

**What are “functional social supports”  
and how do they impact the desire to  
self-harm in individuals who have a  
history of intentional self-harm?**

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## Abstract

**Background:** Intentional self-harm is a phenomenon which has become an international public health issue around the world, and one which has a extensive financial and social impact within communities. Poor relationship dynamics have been shown in the literature to have a negative impact on the psyche of a person, which is capable of increasing anxiety and decreasing self-esteem, both of which have been shown to be significant contributors to self-harm behaviours. As such, individuals who self-harm have been marginalised within society, and often feel alienated from their peers. In contrast, positive social supports, have been discussed in the literature as potentially being a cost-effective and constructive approach in diminishing reliance on self-harm behaviours.

**Aims:** This qualitative study investigated the aspects of professional, social, familial, and romantic relationships that people who have self-harmed identified as having a positive and constructive impact on their self-harm behaviour.

**Method:** Twelve participants with a history of self-harming behaviours were recruited through free press advertising in primary care and interviewed. The participants ranged in age from 19 to 70 years old, and represented NZ European and Māori from across the Southern region of New Zealand.

**Findings:** This study shows that constructive relationships which positively influence self-harm behaviours are characterised by participants' perceptions of authenticity in the relationship, and that the other person genuinely cares. This was also what individuals who self-harm need from their health professionals in order to support the adaptation of damaged view of self, and enable formation of functional relationships within society. Based on the results of this study, greater understanding for health professionals, whanau and friends on the relationship needs of those who self-harm can be realised.

## Preface

I would like to dedicate this study to my mother and father John and Veronica O'Neill who have been so very far away for so very long, but who I carry with me in my heart each and every day.

Thank you to my amazing family: Jason you are a great husband, 'in quietness and trust is your strength', (Isaiah 30:15). Aron, Samuel, Molly and Jorja, my wonderfully challenging children, your smiles and desire for me succeed kept me going, thank you.

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# Chapter 1: Introduction

## **Outline of Thesis:**

Chapter one defines the stimulus for the study, providing a literature review which identifies what is already known about the phenomenon of self-harm in relation to supports, recognising the variances in the literature, as well as the gaps in present research knowledge.

Chapter two outlines the methodology and in particular how the voices of the participants were heard from the approaches used to create relationship, and collect the data.

Chapter three is the first of the results chapters, and introduces the participants via their own reflections on their lives.

Chapter four focuses on the participant's experiences, and how they talk about the health professionals who they have journeyed with.

Chapter five talks about relationships with views of functionality, and dysfunctionality, walking through with participants as they form their understanding of self, and their roles in relationships.

Chapter six summarises findings and links these in with the literature which was introduced in chapter one. This chapter discusses recommendations from perceptions of those who self-harm in relation to the help needed from relationships, in particular it offers messages to health professionals in the potential adaptation of therapeutic relationships.

## **Personal Experience**

At the formation of this study concept, I was really quite ignorant with pity, pity that human beings would need to cut, burn, poison, bite, punch, or drown themselves in alcohol to cope with everyday life. The empathic clinician in me wanted to help, but I had no idea where to even start. Being employed at Servant's Health Centre as a manager and nurse fuelled my desire. As a place where the Christian ethos was intended to be converted into the real world provision of care, a whole new sphere of experiences in health care was revealed to me. With the guiding belief that 'faith without deeds is dead' (James 2:18, Crawford, 1999,

NIV), Servants was intended to be somewhere where Christians could carry out acts of practical professional care, and patients could come and receive non-judgemental care, free from the burden of cost. I quickly realised in delivery of this care that pity was not an option, and in certain circumstance, could be considered as crueller than judging.

As an experienced Registered Nurse, who had been in a health management position for 5 years, I left the comfort of a well-paid, relatively stable role to move into the voluntary culture of Servants. As the manager I was paid to carry out some administrative work, but had many opportunities to grow in relationship as I delivered nursing care in my voluntary capacity, with those who 'dropped in' to find out about what Christian care looked like. Through countless coffees, and multitudes of tears (both theirs and mine), I grew in understanding about the pain some people encounter in their often sad and overwhelming lives. A lack of control over many aspects of their existence, for some seemed to blossom into the need to hurt oneself in order to have some design over person and psyche. Release, relief, and making pain 'real' are points to note on the journeys of those I encountered between March 2011 and March 2013.

At night I could not sleep for the desire to understand, to appreciate, and in some misguided Christian belief, to stop these individuals from needing to physically hurt themselves. But how? This was a burning question that I believed I would not find an answer to by keeping my professional and personal lives clearly delineated. Professional boundaries are discussed at length in nursing research, primarily born of the need to ensure vulnerable patients were not abused within therapeutic relationships, but also to reduce the potential for 'burnout' of the health care professional (Dickson-Swift, James, Kippen, & Liamputtong, 2006). Whilst there is a great deal of argument for clear delineation of boundaries, and professional detachment (Goffman, 1961), there is a growing recognition amongst health care professionals which argues for a blurring of boundaries as a means of enhancing relationships and gaining trust (Scopelliti et al., 2004). However, any 'blurring' of the boundaries is acknowledged as needing to be in the interests of the client or patient, with a professional requirement to maintain safety for both parties throughout any socialization and relationship development. Servants was a place where more than health care provision was, and needed, to be provided. The whole ethos was the integration and support of repressed individuals by helping them with gaining self-worth through employment,

involvement with community groups, and supporting withdrawal from drugs or alcohol should this be required.

It was through the evolution of providing Christian care with a health element that I made the decision to open up my world. I hoped to grow in appreciation and learning of those who suffered self-inflicted pain, and understood that the presentation of health issues once or twice a month would enable awareness of only one aspect of an individual's life. I had known Sara (name changed to protect patient privacy) in my capacity at Servants for over 16 months, and we had grown in our friendship and communication outside of the health issues she presented with. Being a mum, a nurse, a wife and a worker, I decided to open myself up to being a friend, a friend to someone who was hurting and self-hating, someone who had not experienced the attention or opportunities in life that I had. This was way beyond my scope of practice as a Registered Nurse, but I was not acting in a professional health capacity, rather I was responding to need in my position as a caring Christian. I recognised after 2 years that my time at Servants was drawing to an end, and as I could not see how only being a nurse, and patching people up in this capacity was going to be able to change anyone's pain, I opened my heart, not just my medical pack. I undoubtedly believed this was going to help Sara, but in reality, and in hindsight, it helped me possibly more than it helped her.

Sara's story was a sad and harrowing one. Sara had been sexually abused throughout her childhood by her father. Having married young to escape the situation, she was a mum of two who had not been able to care for her children since a breakdown in her early 20s. Divorced, Sara had never worked, and at the time of our meeting, lived alone with only fortnightly access to her children between periods of admission to acute psychiatric care. The impulse to self-harm was significant for Sara, her pain of choice was cutting and burning, but in reality anything which would dull the flashbacks and memories were used. Overdoses were frequently accompanied by the abuse of alcohol and resulted in Emergency department presentations and hospital admissions, her drive during these times was verbalised as a need to forget everything. Sara did not seem to have the means or skills to deal with what had happened to her. Sara informed me she had been diagnosed with borderline personality disorder [BPD], indicating the reason for this diagnosis in her view, was because "they had no idea where to put me". The belief Sara carried was that this was for the apparent need in modern day health care to categorise people, to put people in a

box so as to understand them better. BPD was the 'box' where Sara believed people were put when everything else within the mental health arena did not fit. I quickly realised I needed to put any 'diagnosis' or 'diagnostic expectations' aside, and simply treat Sara as someone with a past, and with pain, someone who was vulnerable, and scared. Sara was not a diagnosis, she was a human being.

So to the study at hand, how did it begin? After opening my world and letting Sara in, I began to teach her about boundaries: social, moral, and relationship boundaries. All of this was carried out with respect for Sara, and in her timing, when she was ready, understanding that she had never experienced, or put in place, boundaries in her own life. Through the maturing of our friendship, I saw Sara drop some of her pre-conceptions about people in what she called the 'outside' world. To me this indicated her perception that there was her world, the 'inside' where she lived and allowed only her children to enter, and everyone else. In a very short period Sara's trust of those on the 'outside' grew as her confidence in herself, and her self-worth appeared to be growing too. This allowed her to open her mind to the fact that she was worth it, worth the help that was available in the 'outside' world, and that not everyone on the 'outside' wanted something from her, or to harm her. Very early on in this relationship, I ceased to provide any health care to Sara, I was concerned Sara would think I was abandoning her as a health professional, but she made it clear to me that my care as a Christian friend was far more important than any health care relationship.

Self-reliance was a major factor in Sara's life, the only one she could depend on was herself, but nothing she had tried had been able to change her desire to self-harm. Engaging with mental health services had always been a problem. Sara accepted community mental health services (CMHS) were a necessary provision, but she often verbalised they did not understand her, and "looked at her like [she was] just a medical problem". I felt certain Sara's feelings about CMHS were founded on her own insecurities, as opposed to how those who work in mental health services acted towards her. However, being a health professional, I know how misguided opinion, and academic knowledge can result in judgemental perceptions without even realising it. For Sara, these perceptions were a barrier to reaching out for, and accepting professional help. I decided to start to introduce Sara to other services which were not seen as 'professional' in nature, these included a local church community, social groups, and other patients at Servant's who echoed a lot of Sara's beliefs about the world. Amazingly, Sara began to open her mind to learning new ways of

coping with life as she heard others stories, and as her circle widened, she began to be instilled with a desire to understand more, and help others. Her focus was changing from self-care and internal pain management, to reaching out to others and helping them. Sara appeared to have found a purpose, but in this purpose she had limited ability to communicate, care and provide support to others, or herself. This was the point at which the doors swung open, as Sara engaged with an individual GP, a counsellor, and mental health services in order to grow herself, and in doing so, be able to provide others who were in as much pain as she was, with hope. Sara had allowed a network of support to be created in her world, which blurred the boundaries of what was 'inside' and what was 'outside'. The change was amazing, as Sara went from daily cutting, burning and alcohol abuse over a 20 year period, to an extended period of over 3 months with no self-harm behaviours, all within 8 months of the support network being initiated.

This was a case study I needed to understand in more detail. Would the creation of such a network, and such purpose help others? Why do people stop self-harming? What changes from when they started to self-harm, to when they no longer rely on it? What difference do the relationships in their world make to their self-harm? These were questions I really wanted answers to.

As the study formed in my mind over the following year, the experiences I had with Sara were expanded to a number of others, not only through me, but through other volunteers at Servants Health Centre, and through Sara herself. Whilst the desire to self-harm, and the periods of reduced reliance were different for all, the formation and introduction of individualised networks did seem to be making a positive difference.

## **Literature review**

Available literature presents a confusing front in its analysis of self-harm, due in the first instance to the issue of identification of the actions, or intentions, which categorise self-harm. Self-harm is defined as "intentional self-inflicted poisoning or injury, which may, or may not have a fatal intent or outcome", by the World Health Organisation (WHO) (World Health Organisation, 2012). Alcohol or substance abuse, anorexia and/or bulimia, or over-exercising are noted as other methods of self-harming in recent years, but are often not acknowledged in the research, or amongst professionals as self-harm, as they appear to lack

suicidal intent (Nada-raj, Skegg, Langley, Morrison, & Sowerby, 2004). Approximately 50% of individuals who complete suicide have previously self-harmed, indicating that self-harm is often a warning, signalling a significant future risk of suicide, and indicating that the relationship between the intent, and the action of self-harm is an important one (Casey, 2011).

The incidence of self-harm is increasing world-wide, and the growth in statistical identification of those who suffer self-harm, exposes the necessity for greater research and understanding into this phenomenon (Fox, 2011). Intentional self-harm is commonly a secretive behaviour, and whilst often associated with mental illness, it is not exclusive to this group (Wilstrand, Lindgren, Gilje, & Olofsson, 2007). Hawton et al. (2012) identified that the prevalence of self-harm increases with age, however, it has also been reported that self-harm in younger adolescents can be far more prevalent, but often goes unreported (Storey, Hurry, Jowitt, Owens, & House, 2005). The conflicting information in the literature, and the potential under-reporting of self-harm, are barriers to understanding the extent of the issue, and the underlying causations. Thus, to greater appreciate the drivers that precipitate intentional self-harm, qualitative research in particular, should be undertaken to investigate the perspectives and experiences of affected individuals.

Poor relationship dynamics can have a negative impact on the psyche of a person, which is capable of increasing anxiety and decreasing self-esteem, both of which have been shown to be significant contributors to self-harm (Wu, Stewart, Prince, Huang, & Liu, 2011). In contrast, positive social supports, whether professional or non-professional, have been shown to be a cost-effective and constructive approach in diminishing reliance mechanisms of intentional self-harm (Dobkin, De Civita, Paraherakis, & Gill, 2002); (Kumar & George, 2013). "Functional social supports", a concept originally described by Cohen and Syme in 1947 (Cohen, 1985), theorises that positive social relationships that provide practical, affirming interventions have a positive impact on health and health outcomes. Therefore, it is probable that positive, supportive interactions would influence the prevalence of intentional self-harm. However, there is a paucity of research on what constitutes a "functional social support", and what therapeutic, and practical interventions from supports avert self-harm. Functional social supports, and the basis of what these actually look like in the practical sense, has not been identified in presently available research. It could be presumed that functional social supports would look different for each individual, given the

diversity of individuals' experiences, however, there is no existing starting point supported by available studies.

This study planned to discover how individuals who have experienced a history of self-harm, report their own experiences of functional social supports. Further to this, the relevance of the self-harm journey, how professional and non-professional involvement shaped that journey, and what individuals who have self-harmed believe they need from support networks has been identified. A complete review of available literature, and identifying what is presently known in relation to the present study question, was the first step.

### **Search strategy**

A three-step search strategy was used commencing with an initial search of select key index terms as independent terms, and as combined searches. The second step involved the extension of key terms and databases searched, and the third step was a review of the reference lists of the studies selected for review.

#### **Key terms:**

1. Self-harm and functional social support
2. Suicide ideation and functional social support
3. Self-harm and social support
4. Suicide ideations and social support

Table 1.0 (Appendix I) shows the search results of individual and combined index terms in OVID CINAHL and MEDLINE. This initial search identified that 'functional social support' was not a term used in relation to investigations or research into interventions for self-harm and/or suicide ideations. After analysis of the key terms returned no results, these were extended to include 'social relationships', 'functional relationships', 'therapeutic relationships' and 'suicide behaviour'. A second search strategy using all identified key terms was undertaken across all available databases which included, but was not exclusive to: PsychINFO, EMBASE, INFOTRAC, Cochrane Library and ProQuest. The reference lists of all identified and selected reports and articles were then reviewed to distinguish any additional relevant qualitative studies [Appendix III]. The search for unpublished studies included dissertation abstracts; sociological abstracts; allied health abstracts, conference reports,

Proquest dissertation and theses, and EBSCO education research. As electronic databases have an international scope, only those studies available in full-text, and in English were included [Appendix IV, V]. All articles were assessed for relevance from their abstracts alone, with full reports retrieved for all studies which met the inclusion criteria. If any doubt was raised about the significance of any abstract through the review, full articles were retrieved.

Studies pre 1985 were excluded as the concept of functional social support networks was first documented for investigation in 1985 and therefore it is not expected that any research which pre-dates this would feature this phenomenon. As such, articles available between January 1985 and May 2013 were included in the search criteria [Appendix IV, V].

### **Methodological quality**

Methodological quality of the studies was assessed using the Joanna Briggs institute (JBI) Qualitative Assessment and Review Instrument (QARI) using the Critical Appraisal Checklist for Interpretive and Critical Research [Appendix VI]. Two appraisers independently reviewed each study. From the 10 questions on the checklist, a cut-off point of 6/10 was set for included studies for this review, as this level was considered to be high enough to establish methodological rigor, but still provide a representative set of studies. However, due to both the lack of available qualitative studies relative to the research question, and the significance of an identified case-study, a score of 5/10 was accepted for one article. Seven of the articles returned scores of 10/10 (100%) and 2 of scores greater than 6/10 (60%) [Appendix VII].

### **Data collection**

Qualitative data were extracted using an adaptation of the standardized JBI Data Extraction Tool for Qualitative Evidence from the JBI- QARI [Appendices VIII,IX].

This review integrated studies from a variety of contexts which included different cultures and environments. Upon collection of data, the information retrieved and the context in which the study was based were taken into account. Consequently, and if relevant, the cultural orientation was included in the extraction data to allow an assessment of the impact of culture on the viewpoint of social supports to occur. (Excluded studies can be viewed in Appendix X.)

## Data synthesis

Qualitative research findings were pooled using JBI-QARI. This involved the synthesis of findings using narrative form, which generated a set of statements from each article selected that represent each studies viewpoint as qualified by the review question [Appendix XI].

## Results

Three categories of findings emerged from the qualitative data that was identified and extracted. Firstly, doctors and nurses in general medicine, whether in community or hospital settings are frequently the primary points of contact for individuals who self-harm or attempt suicide, and are commonly inadequately trained for managing patients who self-harm. Secondly, counsellors are in a position to build support relationships, and be able to explore the entire journey of self-harm, from precursor thoughts and feelings to post self-harm emotions. Thirdly, internet resources as a means of seeking support and validation are growing as they facilitate non-judgemental relationships that are built in anonymity. However, after the initial pilot search, it was clear that the abundance of research that investigates self-harm is quantitative in nature with minimal research being conducted on the role of social support from a qualitative viewpoint. Qualitative research on the topic is scarce, possibly because of the attitude to self-harm and suicide ideation for many years, which has been that if it is openly discussed, its prevalence will increase (Hill, 1995).

Search results of individual key term searches across all available databases:

1. Self-harm	332,234
2. Suicide ideations	31,662
3. Functional social support	125,603
4. Functional social relationships	120,814
5. Functional social support networks	18,729
6. Social relationships	2,748,619

Combination of key term searches:

- 1 and 3 returned 0 articles
- 1 and 4 returned 0 articles
- 1 and 5 returned 0 articles
- 1 and 6 returned 96 articles
- 2 and 3 returned 0 articles

2 and 4 returned 0 articles

2 and 5 returned 0 articles

The searches for 'self-harm' and 'social relationships' were the only searches which returned results from a combination search of two or more key terms, for this reason these 96 articles were selected from this second step search. Of note is that 91 of the 96 articles were identified in the first stage of this three step search process. A reduction to 58 articles occurred from applying the requirement of full texts, and the date range of January 1985 to May 2013. From these 58 articles, quantitative research studies were identified and removed. The remaining 19 full-text articles were reviewed and a further nine studies were removed, six for lack of relevance to the review question, one which focused on acutely psychotic, and unwell mentally ill patients, one which was not primary research (literature search), and one was excluded as participants were under 16 years of age.

Of the 10 articles included in the review, a total of 158 interviews, one case study, and 119 individual postings on an internet self-harm message board, were assessed. Three of the studies looked at responses from health care professionals and their experiences with patients who present after self-harming. Fifty-nine semi-structured interviews including responses from 42 nurses and 17 doctors were investigated. Of these studies two were in acute hospital settings and one was in the community. Counsellor's perspectives and experiences were investigated for two of the articles, with a total of 14 in-depth interviews discussed. Three studies examined 85 interviews by individuals who had actually completed self-harm and were on a pathway of care, and one offered an individual opinion of self, and their experience of services for those who self-harm in a case study format. The tenth study was an Interpretive Phenomenological analysis of an internet based, non-professional self-harm message board, and an exploration of how self-harm behaviours were managed in this environment.

In the final step of the review, all references from the final 10 articles were reviewed to ascertain relevance to the present review question. Eight were considered of interest, two were excluded as they were predominantly quantitative investigation techniques in a mixed method study, two were shown to not be primary research, seven had been included in the study review already (with four of these excluded previously as they did not meet inclusion criteria), two pre-dated 1985, two involved participants under the age of 16, and a further

four were excluded as they did not have more than one key term as either key words in the text, abstract or title.

## **The Literature on the role of relationship for those who self-harm**

The literature search illustrates the paucity of information addressing the specific topic of the impact of functional relationships for people who self-harm. I have structured the literature on the role of relationships for people who self-harm into the following categories: the impact of relationships with counsellors, mental health practitioners, health practitioners (other than mental health), and 'others'. This is to identify the evidence presently available relative to the research question which the present study poses.

### **Counsellors**

Maggie Long and Jenkins (2010) found that counsellors hold a valuable role in the lives of those who self-harm, and that by embodying confidentiality, trust can be facilitated in this relationship. From this trust they found that the individuals who engaged, were able to have more of an open mind relative to their self-harm journey. There are though significant challenges to working with individuals who self-harm. As Fox (2011) found, balancing expectations and risk in relation to policy, and the therapeutic relationship are essential to minimise the impact of this relationship on the counsellor. To effectively accompany clients in a journey of self-healing, there needs to be an awareness and responsiveness on the part of the counsellor to foster understanding. The difficulty is harmonising the needs of the professional with the needs, as they are perceived, of the client. Key findings from research involving counsellors, were the need for acceptance to be prevalent for a therapeutic relationship to exist, and the need to focus on the patient's journey, through the perceptions of the individual who self-harms. These were themes identified in order to ensure the relationship is actually dealing with the context as directed by the individual who harms, and not the context as seen through the eyes of the counsellor.

### **Mental health**

Two of the selected studies, examined the experiences of psychiatric, mental health nurses who were involved with caring for those who self-harm. Wilstrand et al. (2007) discovered that the majority of nurses found it extremely difficult emotionally to manage an ongoing care relationship, and that they were often overwhelmed with frustration. Many discussed

that maintaining professional boundaries was exhausting, and that they often felt abandoned or judged by colleagues and management. A main outcome from this research was the need for supervision, education, and development of practice for those who are involved in building relationships as professionals, with individuals who self-harm. Thompson, Powis, and Carradice (2008) used interpretative phenomenological analysis to examine eight community psychiatric nurses experiences, the results of which echoed Wilstrand et al. (2007). The community nurses could also find working with self-harm clients emotionally demanding, stating that the emotional impact upon themselves was stressful, and that their therapeutic relationship suffered because of the risk management expected from professional boundaries. Both of these studies identified the beliefs of nurses, in that the therapeutic relationship is key to facilitating any change in behaviours. However, restrictions to relationship through professional boundary enforcement, and the need to minimise personal harm from emotional strain, were corroborated.

### **Health Professionals**

Anderson, Standen, and Noon (2003) identified that the first port of call for those who have sustained a self-induced injury, is often Accident and Emergency departments, and as front line doctors and nurses with little or no training, these health professionals believed they were inadequately prepared for dealing with self-harm. Primarily, frustration from the lack of strategies at their disposal was the dominant emotion. Not being able to understand why individuals self-harm, coupled with an often overwhelming work load, resulted in, not only barriers to care, but barriers to relationship. As greater health outcomes are identified from positive first responder contact, Anderson et al. (2003) advocates for research, education, and the development of personal practice in understanding self-harm as a phenomenon, for doctors and nurses. Storey et al. (2005) explored the experiences of 74 individuals who presented to Accident and Emergency departments with self-harm. Predominant outcomes of this research were concerns for the lack of care afforded to those who present with self-harm, and identification of the lack of social support networks evident for them. Single mode care was often experienced by presenting individuals in Storey et al's (2005) study. The research showed though, that single method management for those who self-harm, such as medication, or wound treatment alone, was not appropriate in light of the lack of balance between health professional input, and social care involvement for the individual.

Both Wu, Whitley, Stewart, and Liu (2012), and Wright and Jones (2012), acknowledged in their research the need for supportive attitudes, and ongoing continuous care from both formal and informal sources for positive health outcomes to occur Wu et al. (2012) formalises the impact of negative influences as encouraging self-harm behaviour through the analysis of 20 in-depth interviews. Findings revealed the impact which positive relationships with health professionals, and social supports, can have on individuals who self-harm, supported by treatment adherence and effectiveness. Wright and Jones (2012) present a personal perspective on the formation of therapeutic relationships, and how valuable such relationships can be for recovery. Journeying with individuals who self-harm, and encouraging the formation of a trusting, accepting therapeutic relationship irrelevant of professional, or non-professional status, were dominant themes in both of these research articles.

Understanding why individuals self-harm, appears to be a key element in whether the care afforded by professionals to those who self-harm is effective. A lack of understanding seems to be the catalyst to frustration, and ultimately leads to barriers in the delivery of care. Greater education, and being given the skills and tools to cope and communicate, resonate throughout the available literature, and is not only identified in relation to the provision of professional care, but also to the provision of social care. Social support is highlighted as vital to the balance of care for those who self-harm. This though was the view of those who actually harm, and a cavernous gap is evident between what individuals who harm see as their needs, and what health professionals see as their need. Ultimately, it is clear from the identified research that the impact of therapeutic relationships are not fully realised by professionals, and that the level of involvement and communication required for those who provide support and care outside of a professional relationship are not appreciated.

### **Other supports**

In the desire to find affiliation and understanding, many of those who self-harm turn to the internet. Rodham, Gavin, and Miles (2007) report that the need for venting and validation as functional endeavours for those who harm, are often met with normalisation of behaviours from others who indulge in the act of self-harm. The usage of chat rooms, and message boards on the internet were shown to encourage self-harm behaviours as the exchange of information, and desire of acknowledgement and legitimisation of actions occurs.

There was no available evidence on the actual impact of social supports, other than anecdotal information shared through the case study of Wright and Jones (2012), where stigma was associated with these relationships. Significant findings overall suggest that self-harm is not understood within communities in our society, as much as it is not understood by health professionals affording care. Education, information, and the development of skills to help those who self-harm are identified outcomes from all selected research articles.

Overall, from this literature review, it appears there is a lack of appreciation for the views and perspectives of those who self-harm amid the available research. Whilst there is an overwhelming amount of statistical data to explain the journey of victims of self-harm through quantitative data analysis, there is little subjective data taken from the lives and experiences of the individuals themselves. There also appeared to be a lack of comprehension that those who self-harm need any other services apart from standard health or counselling services, or that any social aspect should be considered for integration into a plan of care for these individuals. Many of the articles investigated the experience of health professionals, or community based professionals who had worked alongside individuals who self-harm. Whilst some appreciation of the patient journey can be ascertained from those who work with them, the inner most values and beliefs cannot be fully appreciated, or realised when the actual individual experiencing self-harm is not asked for their view or opinion. There was only one study, a case study, which was written by an individual who had experienced self-harm (Wright & Jones 2012). This was documented in conjunction with the community nurse who cared for her, and was the only article which seemed to give any insight into the need for social supports within communities and families for those who self-harm. This literature search therefore revealed the lack of insight for many of us in the health care, and research sector, in relation to the needs of those who self-harm, from the perspectives of those who self-harm.

## Chapter 2: Methodology

In this chapter I describe the methodological framework of the research and the methods used to conduct the project.

### Study setting

Initially, as the study was forming, I planned for patients from Servants Health Centre to be the sole participants. After all, this was where it had all begun, these were the people who inspired me to delve deeper into the realm of self-harm behaviours. I had already spent many hours questioning them (in the broadest sense), in my position as a health professional in order to unearth the how, why, wherefores of their actions, and in some small way attempt to empathise, appreciate and understand. It seemed logical to me that this group would be perfect for the study. However, once I began to extend my knowledge of self-harm further than my own health care experiences, I quickly discovered this phenomenon to be indiscriminate with its victims, as it traverses all boundaries of health, wealth, and education. Through this self-education process, I was also learning about the concept of justice and the ethical principles required to safeguard against discrimination in selection and recruitment of participants for research purposes. Further, selecting the Servants Health Centre participants simply because they were a readily available source to me had the potential to manipulate both the research results, and the relationships I had with them in my position as their health care provider. I realised this was ethically problematic, and that I needed to employ a more open and general recruitment process which would be more ethically defensible, and just in its approach. Whilst it was important for me not to reject individuals from Servants Health Centre should they wish to participate, they would need to self-identify for involvement, as any other participant would. Because I wanted this research to make some difference, narrowly focusing on individuals who were predominantly from a low-socio economic group, and who had horrific stories of abandonment and isolation, could thwart generalisation of any results to those in other demographic groups who also experience this phenomenon. As such, using such a defined group could hinder application of any potential study recommendations. Therefore, an open advertising recruitment method was selected as being far more likely to support conscriptions which would represent the general population.

## **Definitions**

It was important to be able to identify the kinds of behaviours which fall into the category of self-harm prior to sampling and recruitment, and as such I needed to define a classification based on the researched evidence. As I studied the research into self-harm and suicide, the majority of analyses did not appear to clearly delineate suicidal ideation from self-harm actions, and as such, these studies appeared to disregard explanation or examination of purpose, or objective in the self-harm actions considered. Though early definitions characterise self-harm as the physical “action of self-injury or self-poisoning with non-fatal outcomes” (Hawton et al., 2003), later definitions identify greater relevance of the psychological and emotional aspects of purpose, through the use of terminology such as “deliberate” (Klonsky, 2007), “intentional” (Wu, Stewart, Huang, Prince, & Liu, 2011), “without suicidal intent”, and through the analysis and examination of the potential influence of psychiatric disorders (Harada et al., 2014). Wilkinson and Goodyer (2001, p106) argue for a non-suicidal self-injury definition of “self-injury that has the explicit aim of injuring the self”. Their inference is that there are different forms of self-harm which carry different intention, motivation, and behaviour, and as such any definition should be encompassing, but yet homogenous in relation to the act. Self-harm does not appear in DSM-V or ICD 10 as a disorder, nor is it established as a component of any current anxious or depressive syndrome. The lack of a world-wide definition for research reveals the difficulty of completely appreciating, understanding or investigating a phenomena upon which there is no agreed, or exact description for comparison.

As such, to enable comparison of the results from this study with available qualitative research findings in this field, self-harm and suicidal ideation was regarded as synonymous during this study.

## **Methods**

A qualitative phenomenological research method was used for this study, as the research is experiential in nature, and examines personalised experiences (belief systems and perspectives) of participants on the subject of functional social support networks.

Quantitative research is excellent at analysing cause and effect in clearly defined questions, and is widely regarded in its reliability and dependability through the stringency of its

numerical reasoning. It is though, less effective at understanding the influence of subjective perceptions and subjective encounters on complex behaviour processes (Braun & Clarke, 2006). Qualitative data is becoming increasingly acknowledged by researchers for its ability to add a new dimension and perspective to strengthen the rigor of intentional studies (Pathak, Jena, and Kalra, 2013). It was important within the present research that such rigor was achieved through authenticating and substantiating the parallels in experiences of participants, whilst also respecting the uniqueness of their journey. The use of phenomenological research techniques, provided a better identification of these essences of the experience of functional social supports, because the interviews were framed in terms of a “descriptive narrative” (Crabtree et al., 1995). Thus, this research sought to capture the quintessence of what each individual perceived as being important for them in relationships which cause or avert self-harm behaviours. This more hermeneutic approach in appreciation moved beyond seeking a “cause and effect” structure, such as in quantitative research, which has the potential to appear to emphasise the apportioning of blame to either the person who self-harms, or to those perceived to be responsible for supporting them. The purpose of the research was not to solve a problem, rather to identify the many facets of an issue experienced by a myriad of individuals in society. It was believed therefore, that the use of a qualitative approach has enabled the research question to be studied without setting a “good” or “bad” value on the viewpoint of the participant, and instead focused on discerning the aspects of social supports that held significance for each participant, from their personal viewpoints.

Generally, participant numbers for qualitative research are less than those recruited for quantitative research. Mark (2010) explains this divergence in terms of data saturation as a “point of diminishing return”, where the occurrence of a data sample, or term on one occasion is all that is required to categorise its relevance within the qualitative research context. Sandelowski (1996) asserted that a common misconception in qualitative research is that the numbers of participants is unimportant, further conjecturing that an inadequate sample size can actually undermine the integrity of the research. Selecting the number of participants required for the present study was difficult, as the emphasis was on individualised personal experiences, presenting a danger that all those experiences would be unique, and would be verbalised as such. Therefore, to support the credibility of the data collected, a viable number which offered similarity, or themes in the data was required. Whilst there is no formula for calculating the number of interviews as a prerequisite to

provide rigor, it is widely acknowledged that the efficacy of the numbers is dependent upon the concept under investigation (Emmel, 2015). Due to the need to penetrate social norms in such a phenomena, and the divide which has been widely documented between sampling for quantitative research versus qualitative research, a small sample size of less than twenty was expected to satisfy analysis parameters (Trotter, 2012). I decided that twelve to fifteen participants would likely be sufficient for the extent of the present study. This sample size was settled on as a number capable of discovering most variations of experience of the phenomena, even if those experiences were not analogous (Crouch & McKenzie, 2006) (Sandelowski, 1996). Nkwi, Nyamongo, and Ryan (2001) state that qualitative research involves data sets that do not indicate ordinal values, and as such are exploratory not confirmatory, and are an expression of where the subject is in their world. In this case, text is used as a proxy for experience, and as such, saturation of data from the text was not expected to be reached within the confines of this study. As such, this research is expected to contribute to what is already known in the field of self-harm, offering another piece of the puzzle which is this phenomenon.

### **Data Collection**

The phenomenon of self-harm is a very personal experience, as such appreciation of this experience can only be attained if the individual feels able to express their thoughts, feelings and experiences with honesty and openness. Allowing the individual space to talk, ruminate and reflect, and be encouraged in self-expression is seen as a means to minimize any potential breach of relationship boundaries, such as the desire to say what the researcher may want to hear (Dickson-Swift et al., 2006). Whilst focus groups or observation techniques could be used to facilitate this, and may instigate revealing discussions, the involvement of others in a discussion which may include graphic descriptions of self-harm can create the natural human response of the need to have the experience fully described. This is a situation where individuals exaggerate their own experiences to magnify their issues, and to potentially compete with others within a group environment (Green, Wood, Kerfoot, Trainor, Roberts, Rothwell, Woodham, Ayodeji, Barrett, Byford & Harrington, 2011). There is also the danger that such a situation could enable a vicarious aspect of potential self-alienation, or self-imposed isolation, causing estrangement by the observing group.

Therefore, I decided on the use of one to one, semi-structured interviews which I believed would aid to minimize this humanistic 'shock effect', whilst still enabling self-expression and also offering direction for myself as the interviewer if the interviews became strained. Observation of non-verbal cues during the interviews was noted immediately afterwards to assist with sub-text analysis, and to allow the interviewer further exploration of the mannerisms and characteristics of processing, conveying and reporting of their stories by the participants. Though it is acknowledged a participant-researcher relationship is not an equal one, because it is the interviewer defining, controlling, and directing the interview situation, I considered that with a semi-structured question based interview, greater freedom could be afforded to the participant because they would be able to pursue their own lines of thoughts and reflections, whilst allowing the interviewer to probe further than the structured questions allow. The pursuit of these reflections and digressions can assist greater rapport and trust as the individual respondent feels the interview is more personalised and focused on their uniqueness (Bernard, 1988). This freedom to probe further invites examination of new lines of inquiry dependant on the twists and turns of the interview, yet it also ensures a small set of the same questions are consistently asked of all participants to support greater theme comparability (Kvale, 2009).

In the present study, each participant was asked a series of nine set questions, and further prompting questions (see Table 2.1 below). The participants were interviewed on only one occasion, making the ability of the interviewer to follow a line of investigation vital. However, it was also critical that the framework of the interview was fluid, in that the discussion following each question was directed through the responses made by the participants. The interviews were recorded via the American app based 'Rev' system, and subsequently transcribed by the 'Rev' transcription service. Participant permission was gained for the recording of the interviews, with each participant granting permission for this purpose, in the form of a signed consent [Appendix XII]. This enabled free flow of conversation without the interviewer needing to take notes, which can be distracting to both participants and interviewer.

Each interview lasted for between 26 and 48 minutes with a mean interview time of 36 minutes and 19 seconds. The time afforded, permitted the set structured questions, and more involved exploratory enquiry to occur. The interviews were transcribed for analysis as soon after the interview as possible, and for most this was within one week.

**Table 2.1 Structured Interview Questions**

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1. What are your first memories of self-harming?
2. Can you tell me about the reasons you began to self-harm?
3. Can you tell me about the support you received [if any] prior to starting to self-harm?
4. Can you tell me of any changes to the relationships you had once you started to self-harm?
5. Do you feel you receive enough support to help you manage your self-harm urges?
6. How would you describe a positive relationship?
7. What do you believe you need from those around you to help you cope with your self-harm urges?
8. What prevents you from seeking help before you self-harm
9. Can you describe the difference between times when you seek help and chose not to self-harm and those times when you seek help but do self-harm

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### **Potential pitfalls to interviewing**

Kvale (2009), in the examination of interview consequences, highlights the seduction which can occur during intimate discussions, and recognises this as potential for greater disclosure than a participant may desire or intend. Such situations can arise from leading questions by the interviewer during non-structured investigation, encouraged by the misreading of signals in a desire to understand. Oppositely, there can be a reluctance of the participant to open up to the interviewer through either self-protection, or lack of a trusting relationship between interviewer and interviewee. The difficulty is safeguarding distance, whilst developing and sustaining trust.

As a registered nurse with over 15 years' experience of attaining a level of relationship which supports information sharing from patients, I felt that the interviews were balanced in what the participants were willing to share, and what they wanted to withhold. During times where more sensitive, or sensational information was shared, I would check in with the participant by stating "are you ok" at an appropriate moment. This allowed them to collect themselves, or to bring them back to the present from their reflection, and enable time for them to gather and consider their thoughts before progressing. There were two interviews during which I personally considered the information to be sensational in nature, with one extensively describing the crushing of insects into gaping wounds in order to increase the chances of an infection. However, during both interviews, I was able to refocus their

attention to their journey with the individuals and community around them, successfully moving attention away from the graphic details of their self-indulgence or methodology of self-harm.

### **Recruitment process**

The cost of accessing primary health care services can be a barrier to seeking help for individuals who self-harm. As this research intended to investigate effectiveness of functional social supports, it was important that participants were able to self-identify as having experienced these supports in some way. Functional social supports are not purely provided within professional relationships, but can incorporate relationships from individuals, or groups in community, as well as whanau and friends. It was considered that recruiting only participants who actively seek out professional help might potentially bias the results, and affect the trustworthiness of the study through the latent omission or examination of relevant broader social supports as they inherently occur in society.

Therefore, the recruitment process needed to take into account how variable population groups could be informed about the study, including those who were not active in seeking professional interventions. The means of advertising for the study also needed to be able to reach individuals within all economic groups. A 'free press' regional newspaper which is delivered to all properties within the Southern region, was therefore used as the primary means to advertise the study, as it was believed this would aid minimisation of recruitment bias. This newspaper campaign consisted of three advertisement features which occurred in October and November 2014. Individuals who self-identified as meeting the criteria for the study, were invited to contact the student researcher for further information on the project.

In addition to the newspaper advertisement, research information and recruitment sheets were sent out to Primary Health Care facilities in the Southern Region, which included a request for them to be attached to waiting room notice boards [Appendix XIII]. It was hoped this second tier of advertising, would aid the researcher in recruiting the agreed upon number of participants. This was decided for a number of reasons. The cost of advertising in health care centres is minimal, and health care for a number of people in community is free (such as for under 6's, as it was at the time of this study). As such, accompanying adults who would not normally access health care due to cost, may see the advertisements. The

intention was to have a recruitment process which incorporated the potential for all economic groups to view the adverts.

Wording of the advertisements for both the free press, and health centres were considered at length, whilst unambiguous wording, easy to understand and consider were the intention, the influence of academia was obvious. After a review by both of my supervisors, an advertisement suitable for the primary health care centres was completed and was sent out to 18 practices in Dunedin. For the 'free press' advert, restrictions on wordage minimised the amount of information which could be disclosed, and the advert was written as simply and directly as possible [Appendix XIV].

After the first round of advertising only three participants had come forward, and I became concerned that the 'wider population groups' may be misinterpreting the study design and the intention in the language used for the advertising. Review of the adverts then occurred in conjunction with the Associate Dean of Maori Health at the Dunedin School of Medicine, Otago University, and the advice received was to re-write the advert giving as many details as possible about the researcher in plain terminology [Appendix XV]. It was considered this would increase trust in the research and researcher, and encourage contact from individuals in society who may (because of their experiences), be less trusting of health professionals, academics, or of research altogether. Reviewed again, the second advert was published only in the 'free press' as it was thought confusion could have been caused by re-sending an altered recruitment advert to all 18 primary health care practices, as well as the cost considerations for this to occur. A second, and subsequent third advertisement round increased the number of self-identified participants to twelve. As this was the minimum number acceptable in this study, it was decided that the interviews would commence, and if others self-identified once the process had started, it would be straight forward enough to include them. The close off for participation was once analysis of data had been initiated.

### **Exclusion criteria**

Self-harm is a circumstance few who do not experience it can understand. Many who are drawn to self-harm behaviours are seen as occupying a space within society which breaches the "boundaries between physical and mental health" (Chandler, 2014). Often associated with teenagers, and issues of not fitting in, it was important that my research did not

perpetuate these misconceptions. Anyone under the age of 16 would be excluded for three reasons, firstly to aid in the dispelling of the myth of age relevant self-harm. Secondly, to raise the potential of the individual having had the time and ability within their life to have developed functional social support relationships and networks. Thirdly, within New Zealand, 16 is the age at which an individual can seek independent care and support, without the requirement of consent from a parent or guardian.

It was decided that a gap of two years since the individual had last encountered the behaviour of self-harm would be set. This was to diminish any potential harm to the individuals from the reflection and reporting of their experiences. Also, I suspected that reflection and assessment of usefulness and functionality of support relationships are better assessed after a period of time from involvement, to allow for appeasement of emotional attachments. Mental health status or diagnosis did not exclude participants, as individuals who self-harm are not necessarily mentally unwell, and not all individuals with a mental health diagnosis self-harm.

### **Ethical issues**

Approval for the study was gained from the University of Otago Ethics committee, No: H14/118 [Appendix XVI]. Approval was also gained from the University of Otago Ngai Tahu Research Consultation Committee.

Each participant was fully informed of all aspects of the study, how the data was to be collected and stored, that the data would be used just once, and would therefore not be used in future studies without their express permission. Each participant signed a consent form, and were made aware that they are free to withdraw from the study at any time, and were assured that their data would be removed upon withdrawal. Each participant was informed that any reporting of, or recording of data either electronically or in printed form would occur in a non-identifying, confidential manner. All participants were informed that they may request a copy of the results of the study once completed.

Self-harm is a typically secretive behaviour, it has been reported that for many this is due to the fear of being judged, misunderstood or “labelled” (Wright & Jones, 2012). Recognising this, and taking steps to avoid it during the study, through close observation and control of terminology used, reduced any potentially alienating factors during the interviews. It was

essential to do everything possible to support the formation of a trusting relationship between the participant and interviewer and support the integrity of the study. It was also critical to minimise the prospect of “normalising” self-harm behaviours, or causing any situation within the study environment that may encourage the participant to partake in any self-harm behaviours. Using safe investigative questions which are open-ended and non-judgemental also assisted with this. It was also essential for the interviewer to be able to discern when a participant was reluctant to talk, or was becoming despondent during the interview, as ethically, no harm should be done to the condition or state of mind of the participants (Farley, Zheng, Rousi & Leotsakos, 2015). After the interviews had been completed, I checked in with each participant as to how they were feeling, reiterating that they had the ability to access counselling services should they need to. Only one participant voiced that they were upset post interview at the details they had shared. I offered for the interview material to be withdrawn, but the individual chose for her information to remain as part of the study. Instead, she requested a session with her counsellor, which was facilitated as soon after the interview as was possible. Later, the individual emailed me and informed me that she was fine and would like to continue to be part of the study.

## **Data Analysis**

Thematic analysis is a method for identifying, analyzing, and reporting patterns within data. Content analysis has a partial quantitative methodology to its evaluation through its use of numerical descriptions from the detection and establishment of categories (Marks, 2003). The relevance of these categories is classified through their frequency. Contextualist thematic analysis has been used to analyze the findings from this research and is consistent with the overall phenomenological framework. Due to its flexibility, it is believed that contextualist thematic analysis achieves recognition of relevance through frequency (as in content analysis), whilst also affording importance to the ways individuals make meaning of their experience through subjective terminology, and the way in which the broader social context experienced impacts upon those meanings (Boyatzis, 1998) (Braun & Clarke, 2006). Sub text is the content of discourse that lies underneath the dialogue, and whilst unspoken, can have great relevance to the perspective afforded to any explanation. Examination of this occurred concurrently with the documentation of Initial themes from my evaluation of the recorded interviews. I anticipated this would support a more naturalistic review of sub text

undertones as elicited from the audio recordings, which included the dynamics of emotional responses, patterns of pauses and the manner in which the individual spoke. This would further support a more contextual awareness of how the participant both viewed and experienced their world.

NVivo was used to facilitate the organization and classification of the rich content of the interview text. Its use allowed categorization of frequency and relevance through identification of trends from pattern based auto coding, as well as in-depth interrogation of transcripts for subtle connections and nuances (Crabtree, Miller & Swenson, 1995). Furthermore, NVivo allowed primary nodes to be highlighted from the text through key word analysis (as per the primary and sub node table below).

Thematic analysis is a process for coding qualitative information, which uses a method of theme identification and categorisation (Burnard, 1988). It allows a researcher to see something which has not been necessarily evident to others (Boyatzis, 1998). For this study, interview data obtained from each participant was examined and categorised through the standard stages of thematic analysis:

- 1) The first stage of thematic analysis is familiarisation with the data (Braun & Clarke, 2006), this is another reason why all the interviews were recorded so they could be clearly transcribed and examined. This first stage generates initial ideas and concepts of themes, and supports the sub-text analysis.
- 2) The systematic generation of codes across the entire data set, produced from familiarisation with the audio recordings then leads to the collating of codes into sub sets as the search for themes continues. A review of the themes gives a thematic map of the analysis, after which the naming of each theme occurs where the generation of clear definitions and names for each theme takes place, with the collated data under each code being able to be categorised and compared (Thorne, 2009).
- 3) Finally, the selection of compelling categories throughout the data produces a clear indication of connected themes and collective experiences and perceptions (Braun & Clarke, 2006).

Throughout these stages, continual review of the data and collated themes occurred to ensure cross-coding by duplication of text between codes was minimised, and that any appropriate themes could be combined for coding.

NVivo permitted the creation of a number of sub nodes which would then be assigned to a primary node. The sub nodes often overlapped between key themes, therefore the final allocation of sub nodes to primary nodes occurred after multiple reviews of the related sections of text as to the relevance to that node. The concluding node structure with sub node allocation were agreed as below:

**Table 2.2 Nvivo node allocation**

<b>Primary Node</b>	<b>Sub node</b>
<b>Abuse</b>	Abuser
	Reason for self-harm
<b>Beliefs and Perceptions</b>	Coping mechanism
	Faith
	Insight
	Self-dependence
	Self-worth
<b>Counsellor</b>	Boundaries
	Accessibility
	Engagement
	perception
	Reluctance to engage
	Seeking help
<b>Family</b>	Children
	Control
	Emotional security
	Father – relationship
	Mother – relationship
	Isolation/alienation
	Siblings
<b>Feelings</b>	Acceptance
	Accessibility
	Accountability
	Fear
	Isolation
	Negative influences
	Perception of needs
	Physical and emotional support
	Positive friendships

Primary Node	Sub node
<b>Ongoing need</b>	Acceptance
	Challenge
	Input and availability
	Self-reliance
<b>Post self-harm</b>	Feeling of relief
	Physical manifestation of emotional pain
	Self-obsession
	Shamed
<b>Pre self-harm</b>	Anxiety
	Impulse to harm
	Response to threat of self-harm
<b>Professional help</b>	Diagnosis
	GP
	Ineffective care
	Nurses
	Outpatients
	Perception of professionals
	Ineffective care
	Positive relationships
	Suicide
	Unsuccessful engagement
<b>Self-worth</b>	Before and after harm
	Belief in self
	Diagnosis
	Insight
<b>Support</b>	Faith
	Input and availability
	Listened to
	Not alone
	Romantic relationships
	Self-harm patients

As can be seen, many of the sub nodes have the same or similar titles between primary nodes, however their meaning in the context of the primary node is really very different as was ascertained from the text analysis.

## Chapter 3: Participants reflections on relationships

### Findings:

Discussed through this results section will be those factors that are dominant in their relevance to the commencement, continuation, and communication of self-harm actions for the participants, as expressed in their own words and perspectives. In addition, the impact or significance that relationships have at meaningful points in time as identified by the participants, will be further examined. These factors will be considered across participant's experiences, to identify what can be learned from the presence or absence of functional social supports during these times, not simply for an isolated individual, but for all of those who self-harm in our communities. Table 3.0 below identifies details of the nine females and three males who participated in this study. A total of 394 minutes of recorded data was collated, and seven pages of documentation from participant twelve comprised the total data collected. Of the twelve participants, eleven identified as NZ European, and one as NZ Maori. The youngest participant was 19 years old, and the oldest 70 years at the time of interview, with the remaining participants evenly spread across the intervening age ranges. This distribution provided a mean age for the participants of 39 years. From factors identified prior to, and during the interview process, I believe that this range of participants offers a good cross-section sample in respect of age, life experience, education and socio-economic status in order to be representative of the larger population. Furthermore, there was enough concordance in the interviews to indicate that the view of these participants may not be untypical for this population.

Methods of self-harm historically used by the participants, ranged from cuts (9 participants), to the lesser reported self-harm of self-mortification (1 participant). Self-mortification was used outside of religious influences of self-denial and self-discipline by this participant, and comprised of attempts to self-castrate, or to mutilate genitalia. Overdoses, burns, high risk behaviours (of both a sexual and violent nature), hanging, abuse of drugs and/or alcohol, and shooting of self were the other methods of harm used by the participants throughout their self-harm journeys. Available research on self-harm identifies the majority of these methods, however there does not appear to be research which distinguishes self-mortification as a method of self-harm in the available studies as it was used here. Latimer,

Covic and Tennant (2012) catalogue 'self-injury with tissue damage', as a classification which includes types of self-harm which are associated with self-mortification, which may be a way of 'grouping' such methods of harm without detailing the actual techniques used. The method of harm itself in these cases is not the primary identifier, rather it is the reasoning behind which the harm is utilised. The participant who used a method of self-mortification did not identify it as self-mortification in their own words, rather they explained the act of harming in the subjugation of personal desires. The purpose of the physical act therefore was the reason for the identification of the action as self-mortification.

**Table 3.1 Interview information**

<i>Interview date</i>	<i>Length of recording</i>	<i>Additional info</i>	<i>Research name</i>	<i>Post interview counselling req</i>	<i>Male/Female</i>	<i>Ethnicity</i>	<i>Age (years)</i>	<i>Self-Harm used</i>
15.11.14	42m		Anna	Yes (also under CMH care)	Female	NZ Eur	33	Cuts/burns/overdose/alcohol
17.11.14	58m		Beth	No	Female	NZ Eur	32	Cuts/overdose
21.11.14	29m 46s		Carol	No (receives counselling)	Female	NZ Eur	35	Cuts
26.11.14	29m 16s		Donna	No	Female	NZ Eur	43	Cuts
26.11.14	48m	email clarity provided	Eva	No (receiving CMH care)	Female	NZ Eur	41	Cuts/burns
15.12.14	28m 58s		Faye	No	Female	NZ Eur	21	Cuts
18.12.14	31m		Gabi	No	Female	NZ Eur	19	Cuts
19.12.14	26m 16s		Hannah	No	Female	NZ Eur	22	Cuts/overdose/hanging
19.12.14	20m 28s		Adam	No	Male	NZ Maori	26	Violence toward self and others/ drugs/alcohol
22.12.14	38m		Ida	No	Female	NZ Eur	62	Cuts/overdose
23.12.14	43m		Barry	No	Male	NZ Eur	66	Overdose/shooting
Written documents	7 pages	text messages to clarify	Carl	No	Male	NZ Eur	70	Self-mortification
<b>TOTAL</b>	393m 64s + 7 pages			1 req session – counselling	9 Females	11 NZ Eur	mean age	9 cuts/5 overdose/2 alcohol/2 burns/1 hanging
<b>Mean interview time</b>	36m 19s			3 in external counselling	3 Males	1 Maori	39	1 drugs/1 shooting/1 self-mortification

During the interviews, participants offered up a myriad of experiences and circumstances, all of which were as distinct as they were compelling. The descriptions of how each individual had dealt with, overcome, or succumbed to their own 'demons' in their individual lives was quite overwhelming. Whilst some had experienced pain and hardship in a multitude of forms during childhood, others reported never having known such distress until fully-grown adults in relationships, and situations of their own making.

### **Reasons to harm**

Each participant's reason for commencing the act of self-harm can be categorised as fitting into one of three groupings which I have identified as common themes, these being an inability to cope (lack of skills or understanding), internal turmoil of feelings (lack of control of self), response to acute and/or ongoing abuse (lack of control in situations).

I think it was out of a frustration. Feeling like you've got all this energy, this negative horrible energy that you somehow need to release. I think it was a release mechanism and also I think a little bit of feeling just so down and hurt and frustrated and angry. (Carol, 35 years)

So that's how it started for me it was more of an anxiety release when I didn't know what to do when I was really panicking and getting really anxious about my health. That's when I did it. (Donna, 43 years)

These feelings of frustration began for most in line with pre-puberty, or pubescent life changes, a time when social expectation is that the individual is able to control themselves, but when the skills of self-control are not yet developed.

For me, I think self-harm.....Initially I hadn't ever thought about hurting myself as a way of managing how I felt at all. When I was about 13, I became quite depressed, but it's only of course in retrospect that I realize that's what was happening. At the time of course I thought I was just going through puberty and that's what everyone felt. I think around the time I was 13, 14ish I can't quite remember my age, I don't know, there was just a particular day where I was really desperate. Looking back now, I must have been quite unwell to be hurting and feeling that way, that young. (Beth, 32 years)

All of the participants, without exception stated they had periods of low mood, depression, or anxiety prior to initiating self-harm for the first time, and a number also recognised these

low periods prior to subsequent self-harm actions. Whilst one of the participants described jealousy of a sibling/father relationship as a precursor, and wanting attention in the build up to self-harm, she too articulated internal frustration at the lack of control over her feelings in not being able to reconcile her jealousy. A lack of control, whether of emotions or circumstance was a prevailing description to the relationships surrounding each of the participants at this time.

It was just...because I remember my dad and my sister were quite close, and I guess I kind of felt left out of that, so I pretended I fell off my bike and then I would cut my knee with glass and just little things like that.....it made me feel a little bit better [about being left out]. (Gabi, 19 years)

To some degree, all of the participants appeared to measure themselves, their perceptions of 'self', and personal identity by the success or failure of particular relationships throughout their lives. Often these were during individual periods of distress which reinforced, or unravelled 'self' identity, or which signalled a period of catalytic transformation in their lives, and as such provided a catalyst to self-harm.

... my [step] father sexually abused me, and I... I did not share that with anyone, or tell anyone about that at the time, and that just caused me to push away people that were close to me. And my mother and all of that, and my family. And get myself into a lot of trouble with the law I suppose. And I did horrible in school. I suppose instead of cutting and that, because I have not even done that once. I was more lashing out at other people over the emotions that I had inside. Not knowing how to deal with them. (Adam, 26 years)

Later in the interview this participant identifies the defining thought from the abuse which was the stimulus to how he would go on to put himself in high risk, violent situations with males:

Because it was a male doing it to me, I had a lot of confusing thoughts about it. You know? Did that make me gay? (Adam, 26 years)

The anger was palpable at this point, as this conflict of self with self-identity, even at such a young age, nurtured ongoing shame within this participant's life.

A few of the participants had experienced abuse of a sexual nature in childhood, the resulting post-traumatic stress of which is often identified in the research as a trigger to self-

harm behaviours (Arens, Gaher, Simons, Dvorak & McMahon, 2014; Gratz & Tull, 2012). However, this was not identified as the predominant reason for ongoing self-harm in this group. Though the affected participants did predictably identify the trauma experienced from sexual assault as an impetus for harm, and in doing so recognising that a link does exist between their childhood trauma and their adult self-harm. It was though, not central as a driving force to continuation of self-harm. Within the discourse around the memory of the feelings of frustration in the context that resulted in self-harm for these individuals, are also elements of insight into relationships, and their impact. Of these key relationships, most would naturally expect them to be protective in nature, such as a mother or a sibling. However, none of the participants who experienced abuse (irrelevant of the type) utilised these relationships for support either at the time, or later in their self-harm journey. In fact, these relationships were actually identified by the participants as connections that were not stable, or not even considered helpful, and as such, were not relationships in which they could reach out for help even at very young ages. Upon personal reflection by each participant, none of those who had siblings and had experienced abuse of a sexual nature, could say if their siblings were aware of the abuse which had occurred, even to this day.

I was living with my mom and my stepdad, and my brother, and my sister. At 12 the abuse got too much. I ran away from home and started to self-harm. (Anna, 33 years)

When asked if her mother or other family members knew of the abuse, Anna states:

I don't know, I still don't know.

Even though this participant went on to explain how she formed stronger bonds with her siblings and her mother in adulthood, the not knowing of whether they were aware of what had happened to her seemed to be easier to cope with, than if they had been aware and had done nothing. Others responses were along the same theme

I have got one brother, who is a year older than me, who is completely different. He was like, I had friends and he did not have any friends. He was quite socially awkward, but really intelligent..... my relationship with him was – it was not great. (Adam, 26 years)

It was difficult to identify whether the bonding between Adam and his brother was strained prior to, or due to the sexual abuse experienced. Sub text analysis of this discussion identified the manner in which the brother's identity was communicated, examination of which gave the impression of distance, almost verbally pushing his brother away in the identification of the lack of relationship. The brother's social awkwardness was being used to rationalise, in that the brother could not possibly be a protective or supportive figure due to his social incapacities. Though Adam identified as having friends around this period in his life, he does not identify these as positive friendships, as when asked if he had anyone in his life at this time who he felt he could turn to, he simply and directly states, "No, Not at all" (Adam). The exact manner with which this was spoken is not in keeping with the 'socially capable' person he appears to believe himself to be in the sentence above. However, denying there was anyone he could turn to for help may be a way to validate the isolation of self he maintained at the time of the abuse.

I was...yeah, ashamed of it. I knew it should not have happened. I did not want it to happen. It just made me ashamed, and I feel sick, you know? (Adam, 26 years)

Shame is identified as a primary reason for the participants deciding to remain in isolation in their pain, and not seek help, with a number describing the feelings and perceptions they had of themselves in their need to rely on self-harm.

I think I was embarrassed and was....I don't know if 'taboo' is the right word or just something you don't really mention because it's not normal behaviour. (Carol, 35 years)

Social norms appeared to have great influence over post self-harm thoughts, and the inaction of reaching out for help at a time when support is clearly required.

I was only like 13 or 14, I didn't really understand. It wasn't until I was about 16....like, once I started hurting myself, that wasn't very normal, but it was also incredibly shameful, it's very difficult to tell people that you do that to yourself. (Beth, 32 years)

Participants did not often describe, or associate themselves as 'self-harmers'. This estrangement of self from the act appears to be important to the recovery and development of self in situations of harm, particularly in adulthood, and is greatly influenced by the

pressure of social norms. In reconciling self within social norms, Beth renounces associations with the label of self-harm, stating:

As more time passes and I get more distance from it, I don't identify myself as being a self-harmer. (Beth, 32 years)

Acknowledging her journey with self-harm changes her image of self, and the internal environment in which she evaluates herself as an adult. As such she rejects the stigma associated with self-harm, through the distancing of herself from the concept of self-harm, however, this distancing in itself appears to indicate internal disparity between who she knows herself to be (or had been), and what she wants others to believe of her.

### **Relationship needs**

"Positive", "negative", "essential", "unproductive", "abusive", and "controlling" are terms used by the participants to describe relationships they experienced at some point on their journey with self-harm, and demonstrate the unpredictable and inconsistent encounters the participants have faced. The expression of need in relationships appeared quite difficult to articulate by many participants, as though they had gotten so used to self-support, that identifying what was needed from others was very challenging.

I still feel that I always felt that I somehow didn't ever quite fit somewhere, that sense of belonging and I've probably always been looking for you know, some sense of belonging somewhere. (Ida, 62 years)

I think I've always been quite a quiet shy person in relationships. It's just that in one to one situations, and if it's a group situation, I tend to be on the edges or like sort of an observer rather than like an instigator or a participator so much. (Beth, 32 years)

The inability to identify what was needed from others often turned into characterising what was wanted internally. It was as though in this re-directing, focusing on self and what they perceived as personal inadequacies, appeared easier to emphasise than investigating what external relationships could or should provide.

In quiet contemplation I search for a clue to who I am and where I'm running to. (Carl, 70 years)

This participant further augments the internal search in which the pursuit of identity in relationship, as much with self as with others, is evident. As human beings it seems we are fundamentally made equal in our need of connection with others, whether those connections are encouraging or injurious. Though our desire for those connections to be positive, and capable of reinforcing self-imagery and self-worth, appear to be key aspects in relationship constructs critical to achieving positive wellbeing outcomes.

### **Relationship harm**

Reviewing negative relationships was important to the participants, and actually encouraged the identification of positive aspects. Therefore, their ability to classify negative relationships was examined. These negative relationships were discussed as having impacted, at least in part, on participant's image of 'self' in line with the strength, and type of negativity felt within that specific affiliation. Peer relationships were significant, and therefore significantly negative, as cruel jibes aided distorted perceptions and imagery of self for the participants, at a very young age.

I hated the person I was. I did not want to be this horrible fat woman. I think that's what it comes down to, you internalize all those horrible feelings and think, 'Oh I'm just a horrible, worthless, disgusting person'. (Carol, 35 years)

Throughout the high school years, I kind of turned to my friends, and I would just say 'I want to cut' or something, and some of them were really good and sent me these long texts saying.....because it was always through texts, I didn't say anything to anyone's face, but others just kind of gave up. Slowly the ones that were sending the paragraphs, I think they just kind of gave up as well.....I felt that they didn't care and weren't really my friends. (Gabi, 19 years)

Friendships through pubescent years have been shown to be influential in the formation of self-identity (Wu, Chang, Huang, Liu, & Stewart, 2013). The comments from the participant above display that her experience was one of being unable to rely on such relationships for support, and certainly not in an ongoing manner. Such damaging relationships, which foster isolation amongst school aged individuals who do experience self-harm is well documented in its impact, and whilst the relationships are limited to a few years of an individual's life, their negative impact is capable of enduring, and influencing future peer affiliations.

I never had high self-esteem. I've always had really low self-esteem, low self-worth. That's something that I've struggled with [and still do]. (Hannah, 22 years)

This participant discussed the impact that ongoing negative relationships have had in her life in such a way that she seemed to believe that low self-esteem explained the struggles she had encountered, and that she was therefore responsible for the harmful circumstances experienced within relationships, due to this apparent 'flaw' in her character. This belief of cause and effect of self-esteem had begun at a very early age, and was a theme that endured from the majority of participants.

Whilst many used affirmative terminology relative to parental, or family relationships in adulthood, this appeared to be in strong contradiction to the language used to explain those relationships from their childhood perspective. From early on in life, bonding with others through the experience of family and social associations begin to mould anticipation of what we expect from others (Anderson, 1999). Problems associated with early life connections in relationship formation have been shown to influence an individual's decision in the contemplation of self-harm (Kerfoot & Huxley, 1995). A participant experiencing self-identity issues describes the agreement his mother made with him which established the boundaries of their relationship:

But as always throughout life there is a shadow, dad wasn't well – mum thought if dad ever found out his son, his only child was female – it would kill him. I was forbidden to speak to anyone (Carl, 70 years)

He was to deny himself; his mother's anger was due to the fear of judgement of the 'family' by others within their community if their secret got out. Another participant describes how she taught herself not to tell anyone anything to abate the negative judgement self-harm creates.

I just learned not to tell anyone anything and not to trust anyone with any feelings so I keep everything really bottled up inside.....it is still very secretive, I guess, it was never something I could share. (Carol, 35 years)

Not being able to be honest about their journey and experiences with self-harm was often self-driven, but could be clearly identified from the perspective of being shamed, either by societal expectations, or the expectations of those around them.

### **Relationships which help**

“Non-judgemental”, “caring”, “seeing of 'me'”, not needing the 'persona' of coping to care, “listening”, “giving”, “empathic” and “nurturing”, were terms used by the interviewees to express positivity of relationships, particularly in relation to personal therapeutic relationships. These being relationships that the participants viewed as mutually beneficial between themselves and another party. Though predominantly these were romantic relationships, friendships in adulthood were also a key feature. Each participant expressed, to some degree, the need of a fully realised image of self as productive in these relationships.

It's important for me to be who I am in the relations with people around me, and [for them to] still love me, still care about me, even if I'm in my pyjamas with my hair wet, they still love me. (Anna, 33 years)

I can be quite guarded if I want to, because people won't necessarily know that I'm being guarded. At the same time I certainly want, desperately want to be known intimately. (Beth, 32 years)

Romantic relationships were predominantly responsible for a positive impact on self-harm, though there was not sufficient ability to examine this further in the data, I wondered if the control over self-harm through ultimatums within the romantic relationship was an aspect which may potentially result in the individual returning to self-harm should the relationship end. When asked when and why she stopped self-harming, another participant stated:

It would have been well over a year ago, and that's because I've got a boyfriend now. That's pretty much the reason, because we've been kind of off and on, I guess, and then last year we got official, because I remember when we were off and once I had done it and he saw it, and he just.....he was so upset and he just said, 'if you do this again, I don't know if I can be with you' or something. So I just haven't done it ever since because I don't want to lose him really. (Gabi, 19 years)

Though there is no doubt that these relationships are virtuous in their ability to stop the self-harm reliance, the balance of power could be seen as a negative component, as neither of these individuals, nor the others who had similar stories, appeared to be working on any other aspects which led them to begin to harm in the first place. One of the participants discussed their experience of a romantic relationships ending, and how this increased her negative self-emotion:

We broke up in 2012, so we would have started going out and....yeah, it would have been 2010. We went out for a year and then he broke it off with me in 2012, and that's when I overdosed and almost..... (Gabi, 19 years)

The incompleteness of the sentence indicates the participant's direct move from self-harm behaviour, which she had used to manage negative self-thoughts, to an attempt to end her life.

### **Parental Relationships**

Without exception, each participant had a 'family story' where they had an overpowering or dominant parental figure; predominantly this was the mother.

I lived in quite an abusive, controlling household in which I wasn't really allowed to leave. Everything was controlled, what I ate, where I went, what I'd see, all those sorts of things. (Faye, 21 years)

The importance of having some control, even over the small things in their lives, was meaningful to all of the participants, and whilst most of the desired control was not experienced in the everyday events as above, control within relationships and family situations was extremely important. Some participants outlined feelings of being "ignored" by a parent, or both parents, giving them their first identifiable feelings of alienation, of not 'fitting in' with expectations of others.

It was more just like, like how I wasn't noticed, or because I wasn't the kind of girl who made waves by acting out as such. I just slipped quietly under their radar. (Beth, 32 years)

Being ignorant to their needs was also seen by the participants as a coping strategy by the parent, with feelings of invisibility encapsulating the lack of relevance many of the participants felt they were to others:

I think mom and dad, I don't think they had the capacity at that time to really think about anything outside of themselves and their marriage, and how much they hated each other. (Beth, 32 years)

Just like....feeling invisible. Like I didn't belong there. Like that was more for my mom. My mom was never around. (Anna, 33 years)

Health literacy was high amongst many of the participants, and was an indication of the level of thought and investigation they had put into understanding themselves and their parental relationships. A few of the participants even went so far as to diagnose depression in the parent who affected them the most. This diagnosing of parent by the child appears to have gone some way to stabilising, or re-balancing the estrangement felt within the confines of the relationship through justification by illness. It also showed a need for association, as most of the participants had experienced, or had been diagnosed with depression also, indicating a need to measure those with greatest influence in their lives by the same diagnostic tools they too had been measured by. Dysfunctional relationships within the family were clearly linked to unresolved parental issues.

... my mom has been somebody that always needs a man in her life. She is one of these people that is constantly in a relationships and needing that support because she was sexually abused as a child. (Adam, 26 years)

... when I was younger, it wasn't very good. I think she had depression, so she was always quite angry. I remember her yelling a lot. (Gabi, 19 years)

I have a history of trauma in my childhood, a lot of trauma, sexual abuse, instability in my early life, a lot of change. Early loss of my father when I was 14 months old or so. My mother who was very depressed when she was pregnant with me, and my [step] father at times was quite abusive. (Eva, 41 years)

Such diagnosing of parental problems appears to have empowered the participants in their acceptance of their parent's instability, or inability to offer them the nurturing environment they naturally yearned for in their childhood. As the participants described the development of relationship with their present parent in adulthood, the dynamics of the relationship, and management of the relationship had changed, with ownership of the parental role often

now belonging to the participant. The balance of control had also clearly shifted, with all of the participants describing when and how much input they could now tolerate in adulthood, from the parent whom they felt wounded them in childhood.

### **Impact of diagnosis**

Some participants placed belief in a diagnosis as being freeing for them, in allowing the investigation of a condition to gain greater knowledge of self. Whilst this was generally to understand themselves more, and to find a means of managing themselves, the rejection of a diagnosis appears to have afforded as much power to the participants as did the acceptance of it, particularly if the participant did not agree with the given diagnosis.

They said that although I didn't meet the criteria, because basically at that point in time, the only DSM classification that contained self-harm was borderline personality disorder, so that's how I tended to be treated up to that point. (Beth, 32 years)

Participant 2 was clearly upset at the allocation of this diagnosis, particularly as more recently she had been, what she describes, 'correctly diagnosed':

I shouldn't laugh, I've been diagnosed with major depressive disorder, and SS1, as well as chronic dyspnoea. (Beth, 32 years)

Finding the diagnosis funny was in the context of confirmation that this participant knew that the allocation of a BPD diagnosis by professionals had been incorrect. This appears to have boosted her self-belief in the confirmation that she was right, but also highlighted for me that a diagnosis that the participants agree with, and therefore can work with, can actually be non-stigmatising.

The experiences of the participants relative to stigma from the act of self-harm, or how they were defined by others in their suffering differed, with some not mentioning anything at all about how they were treated by others in relation to their self-harm behaviours, or the scars they carried. However, the majority of participants did recognise they were treated differently once the information of their self-harm behaviour was shared.

Mom....I did remember one time I asked if I could use the razor to go to the shower, and she made a joke saying, 'for which part of your arms?' It just really annoyed me. (Gabi, 19 years)

Sarcasm was used in many response descriptions, though upon review of the transcripts, I believe the sarcasm, whilst reported by the participants in a negative undertone, was actually being used as a means to cope with the self-harm behaviour, by the parent or partner. It was clear though that as the age of the participants increased, that their ability to be more open about their history with self-harm strengthened, and therefore the need for sarcasm by those around them was reduced.

I think people understand....I'm sort of off on a tangent, but soon it struck me was whilst I was away there was a lady, a colleague...she's just had a bad time. I wrote her, and I said 'are you alright?' She wrote back, said no, I've just been to Cape Town to see the psychiatrist. Then I said, well, if you look at my CV there's years missing. You know where I was? She just broke down. Somebody understands. (Barry, 66 years)

Actually....when you talk to people you often find they have gone through similar situations. (Carol, 35 years)

Seeking and receiving acceptance clearly takes an openness. Possibly this openness comes with age, and as such the fear of rejection may not be as significant as it was in youth.

Some conditions are accepted within society as being beyond an individual's control, and as such, relief is often felt when a diagnosis which is not as stigmatising as self-harm is given. A participant describes the symptoms she was experiencing as uncontrollable, and in conflict with who she believed herself to be. This resulted in her feeling from health professionals that she was "going a bit bonkers". Self-harm developed for this participant as a way to manage anxiety and find peace with the perception that others had of her and her symptoms. Further stigmatisation also came due to her being a sickness beneficiary because the symptoms experienced hindered her from being able to work, and as such re-enforced the perception of others that she didn't want to work and was lazy. She then received a diagnosis that reconciled her feelings, and reinforced her knowledge of self.

Whilst that didn't make things magically better all of a sudden, it just – I think that recognition that I wasn't going crazy and I wasn't going to be like this forever, that made a huge difference. (Donna, 43 years)

Many individuals who experienced self-harm due to symptomology of depressiveness created through negative support structures, progressed in their journey to develop a self-identification as a need to cope in the 'self', a development that often appear to be in line with them reaching a point of self-reliance. As such, this diminished the need to have others so involved in their world.

A number of participants expressed the development of self-reliance through a need to shelter others around them, particularly parents. For others though, it was an isolation within the family structure environment which led to the realisation that they could not depend on, or be sustained by those family relationships. The forethought and ability to be able to pull oneself together in desperate circumstances requires an adeptness not all self-harm individuals are able to develop. Whilst one participants states he "just stopped and made a choice" (Barry, 66 years), others develop an active rage:

... fuck this. I am not going to do this anymore... (Adam, 26 years)

Being able to cease self-harm behaviours in such drastic manners shows a level of capability which must have been embedded within them to some degree by their experiences. These juxtaposed positions of aggressive resilience and passive indignation at potential liability to others are poles apart, but the results realised by them are equivalent, in their outcome of self-management and a lack of reliance on others in adverse circumstance.

Ultimately, the desire and need to reconcile self in the environment in which these participants find themselves is clear. There is an innate need as a human being to belong, and to be accepted as yourself, both internally and externally. Adversity has been a great teacher for each of the participants, who all appear to have found a place and space in which they are now able to see themselves as functional. However, the functionality of the relationships that have been, or continue to be around them, seem moulded by what the participants see that others expect of them. Social norms and boundaries have successfully plied them into a shape acceptable to their present time and space. I cannot help but wonder that if their relationships in childhood, youth, and early adulthood had been more appreciative, more open, and more functional, then would they be more reconciled with whom they find themselves to be today?

## Chapter 4: Relationships with health professionals

### Professional care

Understanding how and why those who experience self-harm access health service is important to discerning their needs in the delivery of care. In this chapter, experiences with general medical services, mental health services, and counselling services as aspects of self-harm support and treatment, will all be discerned through the eyes of the participants. The level of involvement with each service, and the self-expression of personal experiences as positive or negative, both from a care deliver, and an impact on self-harm perspective, will be identified.

### Clinical Encounters – Medical

All of the participants had experienced involvement with health services of some kind, and in one form or another during their self-harm journey. Services accessed were varied, and included aspects of general health care from a range of providers, such as GPs (General Practitioners), Emergency Departments (ED), medical and surgical wards, and outpatient medical facilities. The extent of the treatment provided by these service interventions ranged from acute to none urgent, with ongoing, chronic treatment reported as being minimally required. The duration of care provision appears to have been provided in line with the severity of harm encountered.

I inserted seven sewing needles right under my skin in my arm and could not get them out of course. I ended up at ED and had the doctors there saying that they possibly might leave them in because the surgery to remove them might just be too risky. (Eva, 41 years)

After multiple surgical interventions, this participant reported ward based care as extending over weeks, with her experience of this care reported as predominantly positive. However, as the story of the surgical journey unfolded, it emerged that the pure physicality of repairing the self-harm damage during the delivery of care was the sole focus. Every connection made with individual professionals in this case was for this 'physical healing' purpose, with seemingly no attempt at advancing in knowledge, or comprehension of the

act or aim of her self-harm. This was not something the participant thought was an issue though, as she had a clear perception of the delineation between what medical care could provide, and what her mental health needs were.

I was actually a client at community day program at the time. I had been building a really lovely relationship with one of the nurses there who was my key nurse.  
(Eva, 41 years)

Discussing the mental health input at this time, P5 reveals how mental health is seemingly completely detached and very separate to physical health needs. I wondered here why the complete disconnection between physical and mental health was such an accepted fact.

During her health journey, experiencing empathy was important for the participant, and hearing about the care from an outsider's perspective, it appeared that the brutality of the self-harm in some way directed the level of empathy given. It was unclear as to whether the anticipation of empathy from health professionals was in any way, a driver to the seriousness of the self-harm.

... the two times that I needed surgery, one time for a burn that I did with oven cleaner, I needed a skin graft. That was quite a drawn out period of time and I needed a lot of input and treatment from district nurses, the plastic surgeon, to the wound care specialist. They were all wonderful people, the three key people in that journey that were just really lovely and really caring and compassionate without judgment. (Eva, 41 years)

Judgment was a word utilised by a number of the participants, the absence of which seemed essential for care to be seen as positive. The experiences of the participants with general health professionals did show disparity to this effect.

There have been the odd instances where I felt, I don't know, I don't really know, well probably angry in parts and hurt, but also treated in quite unprofessional ways a couple of times, because I became such a regular patient at the department, nurses and doctors there would know my name....I think a couple of the staff there basically thought I was a bit of a time waster really, because I'd often need some sort of medical intervention like sutures or sometimes it would just be steri strips or whatever.....not everyone there, there's some people who were incredible, and really amazing, but there were sometimes where it was quite clear to me that the doctor or nurse who was treating me, just saw me as a bit of a time waster and clearly not an emergency. (Beth, 32 years)

The anger at being treated, and labelled as a 'time waster' was evident in this interview, balanced though by the need to recognise that not everyone treated her as this. The participants often recognised that they had done this to themselves, and the frustration that the lack of understanding from the varying elements of general medical care appeared to manifest in capricious ways.

There was another time before that that I did it [self-harm], and the ambulance drivers were like...I don't know, I think they made a joke like...I can't remember what it was, but I was just kind of like annoyed. (Gabi, 19 years)

Participants clearly, and predictably expressed that they did not like to feel judged, and emphasized that the attitude with which care was delivered was paramount. A point of note was that some participants wanted health staff to be 'real', and authentic, and to talk about the affect providing care to someone who had chosen to self-harm had on them. This desire for authenticity was immaterial of whether the impact upon the health professional was positive, possibly in teaching them more about self-harm, or negative, in making them angry at the time taken in delivering care to someone who did this to themselves.

... nurses don't tell you how horrible it was to have to put a femoral line in a girl who had just taken some sort of overdose of XYZ. You know, like you don't get that feedback, because that's not the way that system works. Like, we deal with the emergency and then she goes back out into the community. (Beth, 32 years)

Getting 'that feedback' was important to this participant who seemed to be saying she needed her behaviours to be challenged by healthcare professionals because she needed to understand the negative impact on others of her self-harming behaviours. Going 'back out to community' was a common opinion expressed by participants, in explaining the health sectors need to get them treated and get them out, this in turn though, clearly influenced the desire to seek the right level of care, in accessing the right services for their harm.

... towards my time in Wellington I stopped going to the emergency department and started going to my GP instead, so they were really good. I could walk in off the street and they would usually be able to like fit me in somewhere. (Beth, 32 years)

This participant believed herself fortunate in the capabilities of her GP who had undergone some surgical and plastics training, which meant she was able to treat large gaping, infected

wounds appropriately without hospital level care. However, many others were not as fortunate.

When asked about her experiences in the emergency department at her local hospital, P5 states:

Mixed, quite mixed. Probably mostly positive or neutral I guess, being a very sensitive person, particularly to people's tones and voice and facial expressions. At times I have sensed judgments from nurses and doctors. (Eva, 41 years)

The recollection compelled sadness for this participant in that judging oneself appeared to be part of the process in deciding to harm in the first place, so to be judged for the act by professionals gives the impression of a 'fait accompli' of worthlessness. It seems there is no harsher measure than to judge oneself, other than to be judged by others in the vulnerability that the pain and shame of self-harm begets. Understanding and listening skills in healthcare professionals were identified as really important in the provision of medical care, but just as important appears to be how that understanding is communicated.

I can still remember the pain of getting these stitches, but once again quite clinical, it is I suppose these people, and I do remember a nurse saying something like, "Oh, life can be hard", or something like that. But not, I suppose I must have been wanting someone to give me a hug and look after me really. (Ida, 62 years)

Even though a hug was not afforded in this case, in the memory of this care, the participant found solace in the small niceties expressed in even the most minimal of ability to understand why she had done what she had. Ongoing relationships were another key element verbalised in the delivery of care.

I think the longer term stuff is more important. I think there were doctors and nurses that I came to recognize in the emergency department, who had maybe sutured me before, looked after me before. Knew enough about me to ask about my cat or that sort of thing. It can be like those small, those, I don't know, call them like small kindness or something, which can be really touching when you are that unwell. (Beth, 32 years)

Though none of the participants expected medical health professionals to be able to address their mental health issues, it seems that recognising, and acknowledging that the individual who has self-harmed is actually unwell, whether that be physically or mentally, was crucial to building a relationship in care, and for the patient to be accepting, and comfortable in

receiving that care. In the next section I move to participants' experiences of mental health professionals in both acute and non-acute settings.

### **Clinical Encounters – Mental Health**

Participant's experiences with mental health services ran parallel to their mainstream medical encounters in primary and secondary health settings. Mental health care for the participants also traversed professions, phases of harm and periods of care, with some never leaving the solace of ongoing mental health input. Others though accessed services only in an acute capacity, or when required to support the minimisation of self-harm.

It is easier to talk to someone in a professional capacity about it, because to some degree, the emotion is removed, because the relationship with that person probably is less important. I can always get me a GP. It would be terribly difficult to find new flatmates. I suppose so, like the risk is lessened if I talk to a professional about it, than if I talk to someone close to me. (Beth, 32 years)

Recognising the need for professional services, many of the participants sought the stability of independent and specialised support, knowing that this kind of care was not available in either the general health service, or amongst peers. Most participants were able to isolate the forms and styles of interventions, predominantly because of the health professional's titles involved in their care, but also because of the diagnosis that came with such care. Their expression of expected input from a variety of individuals within the mental health system also displayed the level of health literacy many had developed such as EPS (Emergency Psychiatric Services), and PDN (Psychiatric District Nurse).

Most participants had accumulated multiple diagnoses through their interactions with mental health organisations. These predominantly included depression, and severe depression, but nothing incurred a more profound response from the participants than the diagnosis of Borderline Personality Disorder (BPD), a diagnostic title many had received. Whilst one participant did embrace this diagnosis as a way to discover a pathway of care, and a method of intervention for their illness, others fervently rejected this diagnosis. This refutation seemed to be primarily because the participants did not believe that the diagnosis 'fit' them, or accurately reflected who they were in their illnesses.

It's like you're made to fit in a box basically, so if the only box you fit in is the borderline personality box, that's what we'll put you in. (Beth, 32 years)

Overall, those who rejected the BPD diagnosis appeared to do so because they believed they were afforded this label purely from a lack of any other diagnostic categories that covered their actions and intentions.

... the only DSM classification that contained self-harm was borderline personality disorder, so that's how I tended to be treated.....but I was assessed by the personality disorder service and they said 'she doesn't meet the criteria'. (Beth, 32 years)

As a result this participant felt she was in a no man's land of diagnostics, and had no common ground with anyone around her, or even within the mental health groups she attended.

... there's actually something wrong with me. That being of course, it was also quite alienating, because it was just like, no one else gets this. Like no one else I know was experiencing this. This wasn't ordinary. It was quite a lonely thing as well. (Beth, 32 years)

It seemed important for most to have some form of diagnostic title. For the majority this helped to form boundaries of relationship both within and outside of mental health circles in the accessing of care that would not otherwise be available to them. For many, it also enabled them to be able to say they were not alone in their suffering, in that they had commonality with others, who could in some way understand what they experienced. Whilst the terminology used by the participants relative to relationship descriptions is diverse, the principle of need expressed within those relationships appears to be in essence, the same, being to be understood, cared for, listened to, acknowledged, and appreciated. Unfortunately, the behaviour of self-harm can be counterproductive to these needs, alienating those who have little understanding of the affliction and self-destruction of self-harm (Latimer, Covic, & Tennant, 2012).

I think it's because it's very clinical. They kind of look at you like they're looking at their medical book. Everyone's the same but yeah, it's just very clinical. (Anna, 33 years)

It appeared that within the need for a recognised diagnosis, and the unity with other sufferers it can bring, there was also the expectation of individuality. Being identified and categorised was discussed in some form by all of the participants, with all but one of them expressing this process as negative. The reason for this was verbalised in many forms to be due to the belief that identification of an illness was intended as a means to group the participants into a type which would dictate their care needs. Whilst the clinicians fought for finding commonality, it appeared that the participants also needed their uniqueness and individuality to be acknowledged.

I think they just looked at me as another number when it comes to young people being depressed. I think it was almost like 'Here's another one. She's in the same box as everyone else.....I don't feel like I've ever had any continuous support from any mental health team or anything like that surrounding self-harming or anything. Because once again, they don't see it as a really serious issue when it comes to...They see it as a serious issue in the whole and it's reported in the media and they talk about it as serious but as soon as you're sitting in front of them telling them about it it's sort of just like, "oh she cuts. So does every other girl in this mental health system". Do you know? (Faye, 21 years)

The fellowship such commonality offers is expressed by this participant as a negative in her perception of being just another teenage girl who was cutting herself. Her impression was that, as such, in an under-resourced service with high patient demand, she was not seen, or accepted as an individual. The care available from these services were seen as essential by the participants, and were accepted as such, particularly when it was an acute service delivery for wound care or medical intervention post overdose. However, time and availability played a major role in the achievement of relationship in the delivery of that care.

And you know like the mental health people could be there for sometimes an hour a week if you're lucky. Which still leaves a lot of hours in the week. I find that having friends around me is a lot more better. Because sometimes you don't even have to say, actually I feel like self-harming. Sometimes you just have to say how you're feeling, you just send a text and say hey how you doing? And have a two or three minute conversation and it helps more than spending their hour a week with you. (Anna, 33 years)

The amount of time spent in care emerged as less important than availability and access to positive reinforcement in the form of encouragement. However, there was also verbalised recognition of the need for 'self' to engage.

Well the last few months that I've been dealing with the north team. You know I've kind of tried to be a lot more grown up about it and actually talk to them about my feelings and what's going on. I'll get a response like, you just need to keep going and you'll get through this. Sometimes when you're in that moment it doesn't actually feel like you are going to get through it and that you can't keep going. Then you hear comments like, you just need to get on with it, you just need to get out there and enjoy your life and it's time to grow up, and stuff. It's not what you want to hear. You don't .....that's not helpful. (Anna, 33 years)

The failings of the engagement seem to occur when the impression of the mental health professional by the participants is that they are not engaged, or caring, or understanding about what an individual's needs are in this particular moment. This lack of appreciation seemed to be identified as much as an aspect of personality, as it was an attitude to care.

The psychiatrist's I've had to deal with, except this guy...well, the two main ones have been very....the words that come to mind are domineering, aggressive. I would say unsympathetic. (Barry, 66 years)

When asked about the difference of a successful connection versus an unsuccessful one from mental health professionals, Barry identified the absence of a particular attitude as a successful relational factor, and something which distinguished one mental health professional as caring over another.

I would say empathy. Yeah. He....yeah. He just wasn't aggressive. There was still the boundaries, or, you know 'you've got to work at this'. I don't know whether it was easier with him because I was working on it. (Barry, 66 years)

Aggression was detrimental to the receiving of care for this participant, and did not endear him to want to engage in working on his individual needs. It appeared important as a participant in one's own journey of care, to be able to identify when you are ready to work on life factors that are causational to self-harm. The need for 'work' was verbalised by many participants, and identified as being self-directed at the point in their journey when they believed that successes could be made.

I'm the only one who lives in my head. I have to do the hard work. I actually have to like me at home. I actually have to work hard and fight to change. (Anna, 33 years)

Whilst this would imply the journey is one of self-development, and can occur in the absence of any health professional, it was also evident that when they were ready to do this work, professional help was needed help to guide them through the journey.

All of the participants acknowledged that there was a definite battle occurring between wanting to self-harm and needing to fight to resist the desire. It seems that working on self, alongside professional mental health input required a level of acknowledgement and appreciation from those professionals. As a girl who was always quiet and shy and 'slipped under the radar', at the point in Beth's journey when she believed herself ready to begin working on herself, her professional encounters were discouraging.

Like there was a bit of me in play and a bit of, you know sort of medication side that's maybe not wanting to take them, but also not really being heard by the professionals that I was seeing.....I always feel like psychiatrists should have to take every medication they prescribe to people because they're horrendous, but it got to the point where I used to think, you are clearly not hearing what I'm saying to you. (Beth, 32 years)

The anger she felt at being medicated may be a manifestation of her reluctance to comply with the necessities of treatment, which may in fact ultimately aid her journey.

Disempowerment in treatment was frequently verbalised, with terms such as 'not being heard' or 'not being listened to', being a hindrance to the effectiveness of treatment, and went some way to distinguish how some participants believed they were viewed through the eyes of mental health professionals.

He was brilliant. Very clever, but it was...I used to say, he goes through something. I don't know if you've what we call a key. If you've got a plant and you want to identify it, you look at the flower then you....you can sort of see him reading it off. That's you, you know. There was no [individuality]. (Barry, 66 years)

Some participants did experience positive connections in mental health care, though this was notably at nursing level of input, and included predominantly day to day nursing care where the building of relationships was possible. Whilst this may have been due to time and

access, personalities of individual carers in freely giving something of themselves into the delivery of empathic care could also be a significant factor.

I think the psychiatric health nurses, psychiatric nurses, were just amazing and they were basically what held the place together and what got everybody through, rather than the next level up. (Carol, 35 years)

I think they [mental health nurses] were definitely there as part of the mental health system. That doesn't mean to say you can't also have a relationship with them. To me they were there for a particular job and they were there to provide a particular kind of support in a certain environment that was structured around the hospital and all the rest of it. (Donna, 43 years)

Knowing that the mental health nurses had a job to do, was not a hindrance to the formation of relationship for these participants, instead it seems to be seen as a clear indication of a boundary (of employment) around which everything else can be built. The fact that an individual is being employed to carry out care is not a barrier to the success of the care provided, or the relationship formed. Though again, individuality was emphasised as fundamentally important, illustrated by the participant below feeling that the importance of her faith was never acknowledged by health professionals.

I have struggled a lot in mental health services because spirituality has always been really important to me. Even in the times that I have been really unwell it has often been about 'please God'. Calling out to God, the sense of utter abandonment, you know, has always been present in one form or another.....I have been connected in my recovery journey, the sense of God is present. Jesus is present. I have not met people in the mental health services, other clients who have had such a strong spirituality from an early age. Then when I have been in spiritual circles I have not met people who have had mental health issues and struggles. (Eva, 41 years)

Expressing that her faith was not understood, nor was relevant in standardised treatment regimens meant for this participant, that she felt she had to choose a method of support...her faith, or her mental health practitioner. Given the disparity of understanding in both realms of the existence of the other, this appears to be unfulfilling to her on her journey of care, giving the impression that faith could not cross the boundaries of health care intervention.

Boundaries of care in health practice are important for many reasons, including safety and self-care, with carer fatigue being a well-documented event (Taylor & Barling, 2004).

However, the protection of these boundaries did mean for some participants that the challenging which can occur in a relationship of trust was not able to happen.

I don't have too much memory of the follow up appointment I had with [psychiatrist], but I also know if I remember rightly that he was disappointed. I suppose professionally perhaps he thought we're not getting anywhere here. I don't know, you know what I mean? (Ida, 62 years)

Boundaries are present for both the patient and the carers, or practitioner's safety. There is a differentiation between fluid boundaries for therapeutic purposes, and over stepping boundaries in search of self-gratification for either party. However, many participants seem to be suggesting that, if those boundaries were more fluid, then greater, or more authentic relationships may be able to be achieved.

At least on one occasion I went to pay him and he [psychologist] said "oh no, I wouldn't dream of it, I've only been talking about myself". I thought ok, but he would turn things around to himself and when I look back that wasn't alright. (Ida, 62 years)

Some participants saw professionals as having very clear boundary lines within their health provider roles, and as such experienced conflict in their desire of developing a familiar, caring relationship in amongst the distance such clear boundaries afford.

It's so confusing and conflicting because on one hand, it's like I want these professional people to think of me as a person, outside of my own self. On the other hand, I'm like, 'I'm going to come and see you because you are able to think of me objectively, just as my own'. You know? (Beth, 32 years)

There are a number of needs in relationship as verbalised by this participant. The distance of professionalism is needed to provide an independent but reliable and professionally knowledgeable perspective of what an individual is experiencing without being caught up in transference or counter-transference. Then there is the need for connection, to enable honesty and trust to develop, through communication. That communication though, cannot occur until trust is developed in some way because this then leads to the desire for the challenging of behaviours through a secure relationship. Communication, and equality in that communication emerged to be key to a trusting relationship.

Probably more listening and less talking. They did a lot of talking and they never listened, especially my psychiatrist. I mean my counsellor was lovely like I said, but I really struggled to even see her because it was overwhelming to me. Even my psychiatrist, if I said something to her I can remember on many instances where I'd say, I feel like this and she'd go, "no, no, no you don't, you feel like this". And completely flip it around because that didn't fit in with her little 15 minute slot for me, or anything like that. (Faye, 21 years)

Listening was discussed as immensely important, as was the need for a non-judgmental, compassionate professionalism. Participants described the importance of having staff in EPS grasp their immediate predicament quickly, this was seen as an expectation of professionals in such settings.

[EPS] it's guaranteed that someone was there and they weren't going to freak out and I could say exactly how I was feeling and what I was thinking of doing and they wouldn't go 'huh'?. (Donna, 43 years)

Professionalism though was not always experienced, and opinions of professionals were formed from these occurrences, in a 'seen it all before' attitude.

I have rung [EPS] a few times, when I was feeling really shit. And they pretty much just said, "There's nothing we can do here". And, "You'll be fine". You know? I have rung them up about four times when I was just feeling really afraid for my life, just trying to get some help, and they are just really reluctant to help you. (Adam, 26 years)

Although one participant's experience was so intensive in their desire to assist, that it created a fear of accessing acute services in future.

Yeah, when I went to EPS they were really intense, almost overly so like quite scary intense. Talking about obviously putting me into a hospital with all these medications. There was never really "Do you want to talk about it?" It was "How many pills can we put in you? Where can we lock you up until you won't do anything to yourself?" It was quite full on and it made me really scared and that's why I actually went back home. I didn't go anywhere that night. (Faye, 21 years)

Participants appeared well versed on the appropriateness of the different levels of health service provisions, though the exacerbation that Adam showed at being informed of the need to have actually carried out an act of self-harm, was discerning. Though it was unclear

whether Adam had presented previously to this service, or if there had been inappropriate accessing of services by him in the past.

They [EPS] are not interested in you coming, and needing to have someone to talk to, before you have done something. (Adam, 26 years)

Age and history did seem to bear some impact on the expressed attitude of acute intervention service providers, with younger self-harm sufferers, appearing to be more open to trying interventions.

... there were quite a few times when I talked to people on the mental health line, where the things they said just seemed really stupid, but I did them and they were really helpful. (Beth, 32 years)

Overall, there was amazing disparity in the experiences of mental health services across the sector, which was presented in degrees of severity of self-harm, desire to work on causational factors, historical engagement with a service, and age of patient, with all participants expressing both positive and negative experiences across all services dependant on where they were with these influencing factors.

### **Clinical Encounters – Counsellor**

Counsellors were not viewed by the participants as being in the same professional capacity as mental health professionals. Mainly this appeared to be because of the length of time which was spent with counsellors, the manner with which they approached care of the participants, and the level of relationship achieved. When asked if she sees her counsellor as a professional, Hannah states,

Sort of a bit of both. Because I've been seeing her for a while. It's not as professional, in a way. We can talk to each other, like friends. (Hannah, 22 years)

Differentiation of mental health professional and counsellor was verbalised in relation to trust and time by Anna.

I think it's because it's a different relationship you have with your counsellor than what you have with, say your psychiatrist or your PDN. You get a lot closer and you have to....if you want to do the work you have to learn how to trust

them. From there you build an amazing relationship. For me, [my counsellor] knows 99% of my life. She's here every week, she cares, yeah. (Anna, 33 years)

'Doing the work' was a key element, and one discussed predominantly in relation to long term relationships, and being ready to deal with historical issues in a trust based connection with counsellors. The perspective existed that the relationship with a counsellor was reciprocal, and that the counsellor 'cared' about the individual. Many of the participants discussed boundaries, which they seemed to believe were still very clearly defined within the professionalism of the counsellor. However, attempts were made to test these boundaries, even though they were agreed.

But during kind of normal working hours I'm able to take care of it. If things get really really, oh my gosh I can't do this anymore, I can send her a text on her work phone and she will respond within 20 minutes to half an hour.....I understand that there's still boundaries. There is still that counsellor-patient role. But yeah she definitely holds a very special place to me, more than just a counsellor would. She's hugely important. (Anna, 33 years)

Many talked about early experiences with counsellors, particularly school counsellors. The perspective at a young age about counsellors and their purpose was that they only dealt with the most severe of problem children.

There were times where I thought I need to tell someone about this, but I didn't know how to or who to talk to, like I remember in high school, walking back and forth past the counselor's office, school counsellor, thinking I need to talk to someone about this .... the reality of it was that, the people who need to see the school counsellor were the true ones, were the people who are doing drugs, were the teenage pregnancies, were the people who came from really broken home lives, or who were delinquent, got into crime whatever, not the good middle class white girl, who does really well in her subject, and who is just very quiet in the back of class. No one knows that she thinks about killing herself every day. (Beth, 32 years)

Children who were overtly naughty, or who expressed their issues externally with bad behaviour were perceived by this participant as more important than herself, someone who quietly struggled daily, and who believed death was a reasonable contemplation at a young age. It clearly takes courage to be able to reach out to a counsellor, at any age.

My first memory is the day that I ran away and I was sitting outside my school counsellor's driveway and I was scared. I was sitting there with a pair of mini

scissors trying to cut my wrist, but it wasn't enough, the scissors weren't enough, so I went to the supermarket and stole a packet of razors and pulled the blade out and started using that. (Anna, 33 years)

Should these participants have entered into a counselling relationship at such a young age, they may not have actually progressed to the level of self-harm they achieved in adulthood. The shame is, that those who are not overt in their expressions, or their behaviour, appear to be missed in gaining support, or supportive relationships, at a time when it may offer the greatest benefit. Timing of therapeutic relationships with counsellors appeared to be quite important, as some considered themselves too far along on their journey to be helped.

At the very, very beginning when I started getting sick I did have a counsellor. I didn't find it very useful. I only saw him a few times and that was it before I attempted suicide. It didn't feel like it worked I guess. It was more of a...for me the key thing, meeting with the mental health psychiatric nurses. Once a week we'd have a meeting, equivalent to a counselling session which that's how I viewed it anyway. Quite a long time afterwards every couple of months I would go and just check in. (Donna, 43 years)

Just as some participants verbalised needing to be challenged in their thinking and actions around self-harm, the participants also challenged others in their desire to help, particularly counsellors. Many recognised that this process of relationship building did in some way help them, though this insight was often after the relationship had failed.

... my first therapist at Ashburn...Oh, I made him work so hard. Yeah, I feel so terrible. It wasn't really until he left, because he left while I was still at Ashburn, that I actually realised the progress I'd made while I was seeing him. Again, like I can't really tell you why that is. I think in part it was because he listened really well to me, but he's also quite honest with me. (Beth, 32 years)

The effectiveness of counselling was varied, and appeared to be in line with the level of commitment to the relationship that both participant and counsellor had.

I had a couple of counsellors and stuff but I just never opened up to them. (Adam, 26 years)

However, once some confidence in the relationship occurred, the challenging could commence. This challenging emerged as a significant aspect of development and progress on the participants counselling journeys.

It's just making you talk, and thing, and challenge. She [counsellor] challenges very subtly. It's professional, but there is much more of a ...yeah, I was going to say caring, nurturing, and caring. There is concern there. (Barry, 66 years)

With a long-term caring relationship, for some participants, dependency began to develop. Ending such a lengthy therapeutic relationship without harm was expected by all participants, and though many continue today in the counselling relationship, for some whose journey had ended, resentment was evident.

Yeah. It was entirely wrong. Then of course I thought right, so I went and read books at the library about endings of sessions like this and I remember I read one quote, endings should be negotiated not prescribed. So I sent him some emails, saying I wasn't dealing with this very well and he agreed to see me in January and I just let him have it, how angry this affect had on me and I told him that quote and I think he could see he had done the wrong thing by that ending. Just in many ways how he dealt with me really. (Ida, 62 years)

Much like health professionals, counsellors differ in their position, approach, attitude, and ability. The majority of participants knew of counselling in some capacity at a very young age, though none of those interviewed actually accessed counselling until at least, their teenage years. The ability of the participants to engage appears crucial to any effectiveness, with all able to verbalise periods of when counselling had not assisted them, and the reasons why. All but one were able to identify themselves, their ability to trust, and their readiness to 'work' on themselves as reasons for disengagement and failure of effectiveness. Counselling was a process that was long term, and intimate, and was parallel to, not as a replacement of, any mental health input the participants experienced.

## Chapter 5: Participants perspectives of intimate relationships

### Other Relationships

Relationships are undoubtedly a complex human need, and one which can bring great happiness, or great sadness. This chapter aims to identify the different constructs within the complexity of personal relationship networks of participants, and the place their function has in providing support to those who self-harm. The focus here will be the examination of different forms of relationships which prevail in their influence, how and why they prevail, and what impact they are able to have. Three categories of relationship will be examined through the eyes of the participants, being family, romantic relationships, and friendships.

### Family

Family relationships predominantly featured parents as domineering figures, and carried comparisons within the interviews between childhood and present times for the participants. Personal analysis of the past frequently occurred during articulation, often with perceptions, and insights of what the difficulties within the relationships were, and how those difficulties are now managed or reconciled in adulthood.

I don't recall growing up and even talking about how you felt. It's just like people didn't really hug each other. I never really saw my parent's kiss or hug or anything, like we would get a peck on the cheek when we went to bed, and that was like to the extent of any sort of intimacy....Looking back on it now, like the physical intimacy that I had with my family, it was like way more than any sort of emotional intimacy that I had with them. I don't even know that if someone had noticed or if I had been brave enough to talk to someone, I don't even know that I would have been able to tell them really, or to let them know what was going on. (Beth, 32 years)

Discussing the period in her life when she began to harm, Beth sees a link between the absence of emotional language in her family environment, and her inability to talk to her family about her pain. The absence of emotional language seems in some way to have diminished her ability to reach out for help. Not having been nurtured in such a way which would allow her to seek help seems to be something she is not really able to acknowledge, as she goes on to assume responsibility in stating it is due to her own lack of bravery. The

personal absorption of responsibility was a recurring theme for many of the participants. Although, even when emotional intimacy with a parental figure is possible, the ability to talk to them about self-harm does not appear to prevent or eliminate self-harm behaviours.

Yeah, I felt that I could talk to her but I don't know if she really....I didn't want to hurt her at the same time, I didn't want it to concern her. Looking back I think...I've always been a bit funny with my dad but mum definitely she was...I felt like she was one of my closest friends, she was someone that I could talk to.  
(Carol, 35 years)

Not wanting to 'concern', or 'hurt' parents was an intention voiced by the majority of participants when discussing their family situation, and was clearly an influencing factor in determining whether experiences of self-harm were discussed in the home.

I don't talk to my parents a lot about what's going on. I more protect them. (Hannah, 22 years)

Protection of an adult by the participants as children, seemed perfectly routine in the minds of those interviewed. This shows the beginnings of a pattern of personal responsibility and accountability they accept for their actions of harm, even from a very young age.

I did, I did. My mum and dad, I mean they were good but there was an element that I didn't want them – like the second time I was down here when I attempted and I had taken an overdose and ended up collapsing and taken into hospital and they attached a pacemaker to me and things like that. I told them not to contact my parents because I was really embarrassed and I didn't want them to go through any more stress than what I'd obviously put them through, in that respect. They were very supportive parents and 10 years later my dad went through a bad depression and so he felt like he was able to talk to me which was really good because, you know, he knew that I had had problems and the rest of it. I'm very close to my mum too. There was an element that I didn't want to make it any worse for them really. (Donna, 43 years)

Being embarrassed appears to be a justification for Donna, a reason for not informing her parents that she had almost taken her own life. For all the participants, personal accountability in minimising impact on others was an element which strongly endured. Some believed that this responsibility meant emotional distance was required in their relationship with a parent.

I'm not particularly close to my mom or my dad, but I do try to talk regularly to her on the phone and stuff. My dad is probably the only least emotional person in my life next to my mother. She's very practical. ....I remember asking her once how she felt seeing me in the hospital, and she was like, 'Oh you were in the hospital so you were okay, people were looking after you', I'm like, 'how did you feel?' You know what I mean? Like she doesn't have that sort of self-awareness. (Beth, 32 years)

The failure of her mother to respond on an emotional level leads to Beth's acknowledgement that her mother does not have the 'self-awareness' to empathise with her. When Beth responds to a further question about what her needs are in this relationship with her mother, she reverts to a functional, practical level. A level at which she knew her mother could function on:

Yeah, I'm not really sure if there is anything I need particularly, except to be seen, I guess. Possibly maybe the....like it's the thing that comes to mind. I think I spent a lot of my childhood being unseen. (Beth, 32 years)

Not being seen was a common theme throughout childhood recollections, and was a situation a number of participants voiced in recollected sadness. Though it was clear that none of the interviewees believed their parents had given up on them, or didn't want to know about them, it seemed more like an acceptance that they were not able to understand. As such, self-harm made the participants keys which did not fit into the lock which was their family.

I was just thinking about my dad for example. We had a terrible, terrible relationship as a child, when I was growing up, particularly as a teenager but then when he went through his depression we had an opportunity where we sat on the bench out in the gardens and we just told each other what really pissed each other off, you know, what we were really annoyed about and cleared the air and got through it. Now we're – and ever since, we've been fine. (Donna, 43 years)

Appreciating and accepting each other's experiences made a significant difference to the parent-child relationship for Donna, with the ability to 'clear the air' and express frustrations and annoyances in an honest and open fashion, drastically affecting their relationship in a positive way. The expression of honesty in the parental relationship seemed to be a

significant factor in achieving change in this relationship, particularly once the participants had reached adulthood.

It has been a tumultuous journey with my ma. She has stuck by me. It has been traumatic for her as well and I guess with [partner's] death I was in and out of the psychiatric ward quite a lot. I got into drinking and I just was not coping.....she has said it was the most traumatic time of life with me because she was so closely there with me. Living closely with me and like I said I was filled with a lot of anger and had several weeks where – this was before I realized that there were actually other triggers happening from my past, I was really angry with her. (Eva, 41 years)

Mutual appreciation for Eva, just like Donna, depended on honesty and truth within the construct of the parent-child relationship, and appears to occur when the parent is no longer trying to protect the child by minimising, or not dealing with the problems they are going through. Rather they are laid bare and discussed with emotional engagement.

I am just open. I do not see the point in lying to her, you know? I am not – I do not see the point in lying to people. I am not one of these people that goes and talks bullshit. She is a knowledgeable woman, but sometimes she is just a bit overbearing. And the way she does things. But, yeah she has generally got the best intentions in her heart. (Adam, 26 years)

Adam has a strong desire for honesty within his relationship with his mother. This honesty, within his understanding of the relationship, carries some boundaries, being boundaries of acknowledging she is overbearing and as such he does not have to accept her truth. For some, boundaries were crucial, but were actually in place to minimise such palpable honesty.

Mum's a lot more chill now. I can get along with her on a very civil front. If we go around to family dinners it's always very just talk about the weather and really general term things. I could never go to her about anything, personal, relationship, depression, anything. I could never go to her for anything like that, but I can be in a room with her and be civil about it. (Faye, 21 years)

For Faye, her relationship with her mother can only exist because there has been the creation of common ground, an understanding that neither of them will wander into the emotional desert which stands between them. Instead they accept their inability to really get to know each other, appearing to be acquaintances in their civility. Unfortunately, such

civility meant emotional engagement was not possible, nor was more engaged functional support.

Three participants discussed their siblings within the construct of adult relationships, identifying them as peers, able to acknowledge their differences, but appreciate their ability to encourage and care.

My older sister was very (supportive). My younger sister too, she's in Britain. She was very supportive. Both of them I think were...not let me off. I could talk, because I was really upset with her (ex-wife). Particularly my elder sister, she could say, hey, hang on. Think of the other side. She challenged me sometimes. The one in Britain, didn't challenge so much. She was too gentle. (Barry, 66 years)

Barry appreciated the difference in his siblings, finding each as important as the other in their differing approaches to caring for him, but again honesty and challenging are key features to that appreciation. For the other participants who did discuss siblings, understanding that their siblings were different to them appeared to enable restoration of self in that relationship, even when it meant they could not empathise with each other.

With my sister she is a lot like her mother, and like her mother used to be, and I find her very overwhelming and very intense. She really doesn't like me, I'm not sure why. (Adam, 26 years)

I have an older brother....Yeah, we don't stay in contact or anything like that. When we see each other, we see each other. Between times here, we don't text, or talk, or anything. (Hannah, 22 years)

Accepting that they she was very different to her sibling, exposed the reality of the detachment created through distancing herself from her siblings behaviours. For many of the participants, being able to control relationships began with such acknowledgements of differences, it also enabled the participants to manage any impact they felt in their lives from the behaviour of others within their family dynamics.

For those participants who had become parents themselves, the desire to self-harm was seen as an indulgence they could no longer give in to, as their responsibility to another overtook this option.

I have two children, one who's 19 years old and a 10 year old. Sorry, he just turned 11. That also made a big difference, particularly when I had my oldest son because I was 24 when I had him and that sense of responsibility, that stuff's just not an option if I'm not coping. (Donna, 43 years)

Accepting that there were times when she was 'not coping' was important for Donna, it seemed that actually accepting she was not coping, coupled with the pressure of responsibility to a child, essentially positively influenced the decision to harm.

Understanding the impact of self-harm on dependants, was enough to, not only stop Adam for partaking in self-harm behaviours, but instilled a desire to be a better father. His own experiences in childhood appeared to have created a need to improve on his own parenting experiences.

I do not want them to do that (harm). I want them to have a happy life. So it was just, you know, more about opening up and trying to make myself a better person, so that I can be a better father to them. (Adam, 26 years)

It emerged that parenthood is an undeniably compelling driver for change.

The thought of dying does not really worry me. Not in these circumstances anyway. No. I have much more feeling now, because we've got the two young boys. When I was feeling bad in August they were very much in my mind. (Barry, 66 years)

The very thought of the responsibilities he carried to others was an impediment to the rumination of negative meditations for Barry, and as such did not progress to a stage of self-harm. Overall, the influence family relationships have, are significant in the impact they have on the thoughts, build up, and act of self-harm. Whilst some have developed means to manage negative relationships, others that are unable to find common ground, or are unable to maintain contact with negative family relations, see them as destructive, and as such need distance from them. Being able to identify such destructive relationships was a skill developed in adulthood for all the participants, and appears to be a strength in the increased ability to understand why they are not, nor can they ever be, functional.

Ultimately, family relationships which may have been damaging in childhood are not necessarily damaging in adulthood. Honesty, mutual appreciation, reciprocal understanding,

and trust are all aspects of a relationship which can be built in adulthood for those who self-harm, even if they were absent in childhood. Productive relationships can be developed from a damaged past, and with the growth and independence of the participants, strength in the concept of self has enabled the formation of boundaries which can minimise the possibility of further harm.

## **Romantic**

The formation of romantic relationships was seen by some of the participants as a sign that they had reached adulthood, and with that, the autonomy to choose where their support came from. Faced with the inability to form an honest, open relationship with a parent, Faye developed another relationship she saw as capable of providing the personal encouragement and emotional sustenance she needs.

For me, my families been always quite on and off with support, but I feel like the support I get from my partner is enough to tackle anything really, which is awesome to have that feeling. (Faye, 21 years)

Examining the elements that formed a relationship capable of providing sustenance which could not be achieved from a parent, Faye further establishes key attributes which would be supported by the other participants who had experienced positive romantic relationships.

Basically, right up until two years ago I was still doing it off and on. This would have been about 19, I guess, 19, 20. Then I met my partner, who I'm currently with now. It was a listening ear, it was safety, it was security, it was someone who actually really wanted to know me. It was everything I had never experienced before and I just one night just poured my heart out to him, probably a couple of months after I met him. I just poured my heart out and told him everything that had happened to me in the past and all this sort of stuff. For once, all he wanted to do was soak it up, absorb it, listen and then try to help. It wasn't something that I'd had before and I kind of thought, 'Hold on. There's actually other ways of dealing with this?' And I don't need to do this and make the biggest cut possible. Again, like I succeeded, I just (think) there's other ways that I can feel that feeling and I just immediately stopped. Done. Never went back to it again. (Faye, 21 years)

Faye looks to have afforded a great deal of trust and reliance on this romantic connection for her self-confidence. The failure of this she does not even seem to have considered, which could potentially be a challenging position to be in, should disputes within this relationship

arise, and the positive attributes lost. Listening, security and trust in what would be shared, and feeling safe in sharing personal experiences were significant to the success of these relationships in supporting the minimisation of self-harm.

He personally had never struggled with self-harm as such but he had suicidal thoughts and he had depression and eating issues. The aspects of my journey that he did understand, he had a lot of compassion for that part of me that struggled. He could understand it because of the things that he struggled with even though not overtly self-harm, self-injury. (Eva, 41 years)

Just as for the participants whose parents went onto develop a mental illness, and as such have greater understanding about the participant's experiences, that level of connection and understand was pursued by some in romantic relationships. For most though, it did not appear to matter that the partner had little personal knowledge or experience of what the participants had been through, rather that they were just willing to be there and offer care and support in the turmoil. There were though, extremes of reaction to those who were still partaking of self-harm, particularly in the early stages of a romantic partnership.

... it would have been over a year ago, and that's because I've got a boyfriend now. That's pretty much the reason, because we've been kind of off and on, I guess, and then last year we got official, because I remember when we were off and on I had done it and he had saw it, and he just...He was so upset and he just said, 'if you do this again, I don't know if I can be with you' or something. So I just haven't done it ever since because I don't want to lose him really. That's been a big help. (Gabi, 19 years)

The point blank honesty from her partner was powerful enough to be a driver to change for Gabi, though it does seem that should the desire to self-harm be stronger than the desire for the relationship to succeed, such an ultimatum could potentially be counterproductive. However, such blatant demands did develop as a theme evidenced mostly from those participants in a romantic relationship who were relatively young (under 30).

He pretty much said, 'if you keep on doing it, I'm going to take you away from his kids'. I love his kids. He's got two girls and they're amazing. He said, 'if you're going to do that, then I don't want you to be around them, in case something happens, and you disappear,' or you know, something like that. (Hannah, 22 years)

Hannah's partner used his love for his children to justify the ultimatum made, but it was enough to have an enduring, and positive effect on this participant's self-harm behaviours. Romantic relationships undoubtedly caused a change in behaviours for a number of the participants, ironically when asked about what it was that made the relationship so special, so worth changing for, 'acceptance' was the prevalent characteristic discussed.

I definitely feel accepted. He knew, when we got together, I told him it was only a couple of weeks prior to us meeting, that I had been released from hospital with a suicide attempt. (Hannah, 22 years)

Blatant honesty for some was such a strong driver, that when they realised they had such honesty with someone, their whole existence with self-harm was literally poured out in what appeared to be a strong therapeutic, liberating fashion.

I think he was the first person where I felt like he genuinely wanted to listen not for the gossip, not for any medical reason, not for any other reason other than caring. Whereas I always felt like everyone else always had some ulterior motive whether it was to share it with everyone else, whether it was to write it in their psychiatrist diary or whatever it was and share it with the medical team. It was the first person who actually said, 'You know what, I actually just want to listen because this is what you need to do for yourself and I can realize that you need to let this out. Therefore, I'm going to sit and listen to it. Not that I'm going to know how to handle it, but I am going to listen to it'. It was just so genuine, I think that is where the trust just came in. I was like this guy's not going to do anything with this information so why not get it off my chest and have him know what I'm like nowadays as well because of it? (Faye, 21 years)

Though it is difficult to ascertain whether acceptance in these relationships acts as a catalyst to change, or that the change was the catalyst to acceptance, there is strong indication that acceptance by others is key to personal progression on the self-harm journey. Positivity in relationship was easily identified from the euphoria of encountering another human being who could relate to the isolation and pain, but also be intimate in that understanding.

He was a really amazing person to come into my life and an influence in my life in a really positive way. He was my first relationship with a male positively.....It was very healing and he also had a background of sexual abuse so for him it was also very much on that level too. It was like I had my delayed adolescence exploring things and sexuality and aspects that I had not had before in a safe adolescent way since the sexual abuse trauma that happened. (Eva, 41 years)

The significance of these romantic relationships was evident from their social, physical, and emotional elements. I felt the need to ascertain what would happen for the participants if the components which for them created and sustained a romantic relationship in their lives were removed.

That's kind of what I was thinking about, but I don't think I could ever do it again, I feel like I've just grown up and yeah, I just can't even....sometimes if I get mad, I will just kind of 'err', but just scratch my arm or something, but just like not anything bad, but I don't think I could ever pick up a craft knife and cut my wrist again. I just can't do it. (Gabi, 19 years)

Alexander Pope wrote "to err is human" (Pope, 1968). Seeing that the participants accepted that on their journey they would 'err' was almost a relief for me, as this indicated that they accepted their own frailty, and to err from time to time would not mean they would have to return to a previous state of harm. All the participants who experienced romantic relationships which were rewarding to them, believed they would not return to reliance on self-harm, at least not in the fiercely intense manner in which they had previously known it. The belief was that a new way of coping, a self-appreciation, possibly even self-acceptance had been achieved and could not be removed in its entirety even if the relationship did end. To have such a powerful relationship was a yearning of those who had not yet experienced it, possibly because its impact is so significant.

I have this dream. I might be completely wrong. I would like to have a loving relationship. Maybe I've got to the point where it will never happen. I would like that thing where I walked into a room and someone smiles at me, oh, there she is. Cherishes me. Everyone wants this in their lives, I'm not alone by any means. But, maybe that's only an ideal and in the meantime what do I do? (Ida, 62 years)

Romantic relationships were commanding in their influence on self-harm behaviours for the participants, with fundamental essentials of acceptance, listening, understanding, acknowledgement, and care having the most substantial and enduring impact. There is though the clear indication from the participants who had discovered what they called acceptance from others, came with conditions. Challenging self-harm behaviours, and demanding the cessation of self-harm was without a doubt the principal, and most fundamental of these conditions to achievement of acceptance.

## Friends

Friendships had been difficult to form in childhood for all of the participants, without exception, and seemed to align to the problems they each experienced with parental relationships. If formation of emotional relationships had not been achieved at home, it appeared highly likely they would be unable to be formed in community throughout childhood years.

I don't know, I just remember I felt kind of...I guess it was just for attention. I just felt like I was kind of left out from my friends group kind of thing. (Gabi, 19 years)

Often, the participants had not even attempted to make friendships, there was some reluctance to discuss these periods which made me believe these were painful times, probably due to the isolation experienced amongst peers, the very people who they possibly believed should understand.

I was alone pretty much. Maybe one friend? But that was it. (Anna, 33 years)

When Anna was asked if she talked to this one friend about what she was going through, her simply answer was "No".

I did have close friends, yeah. I did have one or two girlfriends that I got on well with. (Carol, 35 years)

Though when asked if she discussed her conflict with self-harm P3 states:

No, not really. (Carol, 35 years)

For others, reflection on friendships brought the belief that self-harm was unspoken due to fear of triggering further bouts, rather than friends not actually wanting to help.

No, I think people were scared. They feel real scared that if they said what they felt or how they felt, that I would hurt myself, or I would kill myself. I think that's the primary reason why a lot of people didn't speak up. Another thing is a lot of ordinary people, not all people don't, they can't comprehend how you could hurt yourself. Do you know what I mean? (Beth, 32 years)

Beth justifies the lack of support from peers in her explanation as to why no-one spoke up as this fear of perpetuating further harm. From what has already been identified by the

participants, this lack of challenging may actually reveal these relationships to lack value. For some who did believe they had strong friendships where they were able to discuss their pain with friends who would speak up, the support they were receiving from peers actually diminished as they reached out, and their issues with self-harm became prolonged through this experience.

Yeah, when I was much younger, I just did it, because that's what I wanted to do, so I did it. Throughout the high school years, I kind of turned to my friends, and I would just say, 'I want to cut' or something, and some of them were really good and send me these long texts saying...because it was always through texts, I didn't say anything to anyone's face, but others just kind of gave up. Slowly the ones who were sending the paragraphs, I think they just kind of gave up as well. That was hard, I guess, because I just was already feeling like no one cared, and then I felt that they didn't care and weren't really my friends. It wasn't very good (Gabi, 19 years)

As the tolerance of self-harm, and the ability to understand its attraction for this young group of friends waned, it led to distance being put between themselves and the sufferer. Although, it would be easy to view Gabi's means of reaching out through text messages instead of using emotional language in human contact, as a tool to intentionally maintain distance. The anonymity of such media actually made it easier for her peers to decide not to support her. Possibly, as time went on there was fear of dependence, and possibly even the belief that self-harm was being used as manipulation. The sad reality for the sufferer is that receiving care and attention is a necessity for the process of developing other tools to manage emotions, or to reconcile self with self-imagery. To manipulate others is more often than not, the furthest thing from the minds of sufferers.

Once through childhood, adolescents and beyond started a journey of appreciation of what was needed from friendships, and what was definitely not needed. Possibly this development occurred due to the identification of harm which had been caused from having disruptive friendships, or even having no supportive friendships at all. Being able to identify which elements of friendships were disruptive to self-development was appreciated and understood as progress in their lives by the participants.

I think a positive relationship is having someone that cares about you in all areas of your life. If you're having a good day, a bad day, that will stand by you. That will help hold you up when you're falling down. That doesn't judge you or that wants the absolute best for you and will help you do that, in the trilogy of that.....I guess a negative relationship for me is that they actually don't care

that much about you it's more about themselves and how they're feeling. It doesn't matter if they hurt you. As long as they feel okay, it doesn't matter what kind of trouble you get into. As long as they're okay. (Anna, 33 years)

When progress had been made in being able to see what was positive and what was negative, actually building those positive relationships was a tough step, but one which all the participants who had experienced unhealthy encounters in childhood, believed they needed to take to be functional. Again the aspects of honesty, trust, and acceptance are raised as key elements to successful friendships.

Like and acceptance in a real way if that makes sense, like this is who I am and this is my history. Like, often when I meet people for the first time, I don't show them my arms, and I keep myself covered up, because I'm like, people do still make judgments of others, based on, well we all do it, based on what they look like or how they talk. You know, like what they are wearing. That's the same with arms, scars, wherever they are. (Beth, 32 years)

Because of the difficulties in being judged, many of the participants relied on 'friendships' which had been developed through shared problems, and as such began in institutions where they had received treatment. For most, this was where honesty was safe, and could occur without judgment.

... they talk to you about what it's like for them to know that you've hurt yourself or to have been part of the process of you hurting yourself, so sometimes patients would steal things from other patients to use to hurt themselves....That would be a violation of the trust between those people. They would talk about, like people would say 'why didn't you tell us that's how you were feeling? Why didn't you come and see so and so. I was so upset when I'd heard that you had gone down. I was really worried for you'. Sometimes people are really angry, they will just say it straight to your face, 'I'm so angry that you did that' you know? (Beth, 32 years)

Around half of the participants had experienced a faith during their journey, and whilst those who had attended a church in childhood had predominantly turned away from their faith, when faith was found in adulthood, and once the participant was open to learning and developing in ways other than in their dependence in self-harm, faith was counted as a valued 'friend'.

Definitely friends at church. It's....I think friends play a big part if you haven't got family support. For me the professional support doesn't really do much. Not really much help like Raewyn (counsellor) does. (Anna, 33 years)

It was like an acceptance, like there is a place for my pain and suffering that I could accept compassion, acceptance of that. Like a bridge, like a healing bridge rather than...I have had many years I struggled to....in some ways it seemed as if I had this big split because of spirituality always being a really big part of my past. I really struggled with the part that has self-harmed, has been really destructive and it is almost like when I have been in this space I have pushed that part away.....Even when I have been suffering it has been my spiritual part, this all disappears out the window. (Eva, 41 years)

Again acceptance is a key element to any relationship development, whether of this world, or within a faith community. It is undoubtedly a human trait to have people who care in our world. When the participants did not have 'someone' able to walk with them, and talk with them, they sought restitution within other external agents to themselves. The frailty of their own existence, and the absence of any friendly supports meant substances were a useful substitute, and one used in proliferation by the participants.

If I don't feel like I have someone there to process that then I certainly just feel like drinking because everything's easier when you're just trying to walk straight. That's all you have to focus on. You don't have to focus on this you just have to focus on walking to the bathroom and not hitting the wall. (Faye, 21 years)

When friendships had successfully been developed, the insights gained from difficult experiences of the impact of positive and negative elements, means that these bonds are often very strong and reliable once achieved.

It was definitely a feeling of belonging and definitely love. They believe in me and.....they just different kinds of friendships than I ever had before. Growing up my friends were all kind of doing the same kind of thing. They all had the same lives and we were all into drugs and alcohol and stealing and stuff. (Anna, 33 years)

Reflection occurred when a friendship was deemed strong enough to withstand comparison to earlier failed friendships. Knowing the difference, and being able to discuss the extremes of those differences seemed to reinforce the participant's belief in those friendships.

Yeah. But like I said before. For me it's like....I can kind of say to myself, if I do this I'm not just hurting myself, it's all my friends around me. Like Raewyn, or my

friend Jo, that broke her heart every time I self-harmed. And so I always kind of get that in the back of my head and that when I feel like cutting myself. Kind of almost feels like it's her that I'm cutting, more than my own and that helps, it's still hard when you have these anxieties ...you have to really really fight, you really have to kind of, for me it's I had to talk about stuff, get a pen and paper, write or draw or something. It's still huge but having that thought in the back of my head. (Anna, 33 years)

As identified, the strength of these relationships carried significant influence on the decision to self-harm. Much like the responsibility verbalised to children, responsibility in friendships appear to be just as compelling.

Yeah, the desires are still there. But when I get that thought I start thinking about friendships and the people that care about me and I'm not only hurting myself but I'm actually hurting them as well. (Anna, 33 years)

The closeness and familiarity achieved in friendships in adulthood were a choice for the participants. The need to control who they allowed into their inner circle was strong, but even stronger was the need to make those who they had accepted, understand their pain.

Like my friends..... they just couldn't understand this at all. To them, and I always try and say it's, just because this is the easiest way I can think to explain it to people. It's only like this much of the iceberg, if you know what I mean. What I find is like it almost comes like an addiction, like the same as alcohol or drug use, where you use it to escape from reality or to numb yourself, or to avoid something in yourself in some way. (Beth, 32 years)

Having the emotional language to be able to compare her experiences with those of an addict, was indication of the isolation Beth had felt. Her want for association, for understanding had developed into an ability to identify with other marginalised groups in society. The difficulty of achieving affiliation though plainly still exists.

I do have a sort of constant to and fro. Like I want to move toward people, but I'm afraid, and I move away quite quickly. Like in an emotional or relational sense. I can be quite guarded.....At the same time I certainly want desperately to be like known intimately if that makes sense? It's like this terrible sort of push and pull scenario. (Beth, 32 years)

As their lives have progressed, the participants acknowledge the difficulties they faced in childhood with dominant family relationships which formed their ideas on emotional

security and emotional vocabulary. Having been disenfranchised through the lack of skills learned as children, for many the skill of self-harm became a safe haven of understanding. As they progressed into adulthood, the skills many had been deprived of were developed through romantic relationships, and friendships. In the need for approval and recognition from another, came the dawning of understanding of the pain felt by others in the decision to self-harm. Ultimately, the cost to others reaches the point where the choice to harm is challenged, both from outside themselves, and within themselves through the desire of unconditional acceptance. Being challenged in, not only the desire to harm, but in the impact and pain it has on others enables the prioritisation of others over self. As such the desire for relationship surpasses the desire to self-harm.

Once broken, family and parental relationships can be rebuilt, though the meaning is in the form in which they are built. For some this meant the use of boundaries for self-protection, for others it meant distance either physically or metaphorically. In the end though the formation of relationships historically broken, had to be rebuilt in the eyes, mind, and understanding of the participant, and within the realms of what was acceptable to them, and what they could manage in the confines of those relationships. The significance of relationship within our existence is often underestimated, but as considered in the lives of the participants, relationship traits such as congruity, equality, trust and challenging appear capable of giving purpose, not only to the relationship itself, but to the lives of those who experience it. In the end, the dilemma appears to be, is the desire for relationship, in whatever form it is presented or understood, greater than the desire to self-harm?

## Chapter 6: Discussion; understanding functionality

### Summary

This research set out to investigate what aspects of relationships make them functional, and how they can positively impact an individual's desire to self-harm. Principal relationships which are accepted as being part of an individual's community, and which are capable of influencing individuals were identified and examined through the experiences of twelve participants. These relationships were distinguished as, relationship with self, family, health professionals, peers, and romantic connections, and were investigated in relation to self-harm beliefs and behaviours.

Why individuals hurt themselves, and partake in self-harm behaviours is a complex human problem, with an exact motivation being difficult to discern. There is no 'one size fits all' to explain why people self-harm, just as there is no 'one size fits all' to the solution. I believe as human beings we strive to appreciate each other in order to advantage both ourselves, and those we journey through life with, and that relationships are able to help us create positive self-images which benefit us on this journey. This study began with myself as a Registered Nurse having a desire to understand more about those in pain on my journey, and whether it is possible that the act of being in a relationship which is purposeful and functional (as opposed to dysfunctional), can change people's behaviours. Being able to question a diverse group of individuals in my career who experienced self-harm in such varied and disparate ways, helped me appreciate that at the end of the day, when the harm is done, and the pain has had its effect, there appears to be two components of immense significance which can cause further harm, or facilitate healing. These being, the relationship we have with ourselves (internal), and the relationships we have with others (external).

Turp (2003) defines self-harm as 'multi-faceted', believing it an all-encompassing term of inclusivity for any behaviour which results, "whether by commission or omission, in avoidable physical harm to self", or which "breaches the limits of acceptable behaviour", which is capable of eliciting a strong emotional response from anyone within the environment in which the act is carried out. Turps' (2003) description incorporates elements not usually associated with self-harm, as it considers the relationship of the act with the

wider societal impact as opposed to being isolated to an individual. Shaw (2002) notes that self-harm is not socially sanctioned, as it is typically constructed as pathological and is experienced by others as unsettling. The certainty is that self-harm has a substantial, and often sustained impact on those around an individual who self-harms. This societal response is what Goffman (1961) argued as stigmatising, and shaming, and which M. Long, Manktelow, and Tracey (2013) consider to be the reason why self-harm is not greatly understood, reported, or cared for effectively. Along the same vein, Anderson et al (2005) believe that the association of negative projections by others augments negative perceptions of self, with McGaughey, Long, and Harrison (1995) adding that the interplay of communication which reinforces the stigma associated with self-harm, heightens risk, and ultimately jeopardises help-seeking activities.

## **Self**

A major component in the creation of self-identity within modern culture, is the association of self with productivity within society (Young, Sproeber, Groschwitz, Preiss, & Plener, 2014). Ellemers (1999) argues that the strength of this identification of self through 'gainful employment' is a foremost factor in the emotional aspect of self-worth, capable of minimising damaging views of self which can be formed in childhood. This would suggest that those at most risk of self-harm behaviours are the currently unemployed, sick or those alienated from the function of productivity either within their communities, or within their families. Labels such as unemployed, sickness beneficiaries, and mentally unwell are given to individuals in society, with the very labels themselves being stigmatising and alienating, (Beales, 2001). The participants here noted that once they had commenced harm, the shame of being labelled, and the fear of being judged were fundamental components which prevented them from reaching out and seeking support, even to those they perceived could help them.

Straiton et al. (2013) identify two sub-themes of destructive emotions and negative social influences as factors capable of contributing to self-harm, these being the quintessence of our relationship with ourselves, and our relationship with others. Ellis, Gormley, Ellis, and Sowers (2002) believes these two factors attribute blame and problem ownership to the individual as a director of their own circumstances and environment, and as such, afford shame to the individual. The association of perception of self to self-harm behaviour was

investigated by Robert Young, van Beinum, Sweeting, and West (2007), and was recognised as important in its identification as to how internal negative feelings are managed. There is evidently a tripartite structure of internal negative belief and emotions, external stigmatisation, and alienation from, or the lack of formation of, relationships which enhance and encourage the act of self-harm. Negative expressions, and negative thoughts toward self were identified as being a key motive behind the instigation of self-harm behaviours by the participants of this study, and were acknowledged as being reinforced by others such as peers and family.

It is believed that social support processes assist individuals coping effects in a similar manner to their own coping strategies, and that being embedded in a social structure provides an individual with a sense of security and self-worth, based on the reassuring knowledge that one's life situation is reasonably stable, predictable and rewarding (Brookings & Bolton, 1988; Thoits, 2013). Romans, Martin, Anderson, Herbison, and Mullen (1995) demonstrated that there are no differences in educational achievement, marital or employment rates, the quality of perceptions of emotional support from others, or existence of someone who could be confided in, amongst those who self-harm. This therefore suggests that stability of life factors is not necessarily the element of social support which reduces dependence on self-harm. It is also believed that the quantity of social relationships may be more influential in self-harm aetiology than the quality of support received through specific networks (Wu et al., 2013). Generally, it seems there is some uncertainty amongst the research as to the effect social supports actually have on the desire to self-harm. A number of researchers have called for a shift in paradigm toward better identification of the social meaning of self-harm in an aim to clarify the importance of social perception, and the need for societal involvement in this phenomenon (Straiton, Roen, Dieserud, & Hjelmeland, 2012).

One theme that was revealed in this study in relation to the communities the participants were involved with, and through the elucidation of the different stages of the participant's lives, was control. Control of their lives, relationships, care, and future were important elements of each segment of their lives before, during and after self-harm. Self-harm is entirely unique in its influence and importance for individuals. Through the words of the participants, just like each of us is created in an image quite individual, the image, perception and effects of self-harm are also very individual. It is important then to discern

as much about what individual need within this phenomena is, as much as it is to appreciate the overarching themes relevant to a self-harm journey.

## **Family**

As human beings it seems we are made equal in our need of relationship with others, and this was critically evident in the voices of the participants as they explained their early relationship formation. Many of the terms the participants used to describe, in particular, childhood relationships were diverse, but the essence of need in these terms was the same. Non-judgemental, caring, seeing of 'me', not needing the persona of coping to get care, listening, giving, empathic and nurturing, are all expressions used by the interviewees to explain what they wanted from parental relationships. The sadness with which the majority of the participants spoke of familial difficulties depicted the poverty of emotional input they felt at such young ages. This poverty created in them a desire to be self-fulfilled, but in these early years, they did not yet have the skills or literacy to understand their own needs, let alone meet them.

The participants echoed each other in their depiction of difficult childhoods, but I do not know if the strained relationships and difficult parental connections were the reason for the initiation or continuation of their self-harm. None of the participants appeared to believe their parents held any responsibility in any way for their self-harm actions, and for many, self-harm did not commence until years after they had left the family home. There are many people within our society who experience difficult childhoods and upbringings and yet do not contemplate self-harm. I believe from the sentiments of the participants that the issue was not dysfunctional parental-child relationships, but rather the absence of key elements needed by children within these relationships that ultimately encouraged a lack of self-appreciation, adding another emotionally injured piece to the puzzle of self-harm. The participants one after another echoed these missing elements as "being seen", and being given space to be "honest" and to be "without judgement" within that honesty.

If a child is not 'seen' by the parent and given a sense of belonging, a place in the landscape of family life, then the honesty of conversations which appear to allow reconciliation of self with feelings within this parent-child relationship cannot occur. It is here where the birth of the need to do something, some action which is purposeful seems to begin, but not usually

realised. Overall, I believe the participants were revealing that even from a very young age there is a need to be productive in some form within relationships. This seems to be because the determining of self-importance, self-worth, and self-control is measured against the success or failure of these relationships in the minds of those who self-harm. Kjelsberg, Neegaard, and Dahl (1994) reason that a lack of support, depressive symptomology, and parental rejection are some of the strongest predictors of a lifetime risk of suicide, and as such are principal impacting factors to a negative self-identity. Kerfoot and Huxley (1995) further found that stressful relationships with parents, particularly mother-adolescent relationships, were significantly related to depression and suicidal ideation.

Sinclair (2005) learned that a defining factor for those participants in a qualitative study who continued to depend and rely upon parental relationships, but who had ceased to use self-harm, expressed that the resolution of a lack of self-control within the family structures had led to the decline in reliance on self-harm behaviour. Within their study, this directed them to conclude that control, or lack of control relative to self, circumstances, and emotional responses were primary factors in the use of self-harm behaviours. Kapur et al. (2013) believes that social support provided by or missing from families has significant implications for suicidal adolescents functioning and treatment, and must be considered before examining the contributions of additional social supports. From this study, the participants identified other relationships which they went on to develop as they sought to grow emotionally, and to find the connections they were devoid of in childhood. As these connections were developed, the participants then voiced how they had learned to manage the relationships with the parent they had felt caused most damage to their self-identity. This reconciliation was done through boundary setting, distancing, and diagnosing of the parent with a mental illness, or an unfilled need. This child to parent diagnosis appeared to defend and rationalise the parent's behaviour in the minds of the participants. These tools allowed relationships to be rebuilt and maintained in such a manner as to ensure protection to the participants. I believe what this process of relationship development shows, was that the needs expressed as missing from parent-child relationships, were the very needs which they then went on to find in other relationships. Potentially, this shows that the relationship in which these factors are found, need not necessarily be a parent-child relationship. Low family support not only is linked contemporaneously and prospectively with suicidal and self-harm behaviour, but is also associated with poor treatment adherence in mental health programs (Dobkin et al., 2002). It is clear that parental relationships play a significant part in

the development of structures of self, and that the absence or destructive elements of such relationships can be damaging to self-identity, and to seeking assistance, treatment, or support for these issues.

Family functioning, in particular communication between family members is an important component to how an individual experiences self. For the participants who had become parents themselves, their desire to make sure they did not make the same mistakes which had impacted them in their own childhoods, was very evident. The responsibility to provide care to a child as a parent, also created a bond and an emotional connection which few of the participants had experienced in their own parent-child relationships. Whilst none of the participants believed they were outstanding parents within the parental role, it was certainly their desire to be better than they had known.

The qualities of being honest, accepting, and encouraging to their children were fundamental elements which the participants strived to achieve. These desires were often verbalised as the reason why they had developed a means to cope with negative emotions in different ways than to rely on self-harm. Without even knowing it, the children of the participants had created a relationship of healing through unconditional love and acceptance, a relationship which none of the participants who had become parents, were willing to put at risk by continuing to self-harm.

Overall, there were three dominant themes evident relative to parental relationships as discussed by the participants. The first was their negative experiences of early relationships through their own childhoods, and the damage this had on the development of self, along with the conflict of self with the world. The second was the reconciliation of those relationships at a time in their lives when they had developed the self-identity and self-worth they had missed out on in early development. Thirdly, the participants as parents themselves was discussed, and the positive influence that their negative experiences had upon their desire to be better people, and to do better in their relationships with their own children. In order to aid the progression of wellbeing for those who experience this phenomenon, there is a need for the provision of professional care which supports the growth and strengthening of family relationships.

## **Professional relationships**

There is little dispute that silos of care exist in health care provision in New Zealand, and around the world, and even more so when this relates to mental health and physiological needs (Horvitz-Lennon, Kilbourne, and Pincus (2006). From the available research, a resonant fact is that front line medical staff do not receive adequate training which equips them to manage presentations of mental health issues, of which self-harm is largely identified as one. Presentations with a physical need, but with a psychological cause to that need, rather means highly educated health professionals who aim to provide holistic care are in fact only able to consider one very small aspect of the presenting illness for an individual in their care who has self-harmed. Many of the participants had extensive health literacy, gained through their diverse experiences in health. None however discussed any aspect of health care, whether physical or mental health, with any degree of overlapping fluency. In fact all discussions clearly identified each interaction of experience in isolation, with no wraparound or interacting care between providers for any of the participants. This highlighted the lack of comprehension that one mode or method of care is capable of impacting or affecting another. An example would be, the care of a mental health illness within day groups, where self-inflicted wounds (or any other physical wounds) would not be discussed, and the care of physical wounds in the Emergency Department, where mental health would rarely be discussed. From the participant's experiences, it was an unwritten rule of the medical care 'game' in which everyone seemed to play their part.

Veysey (2014) contends that identifying a condition, or diagnosis, can brand an individual and present them as encompassing negative characteristics. Borderline Personality Disorder (BPD) is a diagnosis a number of the participants had been given during their journey, generally this was due to the lack of other diagnostic criteria into which self-harm fits. A large body of research has shown that there is stigma associated with a diagnosis of BPD, with research amongst groups with a BPD diagnosis, reporting high levels of shame relative to this label (Aviram, Brodsky, & Stanley, 2006; Fraser & Gallop, 1993). Analysis of clinician's responses to patients presenting with a BPD diagnosis revealed that health professionals believe them to be manipulative, and time-consuming, which has been identified as a barrier for this group to access care (Treloar, 2009).

Goffman (1961) suggests identification of a stigmatising condition allows those who suffer equivalently, to associate themselves with others. What was learned from the participants, is that affiliation and association with others who self-harm can actually encourage self-harm to continue, or increase. Many of the participants learned skills from others who were on a journey of self-harm, and were able to recognise that being alongside others who self-harm could be destructive, and in opposition to them achieving well-being. The participants may have learned much about the actions and management of self-harm from others who undertook these practices, but none described ongoing acquaintances with others who self-harm as positive, or as able to assist in the reconciliation of self with self-harm actions. In fact, not one of the participants indicated any ongoing relationships with any other person who either presently self-harms, or had self-harmed previously. Therefore, it would seem that the diagnosis of BPD, or the association of others with this diagnosis who self-harm, does not aid the development of self-management strategies or enhance insight, which are positive or functional in their impact as reported by the participants.

Doctors working in acute hospital care have been found to prioritise medicinal, curative functions in order to repair the patient (Clever, 2013). Hadfield, Brown, Pembroke, and Hayward (2009) also identified that A&E Doctors prioritised the treatment of the physiological (body) over the psychological (mind) needs of patients who attended A&E following self-harm. As training for these Doctors incorporates little social education relative to the appreciation of self-initiated illness or harm, this is not surprising. Often it is expected within this environment that nurses have a more empathic perspective when dealing with individuals in pain, allowing the Doctors to focus purely on the physical. However Allen et al. (2012) discovered that whilst nursing has made greater claims to consider the patients from an holistic stance, they actual downgrade the psychological dimensions of care when under pressure. Time and availability were valuable components affecting the acceptance of care by the participants, and the development of relationships suffered if these elements were absent. The attitudes held by clinical staff towards people who self-harm, together with their lack of knowledge about self-harm are highly likely to influence their clinical practice and hence the experiences and outcomes of patients (Saunders, Hawton, Fortune, & Farrell, 2012).

Anderson et al. (2003) explored the range of perceptions held by nurses and doctors practising in an A&E dept. The analysis illustrated that nurses and doctors perceived self-

harm behaviour as a powerful form of communication and that establishing effective communication with people who self-harm is recognised as an essential part of preventing further self-harm. This did not appear to be the reality for the participants within this study, most of whom had chosen not to seek A&E input for wounds which would certainly require more care than they should have been providing to themselves. In the majority of studies which examined attitudes of staff to people who self-harm, general hospital staff expressed negative attitudes with feelings of irritation and anger being most pronounced in general medical settings (Saunders et al., 2012). These expressions of frustration may be relative to the pressure and lack of time available to consider any other elements of care apart from the physical. Half of all staff in a UK study reported feelings of sympathy towards self-harm patients (Friedman et al., 2006). This could indicate that as staff knowledge and understanding increases, negativity towards those who self-harm could decrease. Empowering and training staff on the front line in the complexities of self-harm, is clearly essential, whether they work in mental health or not.

Guidelines for the management of self-harm patients are not consistently available to staff, with nearly 50% of A&E staff across hospitals in one Australian study indicating that neither formal nor informal procedures existed in their place of work for managing self-harm patients. Rees, Rapport, Thomas, John, and Snooks (2014) found that individuals who self-harm were informed they were wasting time and resources, which compounded distress leading to premature self-discharge and affecting their future help seeking behaviour. Warm, Murray, and Fox (2002) found that the wounds of self-harmers were sometimes stitched without anaesthetic as a punishing tactic for their deviant behaviour. In the human environment of the A&E department, or the general medical ward, this kind of treatment translates into relationships being highly charged and often emotionally intense, to the point where social interactions can occur in a corrupted and corrupting manner (Jenkins et al., 2014). If relationship cannot be formed, appropriate treatment will never be offered or received. In attempting to provide a treatment services for those who self-harm, it is crucial that the concept of relationship is recognised as a key conduit towards providing appropriate clinical interventions.

Like Jenkins et al. (2014), the present research found that greater sympathy was expressed towards an individual who had made a more lethal suicide attempt. The greater the severity, the greater the support. This would seem to be in line with the 'ambulance at the

bottom of the cliff' scenario often seen in health systems today, and potentially the opportunity to enter into relationship at a point where lessened harm has occurred, could minimise the potential for progression to suicide attempts.

There is a role for all levels of emergency and general medical services in the care of those who self-harm, but Rees, Rapport, and Snooks (2015) state that above all, people who self-harm want to be seen by empathic health professionals who are able to listen, be supportive and non-judgmental. Those who self-harm do not, it appears, expect an ongoing therapeutic relationship with everyone they meet in health care, they do however want to be treated with respect, and not judged for what they have done, purely from a lack of understanding as to why they have done it by the health care provider involved with their care at any point in their journey. Turp (2003) proposed that self-harm behaviour should in fact be seen as a multi professional issue because those who self-harm may seek help from, or be referred to, a variety of different professionals within the community, such as GP's social workers, A&E nurses, teachers, community mental health nurses and psychiatrists. Timson, Priest, and Clark-Carter (2012) identified a need for more systematic training for all staff groups with particular emphasis on providing support networks, regular supervision and improving links between services. Less than a quarter of young people with suicidal ideas or self-harm seek help from emergency services according to (Rowe et al., 2014).

From the information the participants have shared in this study, the silo effect and approach of services do not provide the therapeutic environment which they need. Due to their experiences, there have often been times where they have decided not to access the appropriate services at the appropriate time. Poustie and Neville (2004a) concluded that self-harm could best be regarded as a long term health condition. Suggesting that support services and intervention opportunities should be configured from within, not outside general practice. There should certainly be greater liaison between primary and secondary care and increased support for all of the teams involved. Patients who self-harm are distressed people whose presentation and outcome are often poorly understood, with emergency and chronic medical and mental health care teams appearing to not really be aware of the impact each other can have on an individual's journey. Community based staff such as GPs and community nurses could use their long-term relationship with patients and families to build up trust, which may be advantageous in attempts to intervene, manage and ultimately reduce self-harm behaviours.

## **Mental Health**

Peterson and Collings (2015) indicate that in the clinical context, suicidality is often regarded as an unwanted symptom that should be eradicated, rather than an indicator of unresolved issues. This clinical context can often be the only framework available to people with experience of self-harm to talk about their thoughts and feelings. From the participant's experiences, mental health services try to reduce the risk of an individual undertaking self-harm by compelling as much control over the person and their decision making as possible. Often this occurs at a time when the individual who harms needs to know that they have some control, and are able to have their say in what, and who, is involved in their care.

Encouraging some degree of self-management and self-care, requires a leap of faith by clinicians, and is likely to meet with reluctance by those who are not willing to be party to the perceived increased risk affording some control to the individual who self-harms could bring. Participants' perceptions that they were not listened to by healthcare professionals certainly reduced the level of engagement of both health professionals and participants, and as such created a barrier to either party being able to meet care needs which could have reduced reliance on self-harm.

Significance was placed on professional relationships into which the participants had put great personal investment, and in which they also perceived investment to have been made by the professional. Largely these relationships were with psychiatric district nurses, or counsellors, and were where the participants felt that their voices and opinions were being heard. Of note was that these positions were not seen in the eyes of the participants as being professional within the standard paradigm. They were not seen as being in the same arena as psychiatrists, inpatient ward nurses or A&E doctors, all of whom they reported to be emotionally distanced.

Strong bonds with health professionals were certainly possible, and had been extremely effective for a few of the participants. These bonds though, did appear to have occurred in relationships with health providers who did not uphold or enforce the structured boundaries typically expected by health professionals. Removal of structured boundaries of access, availability and contact, appeared to aid the participants as patients to take some control of their healing, and to be more on a journey with the health professional, as opposed to being

directed by them. It was seen as a validation of trust if a health professional relaxed their professional boundaries, and this fluidity of care was capable of having enormous impact.

An emotional connection beyond standardised treatment regimens was a turning point for many of the participants. Not being judged, or feeling that they were judged was essential in this emotional honesty which, coupled with the emotional investment being made by the professional, helped to empower the participant. These relationships were developed into more of a two-way street, a give and take alliance. The moving of boundaries appeared to let the participants know that they mattered, that their opinion was valid, and that they had equality in the relationship of healing that both professional and participant were on. They were not journeying alone. Possibly this is the form of relationship health professionals need to be seeking? Essentially participants wanted to change, to experience healing, but appeared to be saying that the standardised model of care in which power is afforded the health professional simply does not work for them, and that it was in fact reciprocal relationship formation which ultimately made a difference.

Access, availability and time were aspects of these professional relationships that acted to move the connection from the realm of standard health care delivery, into the domain of being a productively therapeutic relationship. It afforded the responsibility of assisting in healing for those who experience self-harm carries professional ethical obligations, where a health practitioner is expected to provide equal and equivalent care to all, irrelevant of circumstance. It would be unmanageable then to develop the level of relationship that appears to create such functionality, with every patient who a health professional is expected to deliver care to.

The reality of being human behind the role of responsibility in health care is that one's own experiences, feelings and fears undoubtedly influence the attitude and standpoint with which the care and capacity to care is delivered – a condition that can easily create fatigue in caring. Carer fatigue is a widely documented experience, with a large number of health care providers suffering it in some form or another during their careers (Todaro-Franceschi, 2013). Adapting to individual patient needs can be exhausting and troublesome in health care, often boundaries offer a safe place to maintain some distance from ongoing patient demands. Health professionals are trapped in a difficult situation when it comes to professional boundary manipulation, with any fluidity in boundaries being a purely personal decision, and directed by individual experiences. Any action, or miss action then can come

under the scrutiny of colleagues, and professional bodies. Melia, Moran, and Mason (1999) state that traditional methods of setting limits and defining boundaries within health care arenas are no longer convincing, and credible resolutions to the problems we face in our society have to be found within health care. Robert Young et al. (2007) in their study found that none of the participants who had ceased self-harm said that specialist health or mental health services were useful in supporting them to stop. In attempting to provide a treatment service for this group of individuals, it is crucial that the notion of relationship is recognised as a pathway towards providing more appropriate clinical interventions for care.

Boundaries, from the perspective of participants, were very different to the boundaries of professionals. Instead, they were explained as informing the emotional investment in a mutually caring relationship. An example, was that in building a relationship with a participant, a counsellor allowed after hour's access to her support via text messages. This flexibility in availability of her counsellor appeared to help this participant in actually appreciating boundaries, as she attempts to explain that her 'out of session' contact is minimal, and only when in 'dire need'. This participant appears to have achieved greater therapeutic outcomes when standard professional boundaries and expectations were tested in the aspiration of gaining relationship, by the counsellor sharing an out of hour's phone number. I wonder if actually desiring the relationship in the first place is key to this success, as any relationship takes time, effort, and trust, and that possibly, what is holding professionals back from seeking a connection is actually the protection of their time, and protection of self?

Adequate boundary management is a clinical imperative for which responsibility rests principally with the clinician (Peterson & Collings, 2015). Boundary crossings on the other hand, refers to benign and sometimes beneficial departures from traditional therapeutic settings or constraints (Scopelliti et al., 2004). The concept of therapeutic boundaries imply the defining or determining of a limit. Within the interpersonal context, boundaries suggest a 'psychological space' or distance between individuals, one that is often used to emphasize the clinician's stance of anonymity, neutrality and objectivity. Breaching of professional boundaries refers to actions that involve going outside the limits of the therapeutic relationship. Such breaches can occur as a result of actions on the part of the clinician, the patient or both. Milton (2008) found that it is also believed that if the nurse-person relationship becomes too close and intense, rather than being therapeutic, the patient may become overly dependent on the nurse and lose self-reliance. However, the present study

shows the participants appear to grow capacity of self-management within fluid boundaries, as mutual respect is created in the trusting relationship. Once relationships were formed, the participants also showed the ability, and desire to be challenged in their thinking and behaviours. Such challenging could occur to reset and redefine boundaries, as a growth in self-management capabilities occurs. I am not advocating for the demolition of professional boundaries, but rather the re-alignment, or fluidity of those boundaries to allow health professionals to create and maintain therapeutic 'friendships' with those they believe would benefit from them, without the threat or concern of professional repudiation.

## **Peers**

There are two aspects to peer relationships for the participants in this study. One, was in their childhood years, where frequently, a lack of support occurred. At a time when the majority of participants were already struggling with 'not being seen' within the home environment, the absence of emotional language in family dynamics, appeared to mean that they were unable to create and maintain emotional connections with peers. The second stage of peer relationships came later in life, once self-identity had been created, and the emotional language and dynamics of relationships had been learned. Of note is that the participants found peer support in this second stage of social relationship building to be of great benefit.

Self-identity, also known as 'self-concept', 'self-perspective', and 'self-structure', is maintained by Johnson and Lord (2010) as accountable for moderating attitudes and behaviours relative to characteristics of internal and external justice, such as fairness, values and respect. Rajan-Rankin (2014) corroborates this in describing the impact that perception of self-identity have on the development of personal resilience through these characteristics, and the influence they have on subjective emotional management. A main motive behind self-harm for young people is known to be the relief of negative emotions (Young et al., 2007). Trust, co-operation, emotions, behaviour, behavioural responses, awareness, and respect are all accepted components of self-identity in the research, and are understood to manifest, and be activated at implicit levels (Allen et al., 2012; Kühnen & Oyserman, 2002). These factors are developed throughout childhood experiences into adolescence, and indicate the importance of familial and peer relationships in the development of these emotions.

The majority of participants expressed a distorted image of self that they believed to be reinforced by peers at a young age. Michelmore and Hindley (2012) state younger children and adolescents are less likely to seek help than those older than them. This seemed to certainly be the case in this study, and appeared to be due partly to the participant's inability to identify what they needed from others, as they did not even seem to understand what they needed from themselves. Having no reliance on peer relationships was very relevant to the participant self-harm journeys, compounded by a lack of communication skills at such a young age, once the harm had commenced it was seen that it was too late to reach out, as they were already outcast and shamed by their behaviours. The shame of being different and not being able to reconcile self within the environment of peers, was the shame for many which triggered the desire to harm. The action of self-harm then became the shame which stopped them from then reaching out for help to stop. Ultimately, this cycle meant they were becoming even more isolated amongst peers. Inconsistency in friendships, and a lack of ability to fit in were undeniably trigger factors to self-harm for this group.

There is little literature examining why young people are reluctant to seek help for suicidal peers. Worries that a wrong judgment have been made, that their peer would get angry, or that their friendship would be damaged have also been reported as reasons for not seeking help for someone who has self-harmed (Michelmore & Hindley, 2012). Many of the participants in the present study experienced distancing from peers, though physical detachment, but also through a reduction in communication. They interpreted this to mean they were not liked amongst their peers, but potentially this was because their peers did not have the skills or knowledge to know who to go to, in order to help someone they may perceive as mentally unwell.

Though there is an accepted correlation between mental health disorders and self-harm, suicidal thoughts are accepted as common in the population at large (Brent, 1997). There appears though to be some difference between those who have periods of suicidal thoughts, and those who choose to act on them in the manifestation of self-harm (Nada-Raja & Skegg, 2011). Possibly, this is due to prolonged isolation and disassociation in significant relationships, and that those who are able to cope without using self-harm, have reliable relationships in some aspect of their community, in which to seek comfort and support. There is a body of research which examines the destructiveness, loneliness and despair of self-harm, but there is also acknowledgement amongst this research that positive

reinforcement of self as productive within relationships can effectively alter the perception of an individual who has relied on self-harm (Sinclair, 2005). Kerr, King, and Preuss (2006) states that social support frequently acts as a buffer against stress for adolescents, therefore greater knowledge amongst peers from an early age may help to change this trend.

Being in relationships develops responsibility, but these relationships come with a warning. Inconsistency in relationships in which some dependency had begun to be formed by those who self-harm, was reported to be injurious to the participant's image of self-overall, and as such, their ability to refrain from self-harm was negatively affected. This indicates that relationships have a fine balance, and that once a relationship is formed, if little control, or parity within this relationship is afforded the individual who self-harms, then that relationship can ultimately be detrimental. Brunner et al. (2007) found that higher peer support predicted fewer symptoms of depression even in those who had no family support, suggesting stress within personal relationships is important in the genesis of self-harm. Skegg (2005) though states that attachment to peers does not confer protection against self-harm.

Neely et al. (2006) found that social support processes which are seen as most promising are relationships which are amenable to change. Within this study, these were identified as peer relationships formed in adulthood, over which greater control could be ensured by the participants. The findings from Straiton et al. (2012) highlight some important issues about the way in which self-harm is currently conceptualised in society. Strategies used by the participants that minimised or concealed self-harm did lend themselves to an exacerbated emotional situation through a fear of misunderstanding from peers. This was often characterised by isolation from peer relationships, rather than leaning towards them in productive help seeking. Although, once the participants felt able to fully realise their personal experiences within peer relationships, these relationships were then shown to challenge negative perspectives, and to drive help seeking behaviours.

When self-harm behaviours are challenged by others within the 'inner' world of an individual who partakes in self-harm, in that their behaviour is metaphorically held up, examined and confronted in relation to personal beliefs of self, the effects can be remarkable. From external challenging, the development of internal 'self-challenging' was often then developed by the participants, and was related to what they had learned from those around them brave enough to confront their self-harm behaviours. This study, shows though, that

positive effects of challenging in peer relationships can only really be achieved in a forum of safety, where security, acceptance and consistency in relationship is felt.

## **Romantic**

Romantic relationships in relation to self-harm have not been widely investigated, possibly this is due to the unreliable nature of these relationship. For the participants, romantic relationships were seen as equal relationships in which they were afforded a great deal of control. This seemed to be because they saw these relationships as having been designed by themselves, for themselves, and as such they held the greatest impact on self-harm behaviours.

Whilst Doyle and Molix (2014) have determined that romantic relationships are negatively affected by impaired self-image. This study found romantic relationships to be significant in their impact on the individual participants desire to self-harm through support of a positive self-image, to an extent which surpassed familial, health care professional, and peer relationships. Potentially, this could indicate that romantic relationships were commenced or instigated at a point in the participant's journey where their self-image was restored from the stigmatisation of the self-harm they felt. Although, the factors which were present, and discussed as relevant to romantic connections, were also thematically comparable to professional, and peer relationships; comprising control, equality, time, accessibility, and acceptance. The participants voiced the high level of personal investment in romantic relationships as being a key factor to a change in their behaviours. The fact that these relationships had been chosen by them, seemed to result in rapid advancement into stages of acceptance which they did not find in either family, or health professional relationships.

Being listened to, feeling secure, not being judged, being able to trust and rely upon a partner were elements expressed in their understanding that their partners just "wanted to know me". In relating to others, those who self-harm often demonstrate an expectation that they will be harmed, exploited, and let down and the research indicates they continually observe for evidential signs that they are about to be abused and rejected (Melia et al., 1999). I, however, believe that the present study shows that there is a point at which such level of insecurity is lessened by the participants, who then move more into a mode of self-management and self-control where they test for loyalty and dependability within the

relationships they have established, but with more confidence in challenging themselves and their relationships. Many participants seemed to associate a lack of challenging with a lack of value, or even a lack of caring, as they related this challenging with the reliability, and security of relationships.

Poustie and Neville (2004b) state that a major reason given by most patients following an episode of self-harm is ongoing life and relationship stresses. Kerfoot and Huxley (1995) found that in 70% of individuals who had completed, or attempted suicide that interpersonal separations and conflicts were evident. Romantic relationships often end, and these studies indicate that such endings can be of high risk to an individual who has relied on self-harm. When questioned about consideration of what would occur should their romantic relationship end, the participants in this study seemed to believe that the self-confidence, and self-management skills they had learned from the advanced emotional growth and communication within these relationships, would not result in a return to self-harm behaviours. Potentially then, whilst romantic relationships are capable of stimulating the greatest change in behaviours for those who self-harm, the creation of other support networks could be seen as essential to reduce the chance of sole reliance on these relationships. Participants reported that when people have self-confidence they are able to reconcile self, even in the conclusion of romantic relationships.

Brabant, Hebert, and Chagnon (2014) identified that female adolescents and young adults who were victims of childhood sexual abuse were almost four times more likely to have had self-harm behaviours, or to have attempted suicide compared to non-victims. In a study in the USA, adolescents who had been sexually or physically abused reported more negative coping strategies (such as self-harm) than a non-abused group. The participants in the current study had experienced a myriad of abuse, the significance of which cannot be underestimated. However, from investigation, for each of those who had experienced abuse, they found some degree of acceptance within self as being repaired by relationship. This was predominantly through romantic relationships, with acceptance of self within these relationships as damaged, but as a significant individual able to provide and receive care, as being the dominant expression of healing.

## **Conclusion**

To be functional means to be in a position of operation, and to be capable of serving a purpose in that operation. In order to be called 'functional social supports', there are key elements which need to be in place. Firstly, a relationship which incorporates trust, and which is not temporary in nature. Secondly, emotional investment in the form of caring, and empathy, and thirdly, the ability to safely challenge behaviours and thoughts without judgment, whilst holding a belief that self-harm does not define an individual. The reason why these are the factors which are required for functionality within relationships for those who self-harm, are because trust cannot be built without caring, and challenging cannot be achieved without the belief, and the desire for an individual to be better than they are presently. Incorporated into this is the need to have an appreciation of the journey that those who self-harm have been on. The ability to understand that health professionals, family, whanau, or social influences such as friends are all part of the self-harm journey, and that for any of these dynamics to be positive in their impact on someone who self-harms, there has to be fluid boundaries to be able to engage in deep conversation, nurturing dialogue, and challenging. A personal desire for the individual to be healed also means an appreciation of the need for space is present, in order to facilitate self-education and self-management by those who self-harm.

Higher functional social support is a positive predictor in outcomes, with higher levels of social support concurrently related to less psychological distress. Functional social support then, provides the individual with more constant, generalized benefits which are not tied to the presence or absence of a particular stressor.

It is clear that education is needed to address the commonly held belief amongst parents, peers, and professionals that it is harmful to ask young people about their suicidal ideas, or to encourage them to seek help. As can be seen in this study, those who self-harm want to be seen, and want to be challenged.

The conclusion of this study is that functional social supports do impact the desire to harm for those who have relied upon self-harm behaviours. Relationships are complex and multifaceted, but when the key elements of non-judgmental caring, listening, empathy, control, and equity in relationship are afforded, great things can be achieved.

## **Recommendations**

Interventions targeted at peers and families should be developed to improve help seeking behaviours, and to enable a greater understanding of self-harm within our society.

Empowering individuals who rely on self-harm to direct and control their own health journey is absolutely essential, but an appreciation of where they are with other supports should be a primary objective, in order to identify and strengthen those relationships they already encounter.

Use of a test such as: Brookings and Bolton (1988) can measure the perceived availability of 4 specific support resources, and could aid the identification of existing supports.

1. Tangible support – the perceived availability of material aid
2. Appraisal support – the perceived ability of someone with whom to discuss issues of personal importance
3. Self-esteem support – the presence of others with whom the individuals feels she/he is compared favourable
4. Belonging support, the perception that there is a group with which one can identify and socialise.

Health professionals need to be empowered to use, or move boundaries in relationship with those who self-harm without repudiation. This study also acknowledges this is only reasonable in relationships which are consistent, present, and available.

For general health professionals who deal with the physiological aspects of harm, greater education on the psychological aspects of this illness needs to be provided, with guidelines on how to provide appropriate care. Overarching this, is the reinforced understanding that non-judgmental care is a right of patients, irrelevant of the life difficulties they face. Silos of care do not work, and the incongruence, and lack of communication between general medical services and mental health providers needs to be abridged, for the sake of everyone involved in the care of those who rely on self-harm.

From a young age relationships need to have functionality, if a child does not feel productive in family, or in peer relationships, then a pathway of expressing this, where non-judgmental caring and support could be provided, and just might create a change on the journey into

self-harm which many young people are on today. Such pathways and education should be available in schools, primary health care facilities, and community centres.

Functional social support is a phenomena which requires more research. Relationships are a complex human need, and the support which can be given, and the positive impacts which can be achieved in those relationships are critical to understand, should we desire to reduce the self-harm reliance present in our society.

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## Appendix I: Literature search

**Table 1.0**

DATABASE	KEY WORD/S SEARCHED								
	SELF HARM	SOCIAL RELATIONSHIP	SOCIAL RELATIONSHIP AND SELF HARM	FUNCTIONAL RELATIONSHIP	FUNCTIONAL RELATIONSHIP AND SELF HARM	FUNCTIONAL SOCIAL RELATIONSHIP	SUICIDE IDEATION	SUICIDE IDEATIONS AND FUNCTIONAL RELATIONSHIP	SUICIDE IDEATIONS AND SOCIAL RELATIONSHIP
<b>OVID</b>	1861	1975	2	1251	0	0	12	0	0
<b>EMBASE</b>	3197	3220	85	2069	0	0	21	0	0
<b>MEDLINE</b>	3197	3220	4	0	0	0	21	0	0
<b>PSYCHINFO</b>	2226	3666	5	0	0	0	14	0	0

## Appendix II: Search strategy

Search history (total of 130 searches): 3 databases in first step, extended to PsychInfo then all available databases through Otago University library services during second step of the search strategy. Twenty six key term searches across 5 individual database sets = 130 searches.

All searches included key terms as key words in title, abstract and text.

1. Self-harm
2. Suicide ideation
3. Social relationship
4. Functional relationship
5. Social relationship; self-harm
6. Social relationship; suicide ideation
7. Functional relationship; self-harm
8. Functional relationship; suicide ideation
9. Functional social relationship
10. Functional social relationship; self harm
11. Functional social relationship; suicide ideation
12. Suicide ideation; functional relationship
13. Suicide ideation; social relationship
14. Suicide behaviour
15. Suicide behaviour; self-harm
16. Suicide behaviour; social relationship
17. Suicide behaviour; social relationship; self-harm
18. Suicide behaviour; functional relationship
19. Suicide behaviour; functional relationship; self-harm
20. Suicide behaviour; functional social relationship
21. Therapeutic relationship
22. Therapeutic relationship; self-harm
23. Therapeutic relationship; social relationship; self harm
24. Therapeutic relationship; suicide ideation
25. Therapeutic relationship; suicide ideation; functional relationship
26. Therapeutic relationship; suicide ideation; social relationship

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- Ystgaard, M., Arensman, E., Hawton, K., Madge, N., van Heeringen, K., Hewitt, A., Jan de Wilde, E., & Fekete, S. Deliberate self-harm in adolescents: Comparison between those who receive help following self-harm and those who do not. *Journal of Adolescence*. 2009; 32(4): 875-891.

## Appendix VI: Description/scoring of studies

### Number of studies found and retrieved

Number of studies found	Number selected for retrieval
58	19

### *Methodological quality*

#### **QARI**

### Number of studies included and excluded

Number of studies included	Number of studies excluded
10	9

### Final Assessment Table

Citation	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Anderson, M., Standen, P. & Noon, J., 2003	Y	Y	Y	Y	Y	N	N	Y	U	Y
Fox, C., 2011	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Long, M & Jenkins, M, 2010	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Thompson, A. R., Powis, J. & Carradice, A, 2008	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Wu, C. Y., Whitley, R., Stewart, R., & Liu, S. I., 2012	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Rodham, K., Gavin, J., & Miles, M., 2007	Y	Y	Y	Y	Y	N/A	N/A	Y	N/A	Y
Storey, P., Hurry, J., Jowitt, S., Owens, D., & House, A., 2005	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Wilstrand, C., Lindgren, B., Gilje, F., & Olofsson, B., 2007	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Gilbert, T., Farrand, P., & Lankshear, G., 2012	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Wright, K., & Jones, F., 2012	Y	Y	Y	Y	N/A	Y	N/A	Y	Y	Y
%	100.00	100.00	100.00	100.00	100.00	66.67	50.00	100.00	88.89	100.00

## Appendix VII: Appraisal instruments

### QARI Appraisal instrument

#### **JBI QARI Critical Appraisal Checklist for Interpretive & Critical Research**

Reviewer ..... Date .....

Author ..... Year ..... Record Number .....

	Yes	No	Unclear	Not Applicable
1. Is there congruity between the stated philosophical perspective and the research methodology?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there congruity between the research methodology and the research question or objectives?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is there congruity between the research methodology and the methods used to collect data?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is there congruity between the research methodology and the representation and analysis of data?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is there congruity between the research methodology and the interpretation of results?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is there a statement locating the researcher culturally or theoretically?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Is the influence of the researcher on the research, and vice-versa, addressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Are participants, and their voices, adequately represented?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Overall appraisal:  Include  Exclude  Seek further info.

Comments (Including reason for exclusion)

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# Appendix VIII: Data extraction instruments

## QARI data extraction instrument

### JBI QARI Data Extraction Form for Interpretive & Critical Research

Reviewer ..... Date .....

Author ..... Year .....

Journal ..... Record Number .....

#### Study Description

Methodology  
\_\_\_\_\_  
\_\_\_\_\_

Method  
\_\_\_\_\_  
\_\_\_\_\_

Phenomena of interest  
\_\_\_\_\_  
\_\_\_\_\_

Setting  
\_\_\_\_\_  
\_\_\_\_\_

Geographical  
\_\_\_\_\_  
\_\_\_\_\_

Cultural  
\_\_\_\_\_  
\_\_\_\_\_

Participants  
\_\_\_\_\_  
\_\_\_\_\_

Data analysis  
\_\_\_\_\_  
\_\_\_\_\_

Authors Conclusions  
\_\_\_\_\_  
\_\_\_\_\_

Comments  
\_\_\_\_\_  
\_\_\_\_\_

Complete

Yes

No



## Appendix IX: Included studies

### QARI

Study	Methods	Participants	Intervention	Outcomes	Notes
[0], Anderson, M., Standen, P. & Noon, J, 2003	semi-structure interviews	45 doctors and nurses from A & E, Paediatric medicine and Psychiatry specialisms	Exploration of nurses and doctors perceptions of young people who engage in suicidal behaviour	2 key themes of 'frustration in practice' and 'strategies for relating to young people' emerge, identifying major barriers to relationship formation for health care practitioners	discusses communication issues and barriers as well as identifying the 'need to talk' for self harm individuals presenting to hospital.
[0], Fox, C, 2011	semi-structured qualitative interviews	6 registered counsellors with a person-centred approach in counselling practice, included 3 women and 3 men qualified between five - 13 years	experiences of a group of counsellors in working with clients who engage in self harming behaviours	working with clients who self-harm raises significant challenges in relation to 'nature of self harm', 'stopping self harm' and 'organisational issues'	all 3 themes which emerged from the experiences of these counsellors identified barriers and boundaries to relationship formation and maintenance for therapeutic interventions
[0], Gilbert, T., Farrand, P., & Lankshear, G., 2012	semi-structured interviews	27 young people considered to be 'at risk' of a diagnosis of personality disorder	experiences prior to and since referral which followed an episode of risky behaviour such as self-harm or a suicide attempt	Links can be drawn between chaotic lifestyles and the lack of support in the lives of young people who self harm	investigates the impact of difficult relationships in the lives of individuals who self harm
[0], Long, M & Jenkins, M, 2010	Tape recorded interviews with in depth qualitative methodology. Purposive sampling was used followed by snowball sampling	2 counsellors recruited via email invitation then snowball sampling technique until sample size reached 8	counsellors' experiences of and ideas about self-harm and to develop understanding of relational depth when working with clients who self-harm	self-harm is a common issue and counsellors have a pivotal role in improving the lives of these clients.	The therapeutic relationship requires specific qualities of empathy, trust, unconditional positive regard, acceptance, allowing time, creating a safe environment and non-judgementality
[0], Rodham, K., Gavin, J., & Miles, M., 2007	discourse analysis	119 individuals who posted, or responded to posts on an open internet message board site	interactions on a nonprofessional self-harm message board and the need for support, venting and validation by participants	message boards are an important source of support for those who use them, however normalization of self-harm behaviours occurs between participants	anonymous postings facilitate support and validation through openness in relationship among users

Study	Methods	Participants	Intervention	Outcomes	Notes
[0], Storey, P., Hurry, J., Jowitt, S., Owens, D., & House, A., 2005	qualitative interviews	38 individuals aged between 16-22 years who reported a history of self harm from under the age of 16	exploration of the views and experiences of young people aged between 16-22 who present to accident and emergency after a self-harm incident	poor communication is a theme of unsuccessful medical intervention with inadequate social networks being a major contributor to continuation of incidents of self-harm	highlights communication issues as perceived by individuals who self harm and those trying to help them
[0], Thompson, A. R., Powis, J. & Carradice, A, 2008	semi-structured interviews according to IPA guidelines lasting 45 - 60 minutes each	8 CPN's (4 male, 4 female) who had not undertaken psychotherapy training and had experience working with individuals who self-harm within the previous 12 months	community psychiatric nurses' experiences of working with people who self harm	attitudes toward clients who self harm can be positive or negative and impact the therapeutic relationship and therefore the chance of positive outcomes for clients	Identifies the sense of powerlessness health professionals can feel in the therapeutic relationship
[0], Wilstrand, C., Lindgren, B., Gilje, F., & Olofsson, B., 2007	narrative interviews, audio-taped and transcribed into English	6 nurses employed in a psychiatric hospital in Sweden, 3 men and 3 women	nurses' experiences of caring for patients who self harm	Managing professional boundaries and personal feelings are key concerns in the therapeutic relationship	Characteristics for a good therapeutic relationship are identified
[0], Wright, K., & Jones, F., 2012	case-study	1 individual who self reports experiences of 30 years of self harm	therapeutic alliances in people with borderline personality disorder	nothing can be achieved before a therapeutic relationship is established	discusses how to form therapeutic relationship and the maintenance of ongoing trust
[0], Wu, C. Y., Whitley, R., Stewart, R., & Liu, S. I., 2012	qualitative in depth interviews and content analysis	20 individuals who presented to A & E between October 2005 and December 2006 who had harmed themselves and who had already participated in a previous quantitative survey	how and why people who deliberately self-harm access formal or informal help sources	supportive attitudes and continuous care from formal and informal sources of help may facilitate help-seeking behaviour and negative influences from close friends or relatives may trigger self-harm episodes	highlights both positive and negative impact of therapeutic and social relationships

## Appendix X: Excluded studies

### QARI

[1] Fortune, S., Sinclair, J., & Hawton, K., Adolescents' views on preventing self-harm

**Reason for exclusion: excluded as participants are under 16**

[1] Landstedt, E., & Gillander, G. K., Deliberate self-harm and associated factors in 17 year old Swedish students

**Reason for exclusion: not relevant to review question**

[1] Lewis, S. P., Heath, N. L., Sornberger, M. J., & Arbuthnott, A. E., Helpful or harmful? An examination of viewers' responses to nonsuicidal self-injury videos on youtube.

**Reason for exclusion: not relevant to review question**

[1] Navarro, A., The relationship of problem-solving, social support, suicide attempt, and suicide ideation in a psychiatric population

**Reason for exclusion: not relevant to review question**

[1] Pillay, A. L., Bundhoo, H. Y., Bhowon, U., Depression-related distress in Mauritian and South African adolescent girls: An exploratory investigation

**Reason for exclusion: not relevant to review question**

[1] Schum, T. R., Dave's dead! Personal Tragedy Leading a Call to Action in Preventing Suicide

**Reason for exclusion: not primary research**

[1] Scott, J., House, R., Yates, M., & Harrington, J., Individual risk factors for early repetition of deliberate self-harm

**Reason for exclusion: not relevant to review question**

[1] Warzocha, D., Gmitrowicz, A., & Pawelczyk, T., Self-harm done by young patients during their psychiatric hospitalization in relation to the presence of specific mental disorders and chosen environmental factors

**Reason for exclusion: focus on acutely mentally unwell individuals**

[1] Wong, S. P. Y., Wand, C., Meng, M., & Phillips, M. R., Understanding self-harm in victims of intimate partner violence: A qualitative analysis of calls made by victims to a crisis hotline in China

**Reason for exclusion: not relevant to review question**

## Appendix XI: List of study findings / Conclusions

### **Nurses' and doctors' perceptions of young people who engage in suicidal behaviour: a contemporary grounded analysis**

Finding1	Communication difficulties and interplay of previous perceptions can reinforce the stigma associated with suicidal behaviour and therefore jeopardize the effectiveness of professional interventions
Illustration	nurses and doctors are programmed to preserve life and as such suicidal behaviour was seen as a potential waste of life. p592

### **Working with clients who engage in self-harming behaviour: experiences of a group of counsellors**

Finding1	Managing risk and the well being of clients who self harm is essential but examination of self as part of the therapeutic relationship is essential to build and maintain trust and respect
Illustration	throughout the interviews, counsellors discussed their own perspectives and viewpoints but also recognised the focus often had to be communicating with clients about safer self-harming in understanding that stopping self-harm was not an option for all p 46

### **Troubled lives: chaos and trauma in the accounts of young people considered 'at risk' of diagnosis of personality disorder**

Finding1	The establishment of a stable, supportive relationship with a view to providing problem solving for guiding young people away from risky acts of self harm may be fruitful
Illustration	Mandy reports needing someone who cared, and who took her seriously and 'didn't judge' her would have made all the difference to her actions p 749

### **Counsellors' perspectives on self-harm and the role of the therapeutic relationship for working with clients who self-harm**

Finding1	Counsellors who experience clients who self harm can gain insight to the breadth and depth of self-harm behaviour and as such can foster understanding and acceptance in relationship, whilst enabling the challenging of negative attitudes
Illustration	the fourth concept discovered refers to recognition of the need to be open and transparent in the relationship, and to recognise limitations p 197

### **I hear, I listen and I care: A qualitative investigation into the function of a self-harm message board**

Finding1	Internet based, non-professional message boards for self-harm are capable of normalizing self-harm and should be used with caution
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Illustration	Normalizing self-harm behaviour makes it implicit that deliberate self-harm is an acceptable coping strategy to engage in p. 427
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### **Supporting young people who repeatedly self-harm**

Finding1	Without the establishment of trust in a continuous relationship of support, failure in attempts to intervene or reduce self harm behaviours occurs
Illustration	a consultation described by an interviewee explains a therapist kept 'dragging up the past';, with the client indicating the past was not the reason she self harmed, but the therapist didn't appear to trust what she was saying or want to build a therapeutic relationship with her. p 73

### **Community psychiatric nurses' experience of working with people who engage in deliberate self-harm**

Finding1	Good relationships between health professionals and individuals who self harm result in good outcomes, but these relationships can be anxiety provoking
Illustration	there 'seemed to be an absence of a formulation to guide the work'; p. 158 and as such anxiety became a barrier to building relationships

### **Being burdened and balancing boundaries: A qualitative study of nurses' experiences caring for patients who self-harm**

Finding1	The very nature of need in individuals who self-harm makes it difficult for nurses to maintain professional boundaries and manage own feelings
Illustration	Participants discussed shutting off 'their feelings', or using irony as tools to manage. p 75

### **Therapeutic alliances in people with borderline personality disorder**

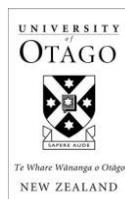
Finding1	The consistency and reliability of investing time and effort builds a mutually respectful relationship between health professionals and individuals who self-harm
Illustration	'she was always there at the end of the phone', and this consistency of support resulted in 1 individual stopping self-harm after 30 years of using it as a means to cope in life

### **Pathways to care and help-seeking experience prior to self-harm: a qualitative study in Taiwan**

Finding1	supportive attitudes and the continuity of care can help self-harm individuals to seek the help needed to influence self-harm behaviours
Illustration	' a confidential relationship built on continuing care' p. 36 created an 'open climate for communication'

## Appendix XII: Signed consent, participants

November 2014



### *AN EXAMINATION OF THE IMPACT OF RELATIONSHIP ON THE DESIRE TO SELF-HARM - CONSENT FORM FOR PARTICIPANTS*

I have read the Information Sheet for this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage. I know that:

1. My participation in the project is entirely voluntary;
2. I am free to withdraw from the project at any time without any disadvantage;
3. Personal identifying information (e.g. audio-tapes) will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for at least five years;
4. This project involves an open-questioning interview technique. The general line of questioning includes questions about your experiences of relationships which have impacted your self-harm behaviours. The precise nature of some of the questions which will be asked has not been determined in advance, but will depend on the way in which the interview develops. In the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage of any kind.
5. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve my anonymity.

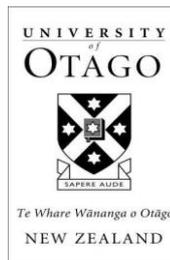
I agree to take part in this project.

.....  
(Signature of participant)

.....  
(Date)

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

## Appendix XIII: Letter for Health Centres / poster for notice boards



*November 2014*

University of Otago – Student Health Services

[address]

Dear GP/Practice Manager

I am writing to request the opportunity to advertise the attached study in your health centre. As described the study has received Ethics Board approval and has reached the recruiting stage. It requires no active involvement of the health centre staff. I have enclosed information to allow you to assess this request.

The study focuses on the experiences of individuals who have a history of self-harm in their lives, but who no longer engage in self-harm (for the prior 12 months to recruitment). The intention of the study is to examine personal experience and perspectives of relationships which have minimized, or perpetuated, the desire to self-harm.

It is hoped this study will be able to provide knowledge and support to health professionals and others who provide support, in understanding the needs of those who experience the desire to self-harm relative to relationships and functional support networks.

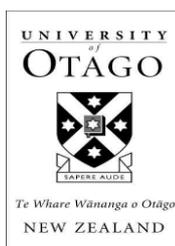
The advertising consists of local newspaper adverts, and local health centre advertising on notice boards. The participants are self-identifying for this study, as such this study does not require the health centre to do anything other than attaching the enclosed information sheet to the centres notice board.

If you have any questions, please do not hesitate to contact me: [jo.rowe@postgrad.co.nz](mailto:jo.rowe@postgrad.co.nz)

Many thanks for your consideration

Joanne Rowe

RN, BA (psych), PGD (HSM), MMgmnt



**AN EXAMINATION OF THE IMPACT OF RELATIONSHIPS ON THE DESIRE TO SELF-HARM**

Our project aims to examine relationships (both professional and non-professional), and the impact they may have had, positive or negative, on the desire to self-harm for those who have experienced incidences of self-harm in their lives. #

Primary aims are:

1. To identify the aspects of relationships which impact individuals
2. Examine the ‘lived experience’ from an individual perspective on how relationships have had an impact on them
3. Examine the changes, if any, relationships have had on the factors related to the desire or drive to self-harm
4. How you managed to cease relying on self-harm behaviours and the identification of supports which helped with this

We are seeking to interview 12-15 people over the age of 17 who have experienced self-harm in the past, with at least 1 year free from any self-harm behaviours. In order to ensure safety, a mental health diagnosis may exclude you from the study. Consent for communication with a health provider to identify any issues from participation may be requested if appropriate.

This study has the ability to inform health professionals and others involved in the care of individuals who self-harm, to support understanding and appreciation of this phenomenon

Interviews will last approximately 1 hour

If you have any questions about our project, either now or in the future, please feel free to contact: Associate Professor Chrys Jaye, Department of General Practice & Rural Health, ph: 03 479 5767, e-mail: [chrys.jaye@otago.ac.nz](mailto:chrys.jaye@otago.ac.nz)  
 Joanne Rowe (Student researcher) can be contacted on 027 5100 291, email: [rowjo221@postgrad.otago.ac.nz](mailto:rowjo221@postgrad.otago.ac.nz)

**#This project has been reviewed and approved by the University of Otago Human Ethics Committee, (Health).# Reference:H14/105]**

What are functional social supports & how do they impact on self-harm. Contact: 03 4795767. <a href="mailto:Chrys.jaye@otago.ac.nz">Chrys.jaye@otago.ac.nz</a> or rowjo221@postgrad.otago.ac.nz
What are functional social supports & how do they impact on self-harm. Contact: 03 4795767. <a href="mailto:Chrys.jaye@otago.ac.nz">Chrys.jaye@otago.ac.nz</a> or rowjo221@postgrad.otago.ac.nz
What are functional social supports & how do they impact on self-harm. Contact: 03 4795767. <a href="mailto:Chrys.jaye@otago.ac.nz">Chrys.jaye@otago.ac.nz</a> or rowjo221@postgrad.otago.ac.nz
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What are functional social supports & how do they impact on self-harm. Contact: 03 4795767. <a href="mailto:Chrys.jaye@otago.ac.nz">Chrys.jaye@otago.ac.nz</a> or rowjo221@postgrad.otago.ac.nz
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What are functional social supports & how do they impact on self-harm. Contact: 03 4795767. <a href="mailto:Chrys.jaye@otago.ac.nz">Chrys.jaye@otago.ac.nz</a> or rowjo221@postgrad.otago.ac.nz
What are functional social supports & how do they impact on self-harm. Contact: 03 4795767. <a href="mailto:Chrys.jaye@otago.ac.nz">Chrys.jaye@otago.ac.nz</a> or rowjo221@postgrad.otago.ac.nz

## Appendix XIV: Free Press Advert 1



### ***THE EXAMINATION OF THE IMPACT OF RELATIONSHIPS ON THE DESIRE TO SELF-HARM***

Have you had experience of self-harm?

Did you have help through or after this experience?

This study aims to examine the personal experience of self-harm and to understand the support received which may have helped you to stop your self-harm.

If you have had at least one experience of self-harm, with the last time being more than 12 months ago, and are over the age of 16 years, we would really like to hear your story

The study will be one interview of approximately one hour in length

**All information is confidential**

A counselling service will be provided after the interview should you wish to discuss any issues from the interview

## Appendix XV: Free Press Advert 2



### *Can Relationships help to stop people self-harm?*

My name's Jo and I'm a health professional trying to understand more about why people hurt themselves.

Self-harm can be anything from cutting or biting to harming yourself with alcohol.

In health we need to understand more about how relationships, such as family, friends, and health workers can help

If you are over the age of 16 and have harmed yourself in your life, but have managed not to in the last year, we would really like to hear your story

The interview will be approximately one hour in length with a health professional

## Appendix XVI: Ethics Approval



H14/118

Academic Services  
Manager, Academic Committees, Mr Gary Witte

24 September 2014

Assoc. Prof. C Jaye  
Department of General Practice & Rural Health  
Dunedin School of Medicine

Dear Assoc. Prof. Jaye,

I am writing to let you know that, at its recent meeting, the Ethics Committee considered your proposal entitled **“What are “functional social supports” and how do they impact the desire to self-harm in individuals who have a history of intentional self-harm”**.

As a result of that consideration, the current status of your proposal is:- **Approved**

For your future reference, the Ethics Committee’s reference code for this project is:- **H14/118**.

While approving the application, the Committee would be grateful if you would respond to the following:

The Committee noted that the reference to the age of the participants needs to be consistent. In section 8.1 it is indicated that participants over the age of 16 will be interviewed whereas on the Information Sheet, it states the age of 17. Please amend accordingly.

The Committee noted the change of supervisor and asks that Shyamala Nada-Raja’s involvement is mentioned on the Information Sheet and is also included as a co-investigator.

Please provide the Committee with copies of the updated documents.

The standard conditions of approval for all human research projects reviewed and approved by the Committee are the following:

Conduct the research project strictly in accordance with the research proposal submitted and granted ethics approval, including any amendments required to be made to the proposal by the Human Research Ethics Committee.

Inform the Human Research Ethics Committee immediately of anything which may warrant review of ethics approval of the research project, including: serious or unexpected adverse effects on participants; unforeseen events that might affect continued ethical acceptability of the project; and a written report about these matters must be submitted to the Academic Committees Office by no later than the next working day after recognition of an adverse occurrence/event. Please note that in cases of adverse events an incident report should also be made to the Health and Safety Office:

<http://www.otago.ac.nz/healthandsafety/index.html>

Advise the Committee in writing as soon as practicable if the research project is discontinued.

Make no change to the project as approved in its entirety by the Committee, including any wording in any document approved as part of the project, without prior written approval of the Committee for any change. If you are applying for an amendment to your approved research, please email your request to the Academic Committees Office:

[gary.witte@otago.ac.nz](mailto:gary.witte@otago.ac.nz)

[jo.farronediaz@otago.ac.nz](mailto:jo.farronediaz@otago.ac.nz)

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval or an extension of approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

Yours sincerely,



Mr Gary Witte  
**Manager, Academic Committees**  
Tel: 479 8256  
Email: [gary.witte@otago.ac.nz](mailto:gary.witte@otago.ac.nz)

c.c. Assoc. Prof. C Jaye Head of Department Department of General Practice & Rural Health