used to examine subgroups and interactions
		(*c*) Explain how missing data were addressed
		(*d*) *Case-control study*—If applicable, explain how matching of cases and controls was addressed *Cross-sectional study*—If applicable, describe analytical methods taking account of sampling strategy
		(*e*) Describe any sensitivity analyses

Continued on next page

Results		
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed
		(b) Give reasons for non-participation at each stage
		(c) Consider use of a flow diagram
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders
		(b) Indicate number of participants with missing data for each variable of interest
		(c) *Cohort study*—Summarise follow-up time (eg, average and total amount)
Outcome data	15*	*Cohort study*—Report numbers of outcome events or summary measures over time
		Case-control study—Report numbers in each exposure category, or summary measures of exposure
		Cross-sectional study—Report numbers of outcome events or summary measures
Main results	16	(*a*) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included
		(*b*) Report category boundaries when continuous variables were categorized
		(*c*) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses
Discussion		
Key results	18	Summarise key results with reference to study objectives
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence
Generalisability	21	Discuss the generalisability (external validity) of the study results
Other information		
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based

Appendix C. Quality appraisal of reviewed studies

Table 2. Quality appraisal of reviewed studies.

Paper	**Percentage % based on STROBE**	**Quality rating**
Wu et al. (2013)	77%	Moderate
Kotler et al. (1993)	77%	Moderate
Jeglic et al. (2007)	73%	Moderate
Suresh Kumar & George (2013)	68%	Moderate
Kaslow et al. (1998)	77%	Moderate
Kaslow et al. (2002)	82%	Good
Compton et al. (2005)	82%	Good
Jenkins et al. (2005)	73%	Moderate
You et al. (2011)	77%	Moderate
Benda (2005)	73%	Moderate
Cheung et al. (2006)	68%	Moderate
Chou et al. (2013)	77%	Moderate

Appendix D. Author guidelines: *Qualitative Research in Psychology*

This journal uses ScholarOne Manuscripts (previously Manuscript Central) to peer review manuscript submissions. Please read the guide for ScholarOne authors before making a submission. Complete guidelines for preparing and submitting your manuscript to this journal are provided below.

Aims and Scope. *Qualitative Research in Psychology* aims to become the primary forum for qualitative researchers in all areas of psychology—cognitive, social, developmental, educational, clinical, health, and forensic—as well as for those conducting psychologically relevant qualitative research in other disciplines.

Qualitative Research in Psychology is dedicated to exploring and expanding the territory of qualitative psychological research, strengthening its identity within the international research community and defining its place within the undergraduate and graduate curriculum. The journal will be broad in scope, presenting the full range of qualitative approaches to psychological research. The journal aims to firmly establish qualitative inquiry as an integral part of the discipline of psychology; to stimulate discussion of the relative merits of different qualitative methods in psychology; to provide a showcase for exemplary and innovative qualitative research projects in psychology; to establish appropriately high standards for the conduct and reporting of qualitative research; to establish a bridge between psychology and the other social and human sciences where qualitative inquiry has a proven track record; and to place qualitative psychological inquiry appropriately within the scientific, paradigmatic, and philosophical issues that it raises.

Please note that *Qualitative Research in Psychology* uses CrossCheck™ software to screen papers for unoriginal material. By submitting your paper to *Qualitative Research in Psychology* you are agreeing to any necessary originality checks your paper may have to undergo during the peer review and production processes.

Types of Manuscripts. *Qualitative Research in Psychology* will publish the following types of paper:

1) Theoretical papers that address conceptual issues underlying qualitative research, that integrate findings from qualitative research on a substantive topic in psychology, that explore the novel contribution of qualitative research to a topic of psychological interest, or that contribute to debates concerning qualitative research across the disciplines but with special significance for psychology
2) Empirical papers that report psychological research using qualitative methods and techniques, those that illustrate qualitative methodology in an exemplary manner, or that use a qualitative approach in unusual or innovative ways
3) Debates
4) Book reviews

Submissions for special issues will normally be announced via an advertisement in the journal, although suggestions for topics are always welcome. Book reviews will normally be suggested by the Reviews Editor, although unsolicited reviews will be considered. The journal will also review other relevant media as well as qualitative research software.

All papers are refereed by, and must be to the satisfaction of, at least two authorities in the topic. All material submitted for publication is assumed to be exclusively for *Qualitative Research in*

Psychology, and not to have been submitted for publication elsewhere. Priority and time of publication are decided by the editors, who maintain the customary right to edit material accepted for publication if necessary.

Submission of Manuscripts. *Qualitative Research in Psychology* receives all manuscript submissions electronically via its ScholarOne Manuscripts site located at http://mc.manuscriptcentral.com/uqrp . ScholarOne Manuscripts allows for rapid submission of original and revised manuscripts, and facilitates the review process and internal communication between authors, editors, and reviewers via a web-based platform. ScholarOne technical support can be accessed at http://scholarone.com/services/support . Authors should upload three files in total: a separate title page with author names and institutional affiliations, a blinded main document, and a separate document for any tables and figures. The editorial office accepts papers in either UK or US page size formats.

Manuscripts should be double-spaced throughout, especially the references. Pages should be numbered in order. The following items must be provided in the order given:

1) Title Page .

Authors and affiliations: Authors should include their full name and the establishment where the work was carried out (if the author has left this establishment, his/her present address should be given as a footnote). For papers with several contributors, the order of authorship should be made clear and the corresponding author (to whom proofs will be sent) named with their telephone/fax/e-mail contact information listed.

Abstract: Please provide an abstract of approximately 150 words. This should be readable without reference to the
article and should indicate the scope of the contribution, including the main conclusions and essential original content.

Keywords: Please provide at least 5–10 key words.

About the author: Please provide a brief biography to appear
at the end of your paper.

2) Text.

Subheadings should appear on separate lines. The use of more than three levels of heading should be avoided. Format as follows:
1 Heading
1.1 Subheading
1.1.1 Subsubheading
Footnotes should be avoided. If necessary, they should be supplied as end notes before the references.

3) References.

The Harvard style of references should be used. The reference is referred to in the text by the author and date (Smith, 1997) and then listed in alphabetical order at the end of the article applying the following style:

For a book: Hollway, W & Jefferson, T 2000, *Doing qualitative research differently: free association, narrative and the interview method,* Sage, London.
For an edited book: Brown, LM 2001, 'Adolescent girls, class, and the cultures of feminity', in MJ Packer & MB Tappan (eds.), *Cultural and critical perspectives on human development,* SUNY Press, Albany, NY, pp. 219–240.

For a journal article: Madill, A, Jordan, A and Shirley, C 2000, 'Objectivity and reliability in qualitative analysis: realist, contextualist and radical constructionist epistemologies', *British Journal of Psychology,* vol. 91, pp. 1–20.

4) Acknowledgements.

Authors should acknowledge any financial or practical assistance.

5) Tables.

These should be provided in a separate file from the text and should be numbered in sequence. Each table should have a title stating concisely the nature of information given. Units should be in brackets at the head of columns. The same information should not be included in both tables and figures.

6) Figure captions.

These should be provided together on a page following the tables.

7) Figures.

Figures should ideally be sized to reproduce at the same size. All figures should be numbered consecutively in the order in which they are referred to in the text. Qualifications (A), (B), etc., can only be used when the separate illustrations can be grouped together with one caption. Please provide figures at the end of your paper on a separate page for each figure. Once accepted, you will be required to provide a best quality electronic file for each figure, preferably in either TIFF or EPS format.

Illustrations. Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean
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Appendix E. Research Ethics Committee favourable opinion letter

[redacted] NHS Board

South East Scotland Research Ethics Committee 01

NHS

[redacted]

Ms Anne Caulfield
Trainee Clinical Psychologist
[redacted]

Date 11 March 2013
Your Ref
Our Ref

Enquiries to: [redacted]
Extension:
Direct Line:
Email:

Dear Ms Caulfield

Study title:	**An exploration of the protective factors that influence desistance from deliberate self-harm in a community based adult population.**
REC reference:	**13/SS/0034**
Protocol number:	**N/A**
IRAS project ID:	**113011**

The Research Ethics Committee reviewed the above application at the meeting held on 06 March 2013. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator [redacted]

Ethical opinion

- The Committee considered that this project was straightforward and worthwhile.
- The Committee discussed the tone, in particular the use of first and third person, of the PIS with the CI and requested that it was consistent throughout.
- The Committee sought clarification as to whether travel expenses would be available or not? The CI agreed to look into this and detail in the PIS what if anything would be available.
- The Committee requested that "What will I have to do?" be replaced with the more friendly ""What will the study involve?"
- The Committee requested that the word "desistance" in the title be replaced and that the standard format of the PIS be used throughout.
- The CI agreed that more information regarding when confidentiality should be broken could be detailed.

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[redacted]

Appendix F. Participant Information Sheet

Participant Information Sheet

I am a Trainee Clinical Psychologist employed by NHS X and studying at the University of Edinburgh. As part of our training, we complete a research project. This project is supervised by Clinical Psychologists in both the University of Edinburgh and NHS X.

We would like to invite you to take part in a research study. Before you decide we would like you to understand why the research is being done and what it would involve. Self-harm is a common experience among people when they feel distressed. This study wants to find out about the factors that help people to stop self-harming. This study invites people aged 18 and over to participate in an interview to discuss their experiences. The interview will ask about experiences of self-harm but it will mainly focus on what has been supportive during difficult times.

Why is the study being done?
We know a lot about what may cause someone to self-harm. Little research exists on what people find makes them less likely to self-harm. Finding out about what makes someone less likely to self-harm may be important in helping health professionals to think about how people can be supported. It could also help to understand if people have found personal ways of coping that they might not get elsewhere from family, friends or health professionals.

What will the study involve?
The researcher will initially contact interested participants by phone to answer any questions they may have about taking part in the research. If they are happy to participate, arrangements will be made to meet for an interview at a convenient time and place. The interview will take about 40 minutes to complete. Firstly participants will be asked for their consent to take part in the research, which will involve signing a consent form before the interview. The researcher will then ask some questions about the person's experiences of self-harm and what has been found to help someone not to self-harm. The participant can pause or discontinue the interview at any point. With participant's permission, the interview will be audio recorded so that the researcher does not miss anything important. This recording will be kept strictly confidential and stored securely. The recording will be destroyed after the study has been completed.

Travel Expenses
Travel expenses will be available to cover the cost of attending the interview.

Are there any benefits to taking part?
Some people find talking about their experiences in a confidential and non-judgemental environment a positive experience. Taking part in the project may not help somebody directly, but it is hoped that the research will help understand how people who self-harm find support or support themselves. This might help to identify things that could be developed in the future to help support people that may be experiencing similar problems. A letter summarising the outcomes of the study will be posted to participants after the study is complete, if they have said they would like to receive this information.

Are there any disadvantages to taking part in the research?
As the participant does not know the researcher, it could make some people feel hesitant about taking part. Taking part in the research will not affect health treatment or future involvement in health services in any way. Some of the topics talked about during the interview may bring attention to things that a participant find's difficult. If taking part in this research raises any concerns or distress, the researcher will be available to discuss this after the interview and there is an option to receive further support from a Clinical Psychologist or CPN.

Will it be private?
All information will remain anonymous; real names will not be used. The interview will be kept private and will not be shared with anyone outside of the research team. It is sometimes useful to use direct quotes when writing up projects like this to show examples. If this happens, the researchers will leave out the name of the person who said it.

The only time confidentiality would be broken is if a participant said that they, or someone else would come to harm. In this case, the researcher would contact the individual's CPN to ensure that enough support is being provided.

If somebody completed the interview but then decided that they did not want to take part after all, the person can contact the researcher to ask for their information to be taken out of the study. This is okay and the researcher will not ask for a reason why.

How to take part?
Taking part is entirely voluntary. Anyone who is interested in taking part can contact the researcher directly using the contact details below, or, they can ask their CPN to let the researcher know that they are interested and the researcher will phone them.

Further questions or concerns
Please contact the researcher and/or research supervisors with any questions about the study: Anne Caulfield, Trainee Clinical Psychologist, Tel: 0000

This project is being supervised by:

Dr Ethel Quayle, Lecturer in Clinical Psychology, University of Edinburgh, Tel: 0131 504698

Appendix G. Research Project Information Page for CMHT

Research Project Information Page

I am a Trainee Clinical Psychologist employed by NHS X and studying at the University of Edinburgh. As part of our training, we complete a Doctorate level research project. This project is supervised by Clinical Psychologists in both the University of Edinburgh and NHS X.

The study wants to find out about the protective factors that influence people with a history of self-harm. I hope that people aged 18 and over will agree to meet me for an interview to discuss their experiences. In the interview I will ask about their experiences of self-harm and what they have found to be helpful during difficult times. I would like to conduct my research with approximately 8 adults between the ages of 18 and 65 years. I am writing to you in the hope that you may be able to assist me in recruiting participants for this.

Why is the study being done?

We know a lot about what may cause someone to self-harm. Little research exists on what factors contribute to people abstaining from self-harm. Finding out about what people find makes them less likely to self-harm may be important in helping health professionals to think about how people can be supported. It could also help to understand if people themselves have found personal ways of coping that they might not get elsewhere from family, friends or health professionals.

What will I have to do?

If you are supporting someone who has a history of self-harm the researcher would like you to give them an information sheet about the study, and invite them to take part. If they agree, I will contact the prospective participant to arrange to take part in the research. It would be helpful if you could provide me with their name and contact details.

What if I have further questions?

Please do not hesitate to contact me or my supervisors if you have any questions about the study:

Anne Caulfield, Trainee Clinical Psychologist, anne.caulfield@nhs.net

This project is being supervised by:

Dr Ethel Quayle, Lecturer in Clinical Psychology, University of Edinburgh, Tel: 0131 504698

Appendix H. Consent form

Consent form for research project

Please initial each box:

I have read the participant information sheet (Version 2: 10/04/2013) for the above study.	☐
I have had the opportunity to ask questions and discuss the study and I am satisfied with the answers to my questions. I have received enough information about the study.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and this will not affect any support I may be receiving.	☐
I agree to the audio-recording of the interview.	☐
I understand that quotes from the interview may be used in research reports, but that my personal details will be removed so that it is not possible to identify me and any material about me will be kept strictly confidential.	☐
I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from the Sponsor(s), from regulatory authorities or from the NHS Board where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	☐
I agree to take part in this study.	☐

Name of participant _____

Signature _____ **Date**_____

Name of person taking consent_____

Signature_____ **Date**_____

Appendix I. Participant Debrief Information Sheet.

Participant Debrief Information

I would like to extend a heartfelt “Thank You” for participating in this research. Again I would like to assure to you that the data obtained will be treated confidentiality and that you will not be identifiable.

If you would like me to keep you updated with the study I will send you a letter after the study is complete to summarise the findings.

If taking part in this research has raised any concerns or caused you distress, you can talk to me or we can discuss options for you to receive further support from a Clinical Psychologist. You can also contact your GP or CPN.

Some other useful phone numbers include:

NHS 24 08454 24 24 24

Samaritans 08457 90 90 90

Breathing Space 0800 83 85 87

Finally if you have any questions or queries regarding this study or the research process please do not hesitate to contact me or the research supervisors:

Anne Caulfield, Trainee Clinical Psychologist, NHS X, Tel: 0000

This project is being supervised by:

Dr Ethel Quayle, Lecturer in Clinical Psychology, University of Edinburgh, Tel: 0131 504698

Appendix J. Interview schedule.

Semi-structured interview schedule

Key

- Question
  - Prompt

- Could you tell me about your experiences of self-harm?
  - How long have you been harming yourself for?
  - What do you do (what method/methods do you use)?
  - What does self-harm mean to you?
  - Tell me more
  - Give me some examples
  - Does the fact that you self harm make sense to you?
  - Why do you think you (Insert method e.g. cutting)

Protective factors

- What do you find helps you at times when you feel like you would like to harm yourself?
  - What do you think prevents you from harming yourself?
  - What do you think you do to stop yourself from harming yourself?
  - Have others helped you to not self-harm?
  - What supports you when you try *not* to self-harm ?
  - Is there anything particular you avoid so as not to self-harm

- Can you tell me about a recent time/the last time you self harmed?
- Was there anything that would have prevented you from [method]
- Has your self-harm changed over time?
- Any particular events/things that reduce the urge to self harm?
- Would you say that harming yourself has been helpful and/or unhelpful in any ways

Support – family friends and professionals:

- Have you spoken to anyone about your self harm?
- Have you ever sought help (from a professional) about yourself harm?
- If yes – what was it like?
- Did you have any fears about telling anyone/ Do you have any current fears
- What kinds of support do you/would you find helpful?

Finally:

- Is there anything else you would like to say which we have not covered?
- Do you have any questions you would like to ask me?
- Do you have any feedback about the questions I have asked during this interview?

Appendix K. Coding Extract from transcript.

Emergent themes	Transcript	Exploratory notes
Ongoing difficulties Avoidance Social anxiety Experience of taking part in research Gradual desistance Self-harm is private	R And now, I know you said you no longer work …so what kind of things do you do now? P I don't really do anything em… I still have a lot of problems, I still see my psychiatrist and what have ya, I still, I still have a lot of problems you know with paranoia and the different things I'm not really one for going out or kinda, I've been at a stage since this last 8 or 9 months when I haven't been going out over the door at all, this is the first time I've been out all week the only reason why I'm doing this is because anything I can do research and mental health I'll do you know, what'll help somebody em but I don't really go out and I've been shutting myself away and … I've got into a kind of rut just now where I've shut myself away I've not been going out ….and I've not been doing much really just watching telly or I try to read but sometimes I try to read but I can't see the letters on the page but I can't, just put the telly on sometimes I don't even look at it I just turn away from it I just listen to it em … but that's what I've been kinda doing which I'm trying to break the now, I'm trying to break that and go out and see my friends em … try and break this… cycle or whatever it is I've got into. Em… I've not been thinking about self-harm you know unless occasions where the only help I've had is CPNs or therapies etc etc it's helped put that to rest. I don't know but I'm just not thinking about it or thinking about actively doing it, as I said the last time was about three months ago so … R And when you think back to that time now, is there anything that would have prevented you from self-harming? P I don't think so because I'd done it all, you now I made sure there was nobody near … I planned it you know, I made sure I had the equipment there, I had the knives em , I done it in my room and the cuts weren't that bad to begin with they were superficial but then secretly getting worse	Repetition "a lot of problems" e.g. paranoia, limited social activity Research is important, helping others by sharing his experience Pattern/rut of isolation, not going out Hard to concentrate on TV or books Hope – trying to break cycle, go out more, see friends Self-harm reduced, therapy and CPN input helpful Self-harm rare now Planned, secret, private

Self-harm as only option Spectrum of self-harm Access to means	more dermal, going into the dermis … so deeper which I needed stitches for em but no there's not, there's nothing that would have stopped me or anyone could have done. If my Mum had been there standing in front of me obviously I wouldn't have been able to do then but as soon as she'd been away or etc I would have done it, or if I had been in hospital I probably wouldn't have been able to do it either because you wouldn't have access to knifes, or things to cut yourself with or, you could be pretty em… imaginative and use things to like paper clips and you know, things like that you can straighten out a paper clip it's quite sharp you can scrape away at your skin you know different things like that … em…	Self-harm increased in severity over time Nothing could have stopped, prevented it Except someone seeing him do it, or being in hospital where access to means was limited. Resourceful – could find alternative means to self-harm

Appendix L. Table 3. Distribution of subthemes within participant transcripts.

Table 3. Distribution of subthemes within participant transcripts.

Superordinate themes		Occurrence of each theme by participant								
		1	2	3	4	5	6	7	8	9
Relief from psychological distress	Spectrum of severity	✓	✓	✓	✓	✓	✓	✓	✓	
	Emotion regulation	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Preventing suicide	✓		✓	✓			✓	✓	
	Loss		✓	✓	✓		✓	✓	✓	✓
	Control	✓	✓		✓	✓		✓	✓	
	Feeling alone	✓	✓	✓	✓	✓	✓	✓	✓	✓
Difficulties communicating	Shame	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Indirect appeal for care	✓		✓	✓	✓				✓
	Scarring	✓	✓	✓	✓	✓		✓		✓
	Mental health stigma		✓	✓	✓	✓		✓	✓	
Social support	Family and friends	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Fear of judgment	✓	✓	✓	✓	✓	✓	✓	✓	
	Private activity	✓	✓	✓	✓	✓		✓	✓	
	Support from health service	✓	✓	✓		✓			✓	✓
	Experience of participation in research		✓	✓				✓	✓	✓

Gradual Desistence	Alternative coping strategies	✓	✓		✓	✓	✓		✓	
	Desistance is time limited	✓	✓	✓	✓	✓		✓		
	Access to means to self-harm	✓	✓	✓		✓	✓	✓		✓
	Ambivalence about self-harm & suicide	✓		✓	✓			✓		✓
	On-going difficulties	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Resilience	✓	✓	✓	✓	✓		✓	✓	✓