

# **Exploring the Use of an Online Peer Support Community for Self-Harm.**

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## **Abstract**

**Background:** Self-harm is a common problem that affects people across the lifespan. Many people who self-harm face barriers in help-seeking for self-harm and turn to the internet for support. However, there are current political discussions of the harms of accessing content related to self-harm online. Online peer support plays a significant, yet misunderstood role in the lives of adults who self-harm and there is a lack of research into the experiences of online peer support in adults.

**Aim:** This thesis aimed to explore the use of an online peer support community for adults who self-harm.

**Method:** Semi-structured interviews were conducted with eight participants who were members of an online peer support community for self-harm. Interviews were analysed using Thematic Analysis.

**Results:** Seven main themes were identified; three related to experiences and hopes before joining the group - Exclusion, Being in Control of Interactions and Seeking Validation of Distress – and four related to consequences and experiences of joining - Maintaining the Hidden self, Cultivating a Mutual Understanding of Self-harm, The Emotional Burden of Peer Support and Online-Offline Interaction.

**Discussion:** This study provides an original contribution to knowledge around the experiences of online peer support for adults who self-harm. Online peer support met specific needs for adults, enabling them to receive support for self-harm that could not otherwise be met in the offline world. Members sought online peer support due to experiences of exclusion offline, the online community enabled them able to seek support in a way that felt safe and validating. Membership of online peer support also had unintended consequences, both positive and negative. Clinicians need to explore with adults who self-harm what use they make of social media and how they experience that use. Future research may explore the experiences of men and of less frequently included groups and evaluate the impact of more open engagement of clinical services with social media related to self-harm.

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## **Abbreviations**

BAME: Black and Minority Ethnic

DA: Discourse Analysis

DSH: Deliberate Self-harm

DSM: Diagnostic and Statistical Manual of Mental Disorders

GT: Grounded Theory

IAPT: Improving Access to Psychological Therapies

NHS: National Health Service

NICE: National Institute of Clinical Excellence

NSSI: Non-Suicidal Self Injury

TA: Thematic Analysis

TW: Trigger Warning

## **Chapter One: Introduction**

I begin this chapter by defining and describing self-harm and discussing rates of self-harm in the population. I then consider understandings of self-harm, including stigma and barriers to help-seeking. A broad discussion around self-harm content online then follows, with consideration of the role of peer support in relation to self-harm. I then present findings of studies of online peer support for self-harm and critically discuss the limitations of these. Finally, I will discuss the potential clinical implications of the current research and outline my research aims and questions.

### **Defining Self-Harm**

Self-harm is defined as: “any act of self-poisoning or self-injury carried out by an individual irrespective of motivation” (National Institute for Health and Care Excellence [NICE], 2011, p.4). Whilst acknowledging the risks related to suicide, it is true that the majority of those who self-harm will not go on to complete suicide, and self-harm does occur in the absence of suicidal motive or intent (Hooley et al., 2020). Various terminology exists, such as “self-injury”, “self-mutilation”, “deliberate self-harm” (DSH) or “non-suicidal self-injury” (NSSI). Some of these terms are problematic, as DSH or NSSI infers some sense of certainty about motivation behind the act. As self-harm occurs for a variety of individual and complex reasons and can occur regardless of motivation or intention, I will refer to the action as “self-harm” within this project. However, when discussing studies by other authors, I may use the terminology adopted by the authors.

### **Features of Self-Harm**

Self-harm is understood to include acts of cutting, burning, hitting, head-banging, biting, self-mutilation, prevention of wound healing, the insertion of objects into the body/under the skin and skin picking (Chaney, 2017). Cutting is understood to be the most

common form of self-harm, followed by self-poisoning, which accounts for the most presentations to hospital (Carroll et al., 2014; Royal College of Psychiatrists, 2010). Self-harm can occur as a one-off occurrence but is most commonly understood to occur repeatedly. Many statutory services also consider misusing substances and eating disorders as forms of self-harm; however, this tends to be excluded from self-harm literature, due to the perceived differences around the intentions behind both of these issues. It has been suggested that for the most part; the primary, explicit purpose of eating disorders and substance abuse is not generally to harm the body, although this might also be an indirect consequence.

Although the aforementioned acts are common methods of self-harm, it is important to recognise that the understanding of self-harm can be very subjective to the individual. Given that any act to intentionally harm oneself can be understood as self-harm, it can be difficult to pinpoint actions that can be defined as self-harm. In this study, I have taken the perspective that the participants' own personal understanding and experience of self-harm should take precedence, as opposed to attempting to identify with certain methods or classification of self-harm.

## **Rates of Self-Harm**

Self-harm has been identified as a major risk factor for suicide in both adolescence and adulthood (Hawton et al., 2003; Nock et al., 2006; Whitlock et al., 2013) and the risk of suicide for those who present to hospital after self-harm is increased (Geulayov et al., 2019). Data from the 2019 Multicentre Study of Self-harm in England suggested that the risk of suicide after self-harm is 50 times higher than in the general population in the first year after hospital attendance, but nearly 200 times higher in the first month (Geulayov et al., 2019). As a result, self-harm is a pervasive public health interest and therefore the study of self-harm is an important area of research.

Epidemiological data suggest that self-harm accounts for approximately 205,000 attendances in hospital per year in the UK (Clements et al., 2019) although this figure is likely to be an unreliable reflection of the true rates of self-harm. Much of the data available in understanding the rates of self-harm in the UK is based on hospital admission data, however this can be problematic as data on presentations to hospital for self-harm that do not require hospital admission is not routinely collected (Carroll et al., 2014). This means that it is probable that the rates of self-harm are significantly larger than the rates reported here. Additionally, it can be presumed that much of the data relating to hospital attendance refers to acts of self-harm that require physical intervention, which may not account for types of self-harm that does not typically cause significant physical injury (e.g. hair pulling or skin-picking) or for those who choose to self-care for their injuries.

In an analysis of repeated cross-sectional studies by McManus et al., (2019) it was reported that the prevalence of self-reported lifetime NSSI increased from 2.4% to 6.4% across three waves of analysis, between 2000 and 2014. The study findings also suggested that prevalence was increased across gender and age groups, finding an increase in prevalence across age groups and within both genders. The increase in prevalence was greatest in women aged 16-24, where the prevalence rose from 6.5% to 19.7%. This study provides an important insight into trends of self-harm over time, and it also included those not in contact with mental health services (who are sometimes excluded from studies). However, it is still bound by similar limitations as other research in the area, which relies on self-report measures (often likely to lead to an underestimation of rates of self-harm in community populations). In contrast to the increase in prevalence of NSSI identified in this study, additional findings revealed help seeking after self-harm did not follow the same trend, with more than 50% of those who reported NSSI (at each wave) not going on to seek either medical or psychological treatment (McManus et al., 2019). It is clear that if the prevalence of self-harm has increased and yet contact with services after self-harm remains low, fewer people are presenting to mental health services for support than what would be expected (Rowe et al., 2014; McManus et al., 2019). This could mean that some people are

not receiving any professional support for self-harm, but it does also raise the question of whether individuals who self-harm are turning to other outlets for support.

## **Who Self-Harms?**

Although commonly associated with adolescence, self-harm occurs across all age groups. The typical age of onset of self-harm is between age 13-16 (Muelenkamp et al., 2019). Studies investigating the rates of self-harm by age have revealed that although rates are highest among adolescents, self-harm continues into adulthood (Bergen et al., 2010; Carroll et al., 2014; O'Connor et al., 2018). Much has been written about self-harm in adolescence, however, self-harm in adulthood and older adulthood is less documented and studied than in the younger generations, and therefore self-harm within these age groups requires greater understanding. Although self-harm is frequently associated with mental health diagnosis; notably depression, anxiety and borderline personality disorder, people self-harm irrespective of a mental health diagnosis (Royal College of Psychiatrists, 2010) and therefore a clear understanding of self-harm that is independent of other mental health diagnoses is required (James & Stewart, 2017; Klonsky et al., 2003).

When considering gender differences in self-harm, there are assumptions that females self-harm more than males (Adler & Adler, 2011) and this does have some empirical support. A meta-analysis by Bresin and Schoenleber (2015) suggested higher rates of self-harm in females than males, although it is of note that the effect sizes reported in this study were small. More recent literature also points towards higher reporting of self-harm in female young adults than males (O'Connor et al., 2018) and that females experience more self-harm urges than males (Victor et al., 2018; Washburn et al., 2010). However, these findings should be considered alongside the wider social implications of gender and self-harm. One suggestion is that males are less likely to view their self-harm as problematic than females (Whitlock et al., 2011) and are less likely to report for this reason, however, another view may be that males are less likely to seek support due to shame and perceived

stigma. This is supported in a study by Lloyd et al., (2018) who found that males experience more stigmatising attitudes in relation to self-harm and this may impact reporting their self-harm, accessing services and participating in research.

Other gender-related differences in self-harm have also been studied; suggesting that age of onset for males and females of self-harm tend to be similar across both genders (Bergen et al., 2010). There is a mixed picture in terms of methods of self-harm; whilst Bergen et al., (2010) found that methods tend to be similar in males and females, more recent studies suggest specific gender differences, with females reporting cutting more frequently (Bresin & Schoenleber, 2015) and burning/branding being more common in males (Victor et al., 2018). There is evidence to suggest elevated rates of self-harm among individuals who identify as homosexual or bisexual (Skegg et al., 2003) which has been linked to high levels of shame and rejection (Cawley et al., 2019). There are also elevated rates in other minority groups, such as those who identify as transgender or non-binary (Liu et al., 2019). Low-sociodemographic status and experience of adverse childhood experiences have also been associated with an increased risk of self-harm in adulthood (Dube et al., 2001; O'Neill et al., 2018).

Consideration of these findings indicates that there are clearly a number of groups of people that would be considered at-risk, in both clinical and non-clinical populations. The literature does indicate some potential demographic trends, which are helpful in understanding risk factors associated with self-harm, however it is equally important to hold in mind that there is not a discrete, well-defined group of people who self-harm and people across age ranges, gender identities, and sexualities self-harm. Furthermore, it is important to note that gender difference findings may be impacted by lower rates of help-seeking in the male population and some minority groups. Thus, there is still a lot to learn about self-harm within these populations in order to understand the wider picture of self-harm in society.

## **Social Understanding of Self-Harm**

The development in understanding and social meaning of self-harm can be dated back to the Victorian era, although injury to self has arguably always been part of human history, it was only in the Victorian era that it was characterised as self-harm (Chaney, 2017). Early 1950's understanding considered self-harm as a psychological pathology; largely associated with suicide and mental health disorders, but not understood as a disorder in itself. Adler and Adler (2011) describe the historical societal perception of those who self-harm as being "deviants"; those who are not understood or accepted amongst typical societal groups. Decades of negative social attitudes and stigma are comprehensively documented within the literature and continue in the present day (Long, 2018; McHale & Felton, 2010; Taylor et al., 2009). The result of this for people who self-harm is often shame, or secrecy, which in turn contributes to the covert nature of self-harming (Long, 2018). For males who self-harm, the stigma is arguably greater. Post-1960's literature often alludes to femininity as being characteristic of "the typical self-harmer" alongside being white and middle class (Chaney, 2017; Millard, 2013). Indeed, today there continues to be a common perception that there is an association between female adolescence and self-harm, which further marginalises those who don't conform to these stereotypes.

Self-harm and suicidality have sometimes been seen as synonymous, in both research and clinical practice (Macdonald et al., 2020; Marchant et al., 2017). Arguably, it is reasonable to assume that in wanting to harm one's self, this could also allude to a desire to want to die. A key change in the understanding of self-harm was highlighted by the inclusion and classification of "non-suicidal self-injury" (NSSI) in the most recent edition of the Diagnostic and Statistical Manual of Mental Health Disorders [DSM] (American Psychiatric Association [APA], 2013). In the latest update, the DSM-V, NSSI is defined as "intentional self-inflicted injury without the intent of committing suicide" (APA, 2013). Although the introduction of the NSSI as a diagnostic category implies that it is a relatively new idea that all self-harm isn't an attempt at suicide, in fact this is not a particularly novel



idea. In the 1950s, Stengel & Cook proposed that people seen after self-harm, have quite different characteristics from those seen after an attempted suicide, such as age, gender and methods (Millard, 2012). A further notable contribution to these ideas came from anthropologist Armando Favazzo, in his seminal 1987 text *Bodies under siege*. His views that some self-harm could be considered as culturally typical and in other cases, a coping strategy, were starkly different to that of previous thinking (Chaney, 2017). Now, contemporary researchers contend that there is a clear distinction between suicidal and non-suicidal self-harm and have advised that this distinction should be reflected within research and also considered in clinical practice (Hooley et al., 2020; Jarvi, 2013). As a result, various terminology to describe self-harm, such as “non-suicidal self-injury (NSSI)” and “deliberate self-harm (DSH)” are commonly used and included in clinical and academic literature. However, one of the many problems with the variations in terminology, is that this seems to suggest some sort of connotation of intent, which can be both an assumption and a generalisation in many cases. These various terms for self-harm are still used in the present day and are sometimes used interchangeably within both academia and media publications, which seems to reflect the overall ambiguity in the understanding of self-harm.

## **Why do People Self-Harm?**

There is a vast amount of literature attempting to explore and gain further understanding around why people self-harm. Attempts to explore the meaning behind self-harm have helped to expand the narrow view that self-harm should simply be viewed as a pre-cursor to suicide. Although it must be acknowledged that there is evidence to suggest self-harm is a risk-factor for suicide (Geulayov et al., 2019; Hawton et al., 2003; Nock et al., 2006), it is also true that viewing this risk factor in isolation is not useful when evaluating the risk of suicide (Geulayov et al., 2019). This perspective on its own constructs a

restricted view and does not allow for a broad consideration of the multiple meanings behind self-harm.

Self-harm can serve multiple functions (Klonsky, 2007) and therefore, the underlying motivations to self-harm can be both very subjective and complex. Several systemic reviews have attempted to summarize the extensive literature of the function of self-harm (Klonsky et al., 2014; Cipriano et al., 2019; Edmondson et al., 2016). The functions of self-harm have been largely considered in two categories by Klonsky (2007) as serving either intrapersonal functions (relating to the self, for example affect regulation or self-punishment) or interpersonal functions (functions serving communicative purposes, such as self-expression and communication with others). These ideas fit neatly with some of the key theories in self-harm - the affect regulation theories of self-harm, and the interpersonal theories of self-harm, which have both received a considerable amount of empirical support (Jacobson & Batejan, 2014) and are widely accepted theories of self-harm. Edmondson et al., (2016) have since expanded on this, providing a descriptive framework of reasons for self-harm, based on their own systematic review and a previous review (Klonsky, 2007). The review acknowledged commonly cited reasons for self-harm, for example “responding to distress”, but also included some novel themes within the framework, which are often overlooked within the literature, including "seeing self-harm as a positive experience" and “defining the self”. “Seeing self-harm as a positive experience” is a particularly novel way of capturing some of the commonly cited reasons for self-harm, such as “sensation seeking”, but also captures reasons that are often overlooked such as “protection (of self or others)”, for example, using self-harm with the intention of repulsing others in order to protect themselves from unwanted attention. It is suggested that these are not new findings, but alternative ways of viewing the existing literature, which can be bound by literal interpretations or a bias to fit data into a pre-defined framework (Edmondson et al., 2016). A further important point made by Edmondson et al., (2016) is that many research instruments do not ask questions that look beyond the prevailing theories of self-harm and

even in qualitative research, where participants' experiences are more likely to be more broadly captured, experiences are still likely to be coded in line with pre-existing theory.

In summary, the research broadly suggests that those individuals who engage in self-harm do so to manage and control negative affect. There are also communicative functions of self-harm, in terms of individuals communicating distress and further reasons related to development and management of self-identity. However, it is also recognised that one perspective of self-harm may not fit for all, and that self-harm can serve multiple purposes which are subjective to the individual.

## **Stigma and Self-Harm**

The covert nature of self-harm means that it goes underreported and is likely to be particularly underestimated in non-clinical populations. As a result, it is difficult to know the true rates in the population. Some potential reasons for this have been suggested above, however there is a particular emphasis on the construction of negative societal attitudes and enactment of stigma or discrimination towards people who self-harm. Adler and Adler discuss how the stigmatization of individuals who self-harm has culminated in an identity of "deviancy", whereby those who self-harm are aware of the negative perceptions towards them in society and consequently hide their behaviour from others (Adler & Adler, 2005; 2012). Therefore self-harm can be understood as a concealable stigmatised identity; a part of the identity that can be hidden from others (Quinn & Earnshaw, 2013) and is accompanied by negative stereotypes. This idea is not specific to self-harm and other examples of concealable stigmatised identities include individuals with a history of mental health problems, those who identify as homosexual, but have not yet "come out"; those with diagnosis of stigmatised diseases, like HIV, or those with criminal convictions (Quinn & Chaudoir, 2009). Unlike other stigmatised identities that are visible, such as race and physical disability, concealable parts of the identity can be hidden. In the case of those who self-harm, this is often a private act which can be concealed, and this means people who

self-harm exist in a world where they can often “pass” as being non-deviant, but are nonetheless aware of the negative stereotypes that exist in relation to self-harm.

Many people with concealable stigmatised identities manage their stigma by avoiding exposure of that identity in certain groups they feel they may be marginalised (Link et al., 2004; Newheiser & Barreto, 2014). Marginalisation is defined as: “the process through which persons are peripheralized based on their identities, associations, experiences, and environment” (Hall et al., 1994, p. 25). Concealable identities are therefore common but will differ in the extent that they are stigmatised and therefore concealed, based on cultural norms and level of understanding or acceptance across different groups (Quinn & Chaudoir, 2009). The perceived negative attitudes towards people who self-harm can lead to feelings of shame and an internalised stigma, where individuals begin to apply negative stereotypes to the self and relate to them (Quinn & Earnshaw, 2013). The effects of stigma and shame shape how people view themselves and others in the world, and individuals may anticipate future stigma from others. To avoid perceived or anticipated stigma and to be deemed as more socially acceptable, those with concealable stigmatised identities often cope with stigma by concealing the stigmatised aspects of their identity from others (Camacho et al., 2020). In the case of people who self-harm, this may include hiding self-harm scars or simply not disclosing experiences of self-harm to others.

## **Barriers to Help-seeking in Self-Harm**

The low rates of help-seeking for those who self-harm point to barriers to seeking professional support. A recent report commissioned by the Samaritans provides an insight into help-seeking after self-harm. The report includes a survey completed by 565 people who had recently self-harmed. When considering most recent episodes of self-harm, 54% of those surveyed did seek help after their most recent episode of self-harm, but only 25% of this group sought support from NHS mental health services (Samaritans, 2020). Previous research has also suggested low rates of help-seeking. In a study of college students by

Whitlock et al., (2011) a third of students reported that they had self-harmed to the extent that it warranted medical intervention, but only 5% actually sought treatment. Similarly McManus et al., (2019) reported low rates of help-seeking following NSSI, particularly in males and those under the age of 35. Preceding research also suggests that adolescents and adults are more likely to disclose self-harm to their peers than to professionals (Hasking et al., 2015; Whitlock et al., 2006).

Perceived barriers to seeking help for self-harm have been explored in the adult population. A population-based study of young adults by Nada-Raja et al., (2003) highlighted both practical and attitudinal barriers in help-seeking behaviour for self-harm. Practical barriers included: not knowing where to seek help or being unable to access due to lack of time or financial restrictions (Nada-Raja et al., 2003). Attitudinal barriers such as: being too embarrassed to ask for help, thinking no one could help, and thinking they should deal with self-harm independently were also identified. Barriers specifically related to fear or stigma were also reported, such as being afraid of treatment or hospitalisation. Furthermore, Freedenthal and Stiffman (2007) reported findings with strikingly similar attitudinal barriers to those identified by Nada-Raja et al., (2003), including embarrassment, self-reliance, and beliefs about self-harm (that it did not warrant help or nobody could help).

Others' responses to disclosures of self-harm also impact decisions to seek help. For example, a study of the relationship between shame, guilt and self-harm suggested that people often worry about placing an emotional burden on friends and family if they were to disclose their self-harm (Sheehy et al., 2019). Responses to self-harm from health professionals towards people who self-harm also contribute to barriers to help-seeking following self-harm (Rowe et al., 2014). Negative feelings such as frustration and helplessness from general hospital staff have been cited in studies of professionals' attitudes to self-harm (McHale & Felton, 2010; Saunders et al., 2012; Shaw & Sandy, 2016) although more positive attitudes are noted in staff with more knowledge about self-harm, for example professionals with mental health training (Pintar Babič et al., 2020). Yet many service users report feeling misunderstood by healthcare staff and perceive them to lack knowledge in

relation to self-harm (Harris, 2000; Taylor et al., 2009) which is likely to impact their experiences of accessing future support.

This may be due to the perceived, or experienced stigma because of their self-harm. Much of the literature relating to experiences of self-harm highlights the role of shame, which has shown to have a negative impact on the wellbeing of people who self-harm (Quinn & Earnshaw, 2013). This is significant, given that individuals who have sought support after self-harm sometimes experience negative attitudes and punitive care from professionals (Quinlivan et al., 2021), who are intended to be a vital source of help. Perceived stigma, and consequential shame and embarrassment can impact peoples' decisions to disclose self-harm to others (Freedenthal & Stiffman, 2007; Nada-Raja, 2003) and many adults do not disclose to anyone after they have self-harmed (Armiento et al., 2014). Further, shame as a result of perceived stigma lead to an increase in psychological distress (Quinn & Earnshaw, 2013) and higher levels of shame measured in a sample of people who self-harm has been associated with an increased frequency of self-harm (Sheehy et al., 2019) Interpretation of the literature could suggest that the presence of stigma and shame may not only increase the risk related to self-harm directly, but also impact one's ability to seek help (whether that be professional help, or help from family or friends). Therefore, shame in the context of help seeking holds particular relevance, when thinking about the likelihood of those presenting to services for support around self-harm.

Alongside attitudinal barriers to accessing support for self-harm, the lack of provision of services and continuity of services for those who self-harm is a longstanding and acknowledged issue (House & Owens 2020; Macdonald et al., 2020). The most up to date NICE guidance states that community mental health teams and liaison psychiatry teams should generally be responsible for the assessment and longer term management of self-harm (NICE, 2011). Accessing this type of support may be done through referral from primary care services, for example presenting to the GP, or presenting for emergency care in hospital. Another route of support is through Increasing Access to Psychological Therapies (IAPT) services, who offer talking therapies to people with common mental health

problems, such as anxiety and depression (National Collaborating Centre for Mental Health, 2021).

According to NICE guidelines, people who self-harm should be offered “3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm” (NICE, 2011). However, it is known that NHS mental health services are rarely commissioned to deal with self-harm directly, in the absence of severe or enduring mental health problems (Samaritans, 2020). Of course, there will be a proportion of people who may be considered to have severe or enduring mental health problems and are therefore able to access NHS mental health services, however this is not the case for all. One of the key findings in a recent report examining the availability of services for people who self-harm was that people who self-harmed struggled to access appropriate care from NHS mental health services. The report emphasised the gap in services for those seeking support for self-harm, primarily between primary mental health care services such as IAPT, and secondary care mental health services (Samaritans, 2020). This presents a significant problem when people who self-harm are often deemed too high risk to receive intervention through IAPT services (House & Owens, 2020). It creates a gap in service provision for those who may not have severe and enduring mental health needs but who also self-harm and are therefore at risk. The issues highlighted in the Samaritans report are also documented in a recent systematic review of patients experiences of UK emergency hospital care following self-harm by Macdonald et al., (2020) which highlights the variation in quality and provision of care across UK hospital services. The review discusses the impact on people who self-harm, including repetitive cycles of futile help-seeking, and avoidance of future help-seeking as a result of negative experiences. For individuals who have been diagnosed with a personality disorder and attend services with a history of repeated self-harm, the outcomes are also concerning. According to Flynn et al., (2020) the lack of continuity of care for this group results in an under-recognition of needs and elevated suicide risk.

Despite clinical guidelines and recommendation, long waiting times and falling in between referral thresholds mean that people who self-harm can struggle to access support when needed (Quinlivan et al.,2021; Samaritans, 2020). Whilst individual services may have different practices for supporting people who self-harm, these differences create a lack of continuity and equality of care for people who self-harm. Alongside the social barriers that exist for help-seeking for self-harm, this contributes to a concerning picture when applied to a hard-to-reach and often stigmatised group, suggesting it is challenging for people to access appropriate support for self-harm. It is also indicative that alternative outlets of support, such as online peer support, could provide a valuable role for those seeking support for self-harm.

## **Self-harm and the Internet**

There has been a significant increase in engagement with digital technology and internet use over the past decade. In the UK, over 96% of the population are active internet users (Statista, 2021a). Many of those people are using the internet as a means of seeking information and support concerning their mental health problems (Townsend et al., 2016) and in relation to self-harm (Mars et al., 2015). The internet has undoubtedly impacted the way that self-harm is discussed, with communities coming together from different cultures, ages and geographic locations in a way that has not occurred previously. It has created a space for people to connect with others who self-harm in a way that is less pressured by societal stigma. In turn, this has shaped discourse around self-harm from both within these communities and from a wider social perspective (Adler & Adler, 2012).

The beginnings of internet-based communities for self-harm can be primarily situated in the early 2000s, where communities could be found on message boards, or blogging sites (Adler & Adler, 2011) and these communities varied in their function and whether they had any form of regulation or moderation. There was a rise in “pro” self-harm sites at this time, which were sites that were known for encouraging self-harm, with users sharing advice on



methods of self-harm, how to conceal self-harm and often sharing graphic imagery. This coincided with the growth of “pro-eating disorder” blogs and sites, which are characterised by the dissemination of material aimed to promote and maintain eating disordered behaviour (Sharpe et al., 2011). There are some similarities between these types of websites and the motivations for accessing them. For example, similarly to those who self-harm, people with eating disorders also face stigma within society, and members are attracted to communities which enable them to experience a sense of belonging or shared identity (Brotsky & Giles, 2007). As more sophisticated developments of the online world began to take place, a more recent evolution of the online self-harm communities occurred alongside the development of social media platforms such as Facebook, Twitter and Instagram, all of which facilitate online communities for individuals who self-harm. Although it is still true that there remains some variation in how closely monitored online self-harm communities are, Adler and Adler (2013) discuss the shift in self-harm communities over time, with “pro self-harm” sites being gradually replaced by better moderated sites which were more recovery focused.

Despite self-harm being relatively hidden in conversations in the offline world, it is openly discussed in both public and private social spaces online. The question is posed then, what is it about these online spaces that provide individuals with the poetic-licence to talk so openly about their self-harm that is different from the offline world? There are two main themes to this - firstly, is the accessibility of support available online. Considering the limitations of professional support and barriers to help-seeking discussed above, the internet can offer easy solutions to some of these limitations. There are several benefits to accessing support online, including managing restrictions associated with geography and time (Naslund et al., 2020). As the majority of UK adults have access to the internet, accessing support online can be almost instantaneous, which is a clear benefit for people who are seeking advice in relation to their health and wellbeing. The second theme is the interpersonal impact of online interactions on users. Many people who self-harm go online to interact with others, share their experiences and seek guidance or support (Adler & Adler, 2011). The anonymity of the online world can make it easier for people to share their

experiences, this is known as the online disinhibition effect (Suler, 2004). Online anonymity allows people to “test out” identities that they may otherwise keep hidden in the offline world (Code & Zaparyniuk, 2009). It has been discussed that individuals who self-harm may be particularly drawn to online communities for support, as the assurance of online anonymity is typically comforting to individuals struggling with shame, isolation, and distress (Whitlock et al., 2006). There is a clear benefit of belonging to a community where self-harm is discussed openly, whilst being able to maintain the comfort of anonymity, as it minimises the risk of social rejection. This may be inherently important for members of marginalised subgroups in society, such as those who self-harm.

Adler and Adler (2011) describe the dichotomous nature of the online world as "simultaneously public and social whilst remaining private and solitary" (p.27); a description that captures both the uniqueness and the complexities of the interactions that take place online. When considering online communities as relational spaces, they hold a unique quality, in that parts of the self can be enacted or muted during interactions with others. Unlike navigating face to face communication, users have a degree of control over how much of their personal information they choose to share and how and when they choose to share it or engage with others.

### **Facebook: Information Sharing and Connecting with Others**

Facebook is a social media platform where users can create individual accounts and use these to connect with other Facebook users. Platforms like Facebook offer several options for users in terms of information sharing. Users have the option to share as little, or as much personal information as they choose, which allows the creation of an online persona, which may be different from the identity they present offline (Attrill-Smith, 2019). Parts of the self may be presented online, with many users choosing to include their real name and a photograph of themselves as a “profile picture”, however many choose to have anonymous or nondescript online profiles (for example, having an alias name attached to their social media accounts). This demonstration of the online persona is also extended to

how people choose to engage with others online, for example in online peer support communities. People may choose to use the space to post personal content or pictures, whilst others opt to be part of these communities at a distance, by observing content posted, but not by directly posting themselves, sometimes known as “lurking” (Clark & Green, 2019). The ability to “mute” or “amplify” parts of the self, creates a level of control for users, which is arguably difficult to replicate in offline interactions with others. In the case of online communities on Facebook, individual Facebook users can join groups based on topics of interest, where they have the option to read, share and communicate with other users on a shared page. These online communities can either be open (visible to all Facebook users) or private (only visible to members of the group).

Interactions online take place in various ways, some of which are unique to the platforms they reside within. For example, Facebook offers users the option to post text and images, to begin and respond to conversational “threads” and also to “react” to other’s posts. Reactions include “liking” a post, or more recent updates, whereby users can offer a reaction with different types of emojis, which aim to communicate social responses such as, love, care, or sadness (Keep et al., 2019). Such cursory responses to social interactions are a feature that is unique to social media platforms. These communicative features are a key feature of social exchange on Facebook, by demonstrating multiple meanings, such as particularly agreeing with the post content or simply noticing it (Eranti & Lonkila, 2015). It seems that there is a relational aspect to this, with users often liking posts in a reciprocal way, or because of their relationship with the original poster (Eranti & Lonkila, 2015). These functions potentially act to foster connections between individuals in the absence of face to face interaction. An obvious debate is whether this sort of interaction can be considered as reflective of offline interactions, or whether this is simply a part of the evolution of communication between individuals in the digital age.

Online interactions can also be directly manipulated by the platform, which may impact what is seen by, and therefore users experiences of the online world. For example, on Facebook, the likelihood of a user viewing a post is directly impacted by an algorithm

which controls the order and presentation of posts. Machine learning determines what sort of posts users may be most interested in and places them at the top of the users “News feed” (Kramer et al., 2014) therefore, making these posts more clearly visible to the user.

Facebook explains that this algorithm is based on the user’s previous activity (who they interact with often on the platform) and the popularity of posts (Facebook, 2021a). Clearly, alongside the choice users have around who they interact with on Facebook, there are also elements relating to the platforms functioning that are directly manipulated and will affect individuals’ online experiences.

## **Censorship of Online Self-Harm Content**

There is ongoing discussion and debate around the harms of social media on mental health. This debate has extended to both public policy and research, resulting in pressure on social media providers to uphold regulatory standards across their platforms. Some particularly well publicised cases of deaths in the media have amplified this pressure and called for censorship of self-harm related content on particular platforms such as Facebook and Instagram (BBC News, 2019a). Central to the discussion around these cases, is the argument that viewing self-harm related content online, through self-harm communities were significant in the deaths of these individuals. It is this argument that led to former Health Secretary Matt Hancock to publicly warn against the harmful effects of online self-harm content, stating that online self-harm content should be “purged” from social media platforms (BBC News, 2019a).

The social media platform ‘Instagram’ recently received media attention due to the availability of self-harm related content and images on its site and a recent government White Paper has since identified content related to self-harm and suicide as an online harm (Department for Digital, Culture, Media and Sport and the Home Office, 2019). In this paper, it is acknowledged that individuals should be able to discuss self-harm online, however the measures proposed to manage this (including removal of graphic content/

content that could be seen as encouraging self-harm, and the use of algorithms to highlight and remove this content) are left open to social media providers to interpret. The implications of the paper has led to a number of changes across platforms, including changes to Instagram's search engine, meaning it is no longer possible to search for any content that is “tagged” as self-harm. Further, images of self-harm (this includes images where scars are visible) and cartoon drawings of self-harm have also been banned (BBC News, 2019b).

Other social media platforms, such as Facebook have made various attempts to respond to demand for the regulation of online content related to self-harm. In the first instance, allowing its users to report posts to Facebook should they demonstrate a “perceived risk of suicide or self-harm” (Facebook, 2021b). These reports then undergo a human review by Facebook, whereby a decision is made to remove the post should it oppose Facebook’s community standards (Facebook, 2021b). Artificial Intelligence has also been adopted to assist Facebook in managing self-harm related posts online. Identified “trigger” words (words relating to self-harm and/or suicide) have been collated, with the focus of the machine learning to identify self-harm related content, as opposed to content about the person posting (Gomes de Andrade et al., 2018). In their “Community Standards”, Facebook do state that content relating to the recovery of self-harm *is* allowed on the platform and allude to pictures of healed self-harm scars as an example of such content, but go on to state that because of the upsetting nature of this type of content, these posts would be hidden by a sensitivity screen (Facebook, 2021b). This blurs any content and requires users to accept they may be viewing upsetting content prior to viewing.

The concern here, is that exposure to self-harm online may create some form of social contagion leading to increased suicidality amongst peers, known as the “Werther effect” (Phillips, 1974). There is some empirical evidence to the idea of emotional contagion online, which is that exposure to emotional content on social media platforms can lead to a change in emotional state (both positively and negatively). Kramer et al., (2014) explored the impact of emotive content posted on Facebook on other users, by manipulating over

680,000 users' Facebook news feeds to present either positive or negative content. Following this exposure, it was found that users were more likely to post either especially positive or negative content themselves, depending on the conditions they were allocated to. The authors' conclusions from this study were that mass emotional contagion can occur through the sharing of emotive content online, leading people to experience emotions without awareness. However, the study raised ethical concerns regarding the lack of consent and direct manipulation of users (Shaw, 2015). There is less empirical evidence to support the idea that exposure to online self-harm content leads to the type of behavioural or social contagion that many are concerned about, however it is thought that social contagion in the case of self-harm exposure sense may occur due to repetitive exposure to self-harm and modelling of behaviours seen on social media (Khasawneh et al., 2020).

On one hand, it could be argued that by censoring this content, this acts as a protective measure. The caution in relation to self-harm online behaviour is ultimately a reflection of the risks that can be associated with self-harm and in some cases, the links to suicidality. However, it can also be argued that a more nuanced understanding of self-harm is needed when considering potential risk to a person. For example, an individual may be discussing self-harm on a platform in relation to themselves past or present, or in relation to another person, perhaps seeking advice or support. This dichotomy proposes a difficult challenge, when platforms like Facebook and others, have been called to regulate posts related to self-harm; yet there is limited empirical evidence regarding the harms this may pose. There has also been a notable absence of professional bodies and experts in the leadership of this public health debate (House, 2020) which is concerning given the implications it may have.

The narrative of social contagion and self-harm are somewhat reminiscent of the same ideas that emerged in the 80s, (and developed in the decade later) that specific types of music were causing self-harm and contributing to suicides (Stack et al., 1994). No causal link has been established, however the response to these concerns was censorship of music lyrics that were deemed as promoting suicide. By simply replacing the type of media

influence 20 years later, it seems the world has come full circle, in attempting to find a linear explanation for self-harm and censor it, rather than dig deeper into the nuances of it. In their discussion of youth safety and the internet, Boyd et al., (2009) emphatically state: “We’re giving agency to the Internet so that we can blame it for what it reveals, rather than forcing us to contend with what we see” (p. 414).

There is in fact, little longitudinal research that supports the view that engagement with social media proliferates self-harm behaviour and therefore consideration must also be given to the wider narrative that this may create. It could be argued that censorship of self-harm content online may contribute to the narrative that self-harm should be a covert behaviour which is not acceptable to be discussed. From a social perspective, censorship of self-harm related content may reinforce the “deviant” connotations that are consistent with early understanding of those who self-harm (Adler & Adler, 2011). The wider implications for this may include further perceived stigmatisation, increased social isolation and a negative impact on mental health for those who are affected by self-harm.

## **Peer Support Communities and Identity**

Prior to the rise of the digital age, peer support was traditionally group based, face-to-face peer support. Peer support is defined as, “a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful” (Mead et al., 2001, p. 6). The value of peer support has already been acknowledged in mental health services, with peer support workers becoming common-place in mental health teams in the NHS and third-sector mental health services (NHS England, 2017). In the Five Year Forward View for Mental Health (NHS England, 2016) the role of peer support for mental health was endorsed and the report encouraged building the evidence base to support the use of peer support in mental health services. Being able to relate to, or identify with the experiences of a peer, or peer group is thought to be a particularly helpful aspect of peer support (Mead et al., 2001) that can positively impact individuals’

experiences of healthcare and overall quality of life (NHS England, 2016). This is because sharing knowledge and experiences with a peer or peer group can increase self-confidence and boost self-esteem, whilst also fulfilling the need to belong to a particular social group (McKenna & Bargh, 1998).

A number of social and cognitive theories provide a theoretical basis in understanding why peer support may be particularly useful for those who are marginalised in society. Social identity theory (Tajfel, 1974) considers that identification with a group is an important source of self-esteem for individuals, which contributes to the overall social identity. Social identity is understood to be a fluid social process; built up of an understanding of how individuals identify themselves, identify with others, and how others identify them. As individuals can identify with a number of different groups, the overall perception of social identity can be made up of multiple identities (for example student, rock music fan, hockey player, etc.). Self-categorisation is a key part of this process, in which members identify themselves as part of a particular group, or identify others as part of a group (Turner, 2010). This is a common social tendency and is seen when people categorise each other to groups by attributes such as race or gender. This can then lead to generalisations and stereotyping, as individuals have a propensity to incorrectly perceive members of groups to be more homogenous than they truly are (Jhangiani & Tarry, 2014). This can go on to impact both intragroup and intergroup behaviour. Collective identification is a dual process that can occur when group members see themselves as part of their “in-group” and conversely see others as part of an “out-group” (Turner et al., 1994). In this case, in-group members are seen to have more influence on each other than out group members (Barnum & Markovsky, 2007). When this occurs, alternative ways of thinking may develop and be nurtured within the group setting, as members of the group make assumptions that others do not or are not able to think like them. In the case of those who have been used to being pathologized within medical or mental health settings, this may include a move away from traditional illness models based on symptom management, to consider a wider systemic view of recovery, promoting empowerment and hope (Naslund et



al., 2016). This shift occurs through the reciprocity of online peer support communities, where members both give and receive support and care from others, as opposed to simply residing in the patient identity (Mead et al., 2001).

For people who self-harm, who often conceal their self-harm and consequently report feelings of shame and isolation, membership of a peer support group offers opportunities for connection and acceptance from others. For example, Corcoran et al's., (2007) grounded theory study of females' experiences of self-harm peer support groups, highlighted the impact of group membership in decreasing the secrecy and isolation associated with self-harm. The study also suggested that this had positive outcomes for self-harm, with women reporting reduced need to self-harm as a result of the decreased secrecy and isolation. Similarly, Boyce et al's., (2018) qualitative analysis of a peer support community for adults who self-harm also shared meaningful findings. Results suggested that membership of a peer support community for adults who self-harm was particularly helpful in allowing participants to share experiences, without fear of negative judgement and that group membership reduced feelings of isolation.

The process model of demarginalization (McKenna & Bargh, 1998) is a useful way in understanding why membership of a peer support community may lead to inclusion and reducing of stigma. The authors discuss ways in which association with other peers of marginalised and often concealed identities can have positive impacts on demarginalizing communities that face stigma. Self-harm can be understood as a concealable stigmatised identity as it can be hidden, unlike other aspects of identity that are more visible. The process model of demarginalization considers that individuals with concealable stigmatised identities are highly motivated to seek identification with a group of similar others, due to their experiences of marginalisation (McKenna & Bargh, 1998).

In contrast with thoughts that online peer support can lead to increased isolation and further concealment of their marginalised identity, McKenna & Bargh (1998) hypothesise that participation in groups with marginalised others can lead to increased self-

acceptance or demarginalization of the identity. This is then expected to make individuals more likely to disclose concealed parts of their identity. In the context of online peer support, this is potentially an easier task for those with stigmatised identities as the internet offers a potential way for individuals to “try out” and test their identity due to the anonymity provided by the internet (Code & Zaparyniuk, 2009).

Peer support in mental health contexts can be used to give and receive support in a less formal way that is free from the boundaries and constraints of the patient-professional relationship. This is important for many reasons; it can offer a culture that protects against some of the societal stigmas associated with self-harm (Corrigan, 2016) with peers being able to share ideas with each other that they may not view as societally “acceptable”, outside of the peer support culture. For those who experience the negative consequences of stigmatisation, peer support communities offer a space for individuals to meet and share mutual experiences, which may not otherwise occur due to the secrecy associated with self-harm.

## **Online Peer Support**

Peer support communities are an established and increasing feature of the online world, and like their face-to face counterparts, exist in multiple contexts such as educational, health and parenting. Online peer support communities are generally understood from the same theoretical standpoint as face to face peer support communities, although there are some differences. One of the significant differences between face to face and online peer support is the accessibility of online peer support. Naslund et al., (2016) discuss how the digital evolution of these groups aids the wide reach they can have, for example, membership of the group is likely to be significantly larger and perhaps more diverse than if it was held in person. Secondly, the online world allows the user to have more control over interactions than if they were face-to-face (Naslund et al., 2016) for

example being able to communicate whilst maintaining aspects of privacy and anonymity, which is unlikely to be replicated in face to face peer support groups.

Online peer support communities are defined as: “any virtual social space where people come together to get and give information or support, to learn, or to find company” (Preece, 2001, p. 348). Online peer support can be accessed in various ways, for example through the form of message boards, forums and increasingly, in groups facilitated by social media platforms such as Facebook. To date, several studies have explored the function of these spaces, with the main body of research looking at self-harm in discussion forums (Rodham et al., 2007), message boards (Whitlock et al., 2006) and websites (Lewis & Baker, 2011). More recently, social media platforms have also been studied (Prescott et al., 2020; Shanahan et al., 2019). The focus of many of these studies is to understand the types of exchanges that typically take place within these communities. For example, a study of self-harm message boards by Whitlock et al., (2006) found that the most common exchanges included informal support and discussion of life events that trigger self-harm. Sharing information related to one’s personal experience of self-harm, discussing fears relating to disclosure and experiences with professionals were also discussed. A similar study also found that individuals using self-harm message boards were primarily seeking support, validation and to “vent” (Rodham et al., 2007). These results add to the consistency within the literature that social media is used as a platform for various methods of shared communication between those who are affected by self-harm.

Brotsky and Giles (2007) argue that online communities lack social capital, describing the support often given and received as simply a “social mirage”. They suggest that the transience of the relationships in these communities is problematic as this type of support is only short-term. Naslund et al., (2016) also argue that although peer support may offer in-the-moment support, this does not often translate into tangible improvements in the offline world. This is linked to the concerns that online peer support communities that are not moderated by professionals can lead to exchanging of misinformation and incorrect advice. Yet studies of other peer support communities indicate that members do encourage

each other to seek support from services (Williams et al., 2020) and that this advice is often well- received by other members (Prescott et al., 2020).

The process model of demarginalization (McKenna & Bargh, 1998) suggests that those with concealable stigmatized identities are more likely to access online peer support and would also consider membership in these virtual groups to be more important in their lives, than people who do not have concealable stigmatised identities. This is due to the complex and cyclical process of secret-keeping and disclosure. Findings that lend support to the theory of demarginalization were reported by Prescott et al., (2020), who thematically analysed 25 mental health online peer support communities on Facebook (14 UK based and 11 US based). Results indicated that peer support had a positive impact on participants' perceived level of social support, gave rise to feelings of empowerment and hope and feelings of stigmatization against participants were reduced. McKenna and Bargh's own empirical studies of two separate online peer support groups suggested that participants who identified with a concealable stigmatized identity experienced more self-acceptance, reduced isolation and felt more connected with society as a result of positive interactions and feedback received from the group. Additional findings suggested that as a result of these positive experiences, participants were more likely to reveal their stigmatized identity to others outside of the group.

The evolution of online communities has escalated quickly in recent years, with the development of social media platforms. Online communities have developed in response to the COVID pandemic (BBC, 2020) where face-to-face interactions have been limited and there is increased social isolation. Understandably, these communities can be perceived as being more essential within the current social context, by offering a means for users to seek and offer support in a way that is not restricted by the physical boundaries of the offline world. There is little known about the way in which this societal change has influenced the way in which online peer support is used, or the longer-term impacts of this. The increased vulnerability of those who self-harm and reduced availability of services (Iob et al., 2020;

Kapur et al., 2021) may indicate that people are more likely to seek support through informal online peer support communities.

## **Studies of Online Peer Support for Self-Harm**

Research focusing on the experiences of online peer support for self-harm has suggested mixed findings in relation to the potential benefits and harms of these communities. A variety of qualitative and quantitative studies contribute to this body of literature, however, much of this research has been carried out with the adolescent population and there is a lack of studies into adults' experiences of online peer support for self-harm. One of the few studies of the adult population by Baker and Fortune (2008) suggested some clear benefits for users. Their qualitative investigation of adults' views of self-injury websites found that users viewed these online environments as supportive places that helped them feel understood and supported them to cope with their problems. Further benefits were concluded by Jones et al., (2011) in their study of online discussion forums for self-harm. Findings of a survey with a small sample of young people (n=46) suggested that young people viewed the forum as an accessible place where they could find and seek support, and where they were able to discuss issues which they are not able to address with family or friends. A recent online ethnographic study by Lavis and Winter (2020) presented particularly novel findings around the impact of online peer support. Analysis included 10,169 posts and 36,934 comments on social media platforms including Instagram, Twitter, and Reddit between 2018 and 2019, alongside qualitative interviews with young people. One of the findings from this study was that online peer support was a valued route of support, particularly in the context of the stigma that exists offline.

Communities which allow for the reciprocal sharing of information between users (such as forums or discussion groups), as opposed to solely viewing content (such as image sharing websites) are seen as having a more positive influence on users (Daine et al., 2013). However, cautionary findings about the helpfulness of reciprocity were discussed in the

previous study by Lavis and Winter (2020) who reported many benefits to users through membership of an online peer support community, but concurrently noted that the reciprocity of online communities for self-harm can have harmful impacts, in that participants often find the mutual expectations of providing support distressing. This tension between helpful and harmful effects is also noted in previous discussions around similar findings, such as Whitlock et al's., study on the role of internet support groups for self-harm, where participants reported finding these spaces valuable and a helpful means of social support, but the authors also warned that this may normalise self-harm within the communities (Whitlock et al., 2006). Lewis and Baker's (2011) analysis of self-injury websites also share these concerns, adding that this may also contribute to reduced help-seeking.

Further negative or harmful effects have been suggested in other studies, for example that these communities are facilitating the sharing of “triggering” content for other users (Jacob et al., 2017; Marchant et al., 2017; Murray & Fox; 2006). Despite the frequent use of this term in the literature around self-harm online, it is not often clearly defined. Hodgson (2004) clarifies that triggering content is understood as any material that may cause someone to want to cut (or self-harm in other ways). The effects of triggering textual content were highlighted in a study by Murray and Fox (2006) which explored positive and negative aspects of membership of a self-harm discussion group. The study consisted of questionnaire responses from 102 members of an online self-harm discussion group and the authors used content analysis to analyse this data. The findings of the study indicated that the majority of respondents viewed the discussion group as having positive effects. When looking specifically at whether the membership of the group lead to an increase or decrease in self-harm, 42 reported a decrease in self-harm, with 10 reporting an increase (a further 47 reported no change). However, a contradictory finding was that 49 people had self-harmed in response to material posted on the discussion group. The authors of this study note that although this appears as a negative finding, it is still to be understood within a context of overall decreased self-harm as a result of membership.

More recently, Jacob et al., (2017) interviewed 21 young people (aged 16-24) about their understanding and use of online images of self-harm. The majority of participants reported that viewing images of self-harm was a motivator in accessing self-harm content. Nearly three quarters of the participants said that viewing images online invoked both a physical reaction and also lead to an enactment of self-harm. Although some participants considered online self-harm material as a having a significant role in the commencement of their self-harm, the majority of participants were already self-harming prior to exposure of self-harm online. Furthermore, a two-wave study by Arendt et al., (2019) examining the impact of exposure to self-harm images of future self-harm and suicidality, also share similar results, supporting the negative impact of exposure to self-harm imagery. Findings suggested that viewing self-harm images predicted self-harm and suicidality-related outcomes at the second wave of the study one month later. However, this study was limited due to constraints of measurement, as self-harm outcomes were measured using a single-item question (directly asking participants whether viewing the self-harm content online led to participants “copying” the act). Significantly, 66% of the participants indicated that viewing self-harm content did not lead to an episode of self-harm.

Comparable findings were reported by Mars et al., (2015), who found high levels of suicide/self-harm related online content in a community sample of young adults (although the authors have not made the significant distinction between self-harm and suicide content). In this sample, there was an association between those who accessed the content having thoughts of suicide and self-harm. Of interest, the study acknowledges that a greater proportion of the sample were accessing support sites as opposed to those that were described as harmful. The conclusions made by the authors in this study in particular should be considered with caution, as the linear relationship between the two variables cannot be used to infer causation. The findings that there are higher levels of self-harm related internet use in those who self-harm tell us little about the direction of the relationship between the two, however it does indicate that if those who self-harm are more likely to access this

content online, there are not only possible risks, but also possible opportunities for help-seeking.

## **Studying the Online World**

Within the field of studies of the online world, there is a longstanding debate in internet-based research around the perspective of the internet as an environment. Whilst some view the online world as an extension of the real world, others view the internet as a distinct environment in its own right (Mann & Stewart, 2000). Evidently, these perspectives have implications for the interpretation of research, particularly when thinking about online communities. On one hand Hine (2000) put forward that there should be a distinction between the online world and real world, arguing that the types of interaction differ online and offline. It is true that online communities have their own established cultures and rules, those which may sometimes differ from the real world. Furthermore, it is apparent that within these groups, individuals are able to adopt identities that are sometimes different from their real-life identities, which is likely to impact online communication and behaviour. However Hine's argument has been challenged by those who suggest that the internet can be viewed as an extension of the real world (Kendall, 1999). From this position, it is considered that individuals are not disembodied from their offline personas and as a result, there is a link between their online and offline experiences. It is argued that it would be extremely difficult to consider a clear distinction between the offline and online world in today's culture where the internet and social media is continuously becoming more merged into daily living. Sade-Beck (2004) considers the integration of the virtual and real world as a broader definition of reality, as people use their knowledge and understandings developed from real life experiences, to navigate their online interactions. The only difference here is that advanced forms of technology mediate communication.

The internet is an important research environment, and it is argued that by studying the online world, (either directly or indirectly) this allows experiences of hard to reach



populations, such as adults who self-harm, a place to be heard. The view of the internet being an extension of the real world is the position adopted within this research, although acknowledging that interactions may be mediated by the culture they are set in, and consideration of this culture will remain a focus point within this research.

## **Limitations of Previous Studies**

Some studies have suggested a connection between individuals who self-harm and accessing self-harm related content online (Mars et al., 2015; Jacobs et al., 2017; Arendt et al., 2019) but it is unclear what mediates this connection. Both positive and negative effects have been identified in regard to online peer support communities for self-harm, however much of this literature is based on studies of adolescents. We must understand that peer-support is a part of social media that is used by adults and young people. Further, much of the literature fails to address the differences in the way that adolescents and adults use social media when considered harmful and helpful effects. For example, 18-29 year olds use online discussion forums at a higher rate of any other age group (Duggan, 2015) and YouTube and Instagram are the leading social media platforms for children (age 4-15) (Statista, 2021b). This is important in relation to the previous suggestion by Daine et al., (2013) that generally more positive effects are found on platforms where there is the possibility to reciprocally share information as opposed to simply viewing content.

It is recognised that self-harm is a problem that continues to adulthood, though less recognised that it can also begin in adulthood too. It is also known that adults use online peer support in other settings, yet there is an overall lack in research around adults' use of online peer support for self-harm. The gaps in the evidence base are also partly methodological, due to the complexities of exploring different platforms and the speed in which online platforms evolve. This also means that alongside the conversations that happen online, ways of interacting and motivations for interacting will also evolve in parallel. It is

important to have a current view of the function of online peer support for adults who self-harm.

To date there is not a substantial body of research that either clearly supports or contradicts the debate around self-harm content online being either helpful or harmful. It is likely that the contradicting field of research is a reflection of the vast online landscape and complexities associated with studying this. Therefore, caution should be taken about generalising all social media as either helpful or harmful and it must be considered that different social media platforms have different functions (for example, image only sharing vs discussion groups). These differing functions may also impact how users engage with the platform and how this goes on to impact their experience of self-harm. Previous research exploring the function of social media platforms for those who self-harm has focused on message boards/forums (Eichenberg & Schott, 2017), Instagram posts (Shanahan et al., 2019) and blogging sites (Cavazos-Rehg et al., 2017) however there is little research on the use of Facebook groups as a form of online peer support for self-harm.

Above all, we know that adults do use online peer support for self-harm, and it is expected that this can have a meaningful impact on their experiences of self-harm. The extent to which membership of an online peer support community has implications offline, is lesser understood. Understanding the experiences of online peer support for adults who self-harm is imperative if we are to make advances in the wider understanding of self-harm for individuals, but also within society.

## **Possible Clinical Implications**

Previous studies have either focused on online peer support, or on online self-harm content more generally, but neglected to fully explore what draws those who self-harm to online peer support communities and the impact this has. The Royal College of Psychiatrists (2010) encourage that research be undertaken on the lived experience of people who self-harm, with consideration of pathways into and out of self-harming behaviour and focusing

on what works for people who self-harm. Preceding research has suggested there are mixed findings about the helpfulness of social media in relation to self-harm, however within the literature, online peer support communities are a significant source of data which have been understudied. Concerns around risk and safety are a barrier for some professionals to encourage service users to access peer support and as a result, peer support for self-harm is not often a regularly considered source of support for people who self-harm.

Studying an online peer support group indirectly, allows for an alternative perspective into participants' personal attitudes and feelings towards self-harm and aids understanding around the types of interactions and support available in these communities. This is important as it has particular relevance in understanding help seeking behaviour in a population who are perhaps not seeking professional support for self-harm. Roberts et al., (1999) highlight the importance of a caring community in relation to help-seeking, suggesting that people online are more likely to experience feedback from other members as helpful if they feel socially integrated within that particular group. Therefore, despite the lack of professional input into these communities, it could be put forward that peer support could be seen as equally helpful or even more helpful than professional support.

The current study also helps to provide evidence to a confusion of literature about the helpful/harmful debate around self-harm online. Careful consideration of exactly what people hope to seek from these groups and also whether group communities enable people to get their needs met is required. The findings of this study will provide insight into why people seek online peer support for self-harm, what they gain from it and any unintended consequences (both positive and negative).

## **Research Aims and Questions**

The aims of this research are to understand why individuals seek online peer support for self-harm and to understand what their experiences are of engaging with the community. To address the research aims, the following research questions have been identified:

1. What influences users to seek online peer support for self-harm?
2. What do users hope to gain from engagement with an online peer-support community?
3. Are users' needs met through engagement with the community?
4. Are there any unintended consequences of engaging with the community?

## **Chapter Two: Method**

In this chapter, I will provide an overview of the methodology used to achieve my research aims. Within this, I will also justify my choice of analytic method. I will then discuss my participants, and all ethical considerations. Procedures for recruitment and data collection are then described. When discussing the analytic procedure, I will detail the steps taken in conducting a thematic analysis of the data. Finally, I will share an account of my reflective thoughts on the process, as the researcher.

### **Research Design**

This study aimed to explore experiences of an online peer support community for self-harm. Qualitative research methods were considered a suitable approach in response to the exploratory nature of the research questions and the experiential nature of the topic.

### **Justification of Methods**

Qualitative methods are commonly used to gain a first-hand account of understanding about experiences, meaning and perspectives (Hammarberg et al., 2016). As my research aims were to explore the experience of use of an online peer support community for self-harm, as opposed to identifying linear, causal relationships between variables, I was immediately drawn to qualitative approaches. Another significant factor in this decision was the consideration of the impact of the methodology on the population I am choosing to study. Qualitative approaches to research would consider that language gives us access to understanding people's experiences and they are therefore well placed to understand the experiences of groups who may otherwise be marginalised (Braun & Clarke, 2013). As this research is concerned with adults' experiences; a group that have often been neglected in the literature in relation to online behaviour and self-harm, it was important to address this within the methodologies chosen.

There are limitations to qualitative research methods, which were considered when choosing the methodology. Firstly, the overall quality of the research depends on the ability and level of skill of the researcher. Researcher bias can influence the findings of the research if appropriate steps are not taken to minimise this (Anderson, 2010). Additionally, the researchers' presence during the data collection process can also affect participants responses. For example, participants may be inclined to discuss what they think is expected of them, or they may omit details from their accounts if they do not feel comfortable disclosing them (Anderson, 2010). Furthermore, self-reporting personal experience is not always an easy task and participants are required to be able to articulate their experiences to the researcher. There are also limitations to the extent that people are able to reflect and recollect their experiences, which will go on to affect the data that is collected and subsequent findings (Polkinghorne, 2005).

In research planning, I did consider the use of quantitative methods, and specifically considered using a survey to study the use of online peer support for self-harm. This may have enabled me to engage with a larger sample, which would have helped gain insight into the frequency and ways in which people engage with online peer support. However, given the exploratory nature of the research questions, quantitative methods would not have been appropriate to meet the aims of the research, as it would not have allowed me to capture such a detailed account of individual's experiences. I decided that it was particularly important to use an approach that allowed the participants to share the aspects of their experience that they felt were important, rather than being constrained or limited in what they were able to share.

I therefore chose to use semi-structured interviews as my data collection method. Unlike structured interviews, questioning is not rigidly structured and semi-structured interviews are more conversational in nature. Semi-structured interviews are a popular method of data collection due to the flexibility of their application and the ability to gain rich accounts of participants experiences through open-ended questions and discussion (Willig & Stainton-Rogers, 2008) and therefore I decided this would allow me to capture the

thorough level of detail required for this study. This type of interview was chosen, as I was particularly concerned with capturing the true experiences of participants, without them being restricted by discussing specific pre-defined questions as this may have biased the data and findings. As an “outsider” researcher, with limited knowledge of the research environment being studied, having fixed, pre-defined questions may have meant that I missed significant, unanticipated aspects or social norms that may be specific to the particular online peer support community.

Many adults who self-harm worry about perceptions of others in relation to their self-harm, having experienced hostility or perceived negative judgement (Harris, 2000) and so I was particularly mindful of the importance of this during data collection. One of the benefits of semi-structured interviews is in their conversational application, which can feel more natural than a prescriptive interview. The interviewer can also provide prompts, to encourage a deeper level of reflection and additional clarification can be sought if required. This type of interviewing is thought to be beneficial in establishing rapport with participants and enabling them to discuss experiences more honestly and openly (DiCicco-Bloom & Crabtree, 2006). As an “outsider” to the population being studied, and given the personal nature of the topic, this felt like an appropriate consideration and contributed to my decision to use this method of interviewing.

Other methods of data collection, such as the use of focus groups, may have also given insight into participants’ experiences in their use of online peer support for self-harm. I considered that this method could offer a particularly valuable insight into normative group discourses and gaining an understanding of shared experiences for users. However, I decided that focus groups would not have been a suitable method, given the personal and sensitive nature of the topic. I was also concerned that focus groups may limit participants from voicing certain thoughts and opinions, if they did not fit in with the general consensus or that they did not feel they could be open. Given that anonymity is understood to be an important factor in online help-seeking, I also wondered if the experience of being in a

focus group may be off-putting for those with privacy concerns and may discourage potential participants.

The interviews took place either by telephone or by video conferencing. Typically, interviewing in qualitative research takes place face to face as there are non-verbal cues that provide an important view into the experience of participants. Telephone interviews have previously been discounted by some qualitative researchers, with claims that face to face interviews can provide a richer qualitative account of participants' experiences (Irvine, Drew, & Sainsbury, 2012). Whilst there is a growing body of evidence to support the successful use of telephone interviewing in qualitative research and I consider non-verbal communication as particularly valuable and interesting parts of human interaction. For this reason, I would have preferred to conduct interviews face to face, however due to COVID restrictions this was not possible. The decision to offer both telephone and video-conferencing interviews was made in the interests of being both flexible and accessible to all potential participants.

This research aimed to explore adults' experiences of an online peer support group for self-harm. Thematic analysis (TA) was chosen as the method of analysis for this research. TA is a type of analysis that aims to identify, analyse, and interpret patterns of meaning (referred to as "themes") within qualitative data (Braun & Clarke, 2013). It is a flexible qualitative analytic method that can be applied across a range of theoretical and epistemological approaches (Braun & Clarke, 2006). This felt like an appropriate analytic choice, due to its ability to explore a range of questions relating to participants' lived experiences, such as behaviour and perspectives. It allows for consideration of the factors and social processes that influence particular phenomenon (Braun & Clarke, 2013). It has also been highlighted as a useful method in considering different perspectives, which was a particular interest in this study. King (2004) suggests that TA is particularly helpful for highlighting similarities and differences and generating unanticipated insights within the data. Furthermore, Thematic Analysis can be a particularly useful method to investigate



topics that have not been extensively researched (Braun & Clarke, 2006), as is the case with the topic of this research.

Other qualitative methods such as Grounded Theory (GT) and Discourse Analysis (DA) were considered. Discourse Analysis considers that experience and meaning is constructed through language itself and as a result, discourse and conversation should be the focus of analysis (Willig & Stainton-Rogers, 2008). Although I was interested in the language used by the participants and how this may have impacted their experience of being a member of the group, this was not the primary focus of the research and therefore DA would not have been a suitable method. Another option would have been Grounded Theory. GT is a well-recognised qualitative method, that is concerned with the inductive generation of theory (Bryant & Charmaz, 2007). It is therefore particularly useful when researching topics that are understudied. Given the lack of research into online peer support for adults, this was a considered method. However, there were several reasons this would not have been a suitable method for me to adopt. In early versions of grounded theory, it is suggested that researchers should not have any preconceived ideas about the topic of study, as this can prevent theory from emerging from the data. As a Clinical Psychologist in training, with prior experience of working with people self-harm, I already have pre-existing knowledge and beliefs in this area. I had also done a lot of reading about the area of self-harm and online peer support groups prior to data collection.

Furthermore, theoretical sampling is a key strategy in Grounded Theory (Hood, 2007), in grounded theory this involves an iterative process of analysing data and then seeking out participants based on the findings of this data, to either confirm or actively disprove such findings. Based on the timescales for this study, this would not have been a viable option. Overall, through discussion with my supervisors, TA was agreed to be the most appropriate “fit” for this project, as it would allow me to explore the research questions with a broader focus on experiences, in a way that felt accessible to me as an early-stage qualitative researcher.

I took a reflexive approach to Thematic Analysis (Braun, Clarke, Hayfield & Terry, 2018; Braun & Clarke, 2019) Since Braun & Clarke's 2006 paper, thinking around TA has evolved, both in terms of the principal philosophy and also in its procedure. One of the earlier critiques of TA, was that its application was perceived as too simplistic for complex qualitative research. Braun & Clarke have since responded to this critique, arguing that their ideas extend beyond the identification of themes, and that the researcher holds responsibility in conceptualising the data (Braun & Clarke, 2019). The authors suggest that the sophistication of the method in its own right, comes from the researcher's ability to engage and apply it both thoroughly and reflexively. It also relies on the researcher's ability to look beyond the manifest content in the data and consider the latent content too.

In reflexive TA, theoretical reflexivity is key when conducting a credible analysis. Braun & Clarke (2019) emphasise the need for researchers to explicitly state their positioning with regards to their own theoretical assumptions. Reflecting on my own position as a researcher is an important consideration in the research process as this is a factor that helped guide me to my choice of research method. In understanding my own theoretical stance and epistemological stance to this research it is important to consider the epistemology underpinning the decisions that were made during the research process.

I consider human experience to be subjective but also context-bound, and situated within the social systems that we exist in. My stance to conducting qualitative research is that it offers an interpretive way of storytelling and meaning making, as opposed to finding out an objective truth from data. My beliefs could be seen to fit within a contextualist framework, which assumes truth can be accessed through language, but that accounts and experiences are mediated through social experiences (Madill, Jordan, & Shirley, 2000).

### Summary

In discussing my research design and methodological approach, I have described justification for the decisions made during this part of the research process. In doing so, I have reflected on my own positioning as the researcher and have discussed alternative

methodologies considered. The next section of this chapter will detail the procedural stages of carrying out the research

## **Recruitment Strategy**

The adult population is understudied in this area, with much of the research into self-harm and online behaviour focusing on adolescents (Royal College of Psychiatrists, 2020). I chose this population to gain much-needed understanding of adults' use of online peer support for self-harm. Help-seeking for self-harm in adulthood is reduced (Armiento et al., 2014; McManus et al., 2019; Nada-Raja et al., 2003), which increases the risks associated with self-harm.

Alongside YouTube, Facebook is currently one of the most commonly used social media platform (86% of its users are reported to be over the age of 18) and adults between the ages of 25 to 34 make up the highest proportion of its users (25.1%) (Kemp, 2021; Statista, 2021c). Given the platforms' relevance to the adult population, a self-harm peer support group on Facebook was chosen to study. The particular group studied exists as part of a wider peer-led self-harm charity.

## **Inclusion Criteria**

The inclusion criteria were agreed upon and was decided to remain broad, to ensure that a wide range of experiences could be captured through the semi-structured interviews. It also aimed to capture different ways users might engage with the Facebook page (for example, sporadic use vs everyday use or active posting vs passive observation). The inclusion criteria included:

- Being a UK based adult (aged 18 or over)
- Identify as a user of the self-harm peer support community. Specifically, this means anyone who is a member of the page (and is not limited to include those who posted regularly, or within a specific time frame).

- Are deemed to have capacity to consent to participate in research

## **Exclusion Criteria**

The exclusion criteria for the research were considered primarily to manage risk. Potential participants were excluded if they were deemed to be at significant risk. My own clinical judgement, alongside feedback from my supervisors informed my decision as to whether to suspend or end any participation in the study. This type of exclusion was not required, however, if I had reason to think that the interview was placing participants at significant risk of harm or causing severe distress, participants would not be able to continue with study participation.

Participants were not able to take part if they were not located in the United Kingdom. This decision was made in line with the participant risk protocol (see Appendix A) as support services that were provided to potential participants were all UK based.

## **Sampling Strategy**

The decision on sample size was made considering previous guidelines on sampling in qualitative research, the size of the project, and consideration of the research aims. It was decided that a sample size of between 6-10 participants would be a sufficient sample size to generate themes and this was what I aimed for. This is in keeping with previous suggestions that 6- 10 participants is an appropriate sample size for doctoral level qualitative research projects (Braun & Clarke, 2013; Turpin et al., 1997; Willig & Stainton-Rogers, 2008).

A common approach to determining sample size in qualitative research is the principle of theoretical saturation, which considers that data should be collected until the researcher reaches a point where no new information is obtained (Willig & Stainton-Rogers, 2008). However, Braun & Clarke critique this approach, arguing that by solely focusing on saturation as a sampling strategy, this can restrict the researcher's interpretation of latent content. This is because researchers are likely to be paying attention to the manifest content in the data in order to determine when they believe saturation has occurred (Braun &

Clarke, 2019). I made the decision to stop collecting data after I had interviewed 8 participants. This decision was made subjectively and through discussion with the research team, as I felt that participants accounts were rich and detailed enough to meaningfully interpret the data in relation to the aims of the project, whilst also recognising the pragmatic restraints of the project size (Braun & Clarke, 2019).

## **Recruitment Procedure**

The Facebook group being studied is ran by a peer-led charity for people who self-harm. I had become aware of the charity in my clinical work, through a discussion with a service user, which sparked my interest in the topic of self-harm. My research supervisors had also previous experience of recruiting for other self-harm research through the charity. Prior to recruiting, I approached the chief executive of the charity, to discuss my plans for my research and seek approval for recruitment. Participants were recruited directly from the Facebook group using an online advertisement that was posted on the Facebook page.

Participants were invited to contact the researcher with an expression of interest and to ask questions about the research. 10 potential participants responded to the recruitment advert and were sent participant information. Following initial contact, eight participants agreed to participate, and interviews were scheduled. They were provided with a participant information sheet (Appendix B) detailing the purpose of the research and were asked to provide verbal informed consent to participate in the research. Verbal consent was gained as opposed to written consent due to COVID-19 restrictions, which prevented face to face contact between the researcher and participants. Verbal consent was audio recorded and in addition, was recorded on a copy of a consent form live with the participants (Appendix C). All participants were then provided with a copy of the consent form via email.

There were some minor issues with recruitment that I had not fully anticipated. The recruitment advert was posted at various times between July 2020 - October 2020. Initially there was a fleeting spell of interest, following the first recruitment advert being posted and

I was contacted by three potential participants, however there was a decrease in interest after this. Mid-way through recruitment, I made the decision to include a photograph of myself on the recruitment advert. This was based on feedback from participants who had completed the research, who said this would have been helpful to manage anxiety about who they were going to be speaking to. This appeared to slightly increase interest, and lead to potential participants getting in touch. Some potential participants expressed anxiety about being interviewed about their experiences. In some instances, telephone calls were also arranged prior to the interview to allow for a more in-depth discussion about the research. This happened with two participants who disclosed some worries about what would be expected of them.

## **Interview Procedure**

A semi structured interview schedule was used, to give the interviews a framework. The semi-structured interviews were conducted based on the topic guide (see Appendix D) which was developed through discussion around the research questions, using feedback from supervisors. Participants were given the choice to complete interviews either via an online video-conferencing network (Zoom) or by telephone. Due to COVID restrictions, it was not possible to conduct interviews face to face, although this would have been my preference. However, there were benefits to completing the interviews remotely; this meant that interviews could take place largely at participants' convenience, and where they could be in a comfortable space such as their own homes. This method also allowed for geographical dispersion of participants.

Drabble et al., (2015) suggest that cultivating rapport and maintaining connection, demonstrating responsiveness to interviewee content, and communicating regard for the interviewee and their contribution are all important factors in conducting a successful qualitative interview, and these were all factors I made efforts to attend to during the interviews. For example, I took time at the beginning of the interview to introduce myself

and informally chat to participants. I then reiterated the purpose of the study and remind the participant of their right to withdraw. The semi-structured interviews were conducted flexibly, to allow the interviews to flow in a conversational style; appreciating the need for participants to discuss and reflect on their experiences in a comfortable way. During and after the interviews, I noted down my key thoughts and reflections in a reflective journal.

Throughout the data collection phase, I was mindful about the sensitive nature of the research. Prior to the interviews taking place, a risk management protocol was discussed, whereby participants were offered the opportunity to create a safety plan, in the event they became significantly distressed during the interview. Participants were also offered contact details for crisis support and additional mental health support.

All eight interviews lasted between 36 and 49 minutes. Following the interviews, I arranged time to check in with each participant to discuss anything they might have found challenging and to ensure they were feeling safe. This also allowed opportunity for less formal conversation and for participants to ask any questions. Participants were reimbursed for their time with a £10 Amazon voucher, which they were emailed following their participation in the interview.

## **Ethical Considerations**

### **Ethical Clearance**

Ethical clearance was sought from the University of Leeds School of Medicine Ethics committee (SOMREC) and approval was granted on 04/06/2020 (See Appendix E for ethical clearance statement).

### **Informed Consent**

Potential participants were given a participant information sheet (Appendix B), which clearly detailed the research aims and implications of participating in the research, in advance of scheduling any interviews. They were also provided with a consent form

(Appendix C) in advance of participation. This was to give participants adequate time to make an informed decision about participating and to ask any questions about the research. They were informed of their right to withdraw their information and given contact details to do this.

### **Risk of Harm**

Interviews took place remotely, minimising any risk of physical harm to myself. In terms of risk of harm to participants, participants' disclosures about their experiences online and conversations related to self-harm have the potential to cause emotional distress. As a trained mental health professional and a Trainee Clinical Psychologist, responding to emotional distress is something I am equipped to deal with. As an additional measure, two Clinical Psychologists (both members of the Leeds DClin course team) were informed of the dates and times of interviews, in the event that I needed additional clinical support. I also received regular supervision during data collection, to discuss any issues that arose.

Risk of harm to participants was thoroughly considered throughout the research process. Although there is limited evidence to suggest participating in research about suicide or self-harm leads to an increase in risk related to self-harm (Cukrowicz et al., 2010) there was the possibility that discussion of personal issues could cause distress. Participant wellbeing was at the forefront of my mind throughout and they were informed that they could take a break from the interview or terminate the interview at any time.

A risk assessment protocol was developed through discussion with my supervisors (see Appendix A). This detailed measures to take to ensure participant wellbeing and additional steps to take should a participant disclose or be deemed to be at significant risk during the interview process. There were no significant risk issues that arose during the research process and therefore no additional actions were required. During the interviews, I was sensitive in my questioning and aimed to be alert to any signs of potential distress the participant was experiencing. As some of the interviews took place via telephone, I was unable to see the participants and was particularly alert to verbal signs of distress. Whilst



some participants did experience some distress during the interviews, as per their wishes, they were able to continue with the interviews. It was important to acknowledge this and respond sensitively to the participant and their distress. Following all interviews, I was able to have an informal conversation with participants to check on how they were feeling and if they required any additional support.

## **Confidentiality**

Given the amount of personal and sensitive information gathered in the interviews, a number of steps were taken to ensure confidentiality and anonymity were maintained. As the interviews took place remotely, participants were asked to ensure that they were located in a setting where they could talk comfortably and openly. They were advised to complete the interview at their homes, although one participant preferred to go on a quiet walk. As the interviewer, I ensured that I was conducting the interviews in a confidential space in my own home.

Participants were all given pseudonyms and participant identification numbers, which were used to identify them during the research process. During the process of transcription, all participant identifiable data was removed and has been omitted from any quotes used in the research. This included names, locations, particular location-based services and in some instances, occupations. Only personal information which is deemed essential for the reader to understand the analysis is included. I made the decision not to include the name of the Facebook group in the write up, as the group can be easily searched and potentially accessed by anyone who has a Facebook account, which leaves participants open to identification.

## **Data Protection**

The interviews and verbal consent were recorded on an encrypted Dictaphone. Immediately after the interviews, I uploaded the recordings to the University server, which is password protected and the files were deleted from the Dictaphone. Transcriptions,

consent forms and any other electronic data relating to participants were also stored on the university server. Steps will be taken to ensure the protection of the data beyond my studies and all data will be destroyed in three years, by the Doctorate in Clinical Psychology Research Coordinator, in line with the University of Leeds Information Protection Policy.

## **Analysis Procedure**

I will now give an account of how the data analysis was undertaken to aid the reader in understanding how the results and conclusion were reached. This includes a description of the analytic process, how credibility checks were completed and then finally a reflexive statement. The analysis was guided by Braun and Clarke's (2006) six phases of Thematic Analysis, which are presented in Table 1 below.

**Table 1**

*Phases of Thematic Analysis (Braun & Clarke, 2006)*

<b>Phase</b>	<b>Process</b>
<b>1. Familiarisation with the data</b>	Transcription of data, reading and re-reading data and developing ideas
<b>2. Generating initial codes</b>	Coding ideas in a systematic way, collating data relevant to each code
<b>3. Searching for themes</b>	Collating codes into potential themes, collecting codes into each theme
<b>4. Reviewing themes</b>	Checking themes against codes and the entire data set; generation of a thematic map

<b>5. Definition and description of themes</b>	Ongoing analysis to refine themes. Generation of theme names
<b>6. Producing the final report</b>	Final opportunity for analysis. Integration of themes into the report.

The first phase of Thematic Analysis is to familiarise one's self with the data. This began early in the research process, during the transcription of the interviews as I listened back to the audio recordings. I transcribed the interviews verbatim in Microsoft Office Word for Windows. The decision to self-transcribe was made so I was able to fully emerge myself in the data from the earliest stage. The process of data transcription is considered by Braun and Clarke to be a significant part of the initial stage of Thematic Analysis (Braun & Clarke, 2006). Although time-consuming, I found the process of transcription to be extremely useful in immersing myself in the data. I made a number of reflections during this stage in the research that I may not have encountered if I had outsourced transcription. During this phase, I printed out the interview transcripts, and continued to familiarise myself with the data by reading and re-reading the transcripts, annotating each transcript as I read. I also began making notes at this stage, documenting my initial thoughts and ideas, or any questions I had in mind.

In phase two I started to organise the data and identify initial codes within the data. The data was coded manually, by working through the transcripts thoroughly and coding any data that related to the research questions. The codes were written directly onto the transcripts. Each transcript was given equal attention during the coding process. This process involved organising the data systemically into a word document, copying extracts of data that supported each identified code.

During phase three of the analysis I began collating the individual codes into potential themes. I used mind-maps to explore relationships between ideas in the codes

strengthen the development of potential themes and sub-themes. This facilitated the grouping of codes into meaningful categories, for example “anonymity” “validation” and “free of consequences” were grouped into “Maintaining the hidden self”.

In phase four I reviewed the themes against the original data set, checking that there was enough data to support each of the themes and that the coding was being accurately captured with regards to each theme. Also, at this stage, I considered whether there was potential overlapping of each of the themes and subthemes. It was at this stage that I began to generate a thematic map, mapping out all of my themes.

Phase five of Thematic Analysis involves the refining of themes. This involved generation of the final theme names. I had initially come up with preliminary names for the themes and sub-themes. Through discussion with my supervisors some of my themes were further refined, for example “Applying learning” was renamed “Online – Offline interaction”

In the sixth and final stage of analysis involved producing a report to summarise the themes and sub-themes that were developed from the analysis, which can be seen in Chapter Three: Results. Even in the final phase, refinement of themes continued to take place. A first draft of this report was shared with my supervisors and discussion lead to final refinements.

## **Conducting Robust Qualitative Research**

I took specific measures in order to ensure the quality of my research, which were informed by guidelines set by Elliott, Fischer, and Rennie (1999) to support qualitative researchers in conducting rigorous qualitative research. I will briefly describe the guidelines and how these were considered in the research process.

### **Credibility Checks**

In qualitative research, credibility checks often take the form of cross-coding (Hammarberg et al., 2016). Throughout the analytic process of this study, frequent review of

the data took place between myself and my supervisors. This included the early stages, whereby initial ideas and codes were being identified. I was able to share my examples of coding and prospective results with my supervisors at various points throughout my analysis and discuss any differences in interpretations. Through these discussions, themes were then refined. This ensured that the themes and sub themes identified were clear, accurate and representative of the data collected.

### **Situating the Sample**

In qualitative research, situating the sample is an important way of providing the reader with context around the participants, which may provide details that would be relevant to the research (Elliott et al., 1999). I have therefore included pen portraits in the result section for each participant and provided information around the Facebook group. Furthermore, I have included information about the context of which the research was set (during the COVID-19 pandemic) and how this may have influenced participants in this study.

### **Grounding in Examples**

Grounding in examples means presenting direct examples of procedures and data to support findings (Elliot et al., 1999). I have included direct participant quotes when describing my results to the reader, in order to increase transparency of any findings. Kalinowski, Lai, Fidler, & Cumming (2010) discuss how this transparency allows the reader to appraise interpretations and think about alternative ways the data could be interpreted. Using direct participant quotes can sometimes be a challenge to participant anonymity, however I have made efforts to avoid identification of participants, and only included quotes and information that is necessary for the reader's understanding in order to minimise this risk. I have also included the topic guide used in this study (Appendix D) which is a way of supporting transparency in qualitative research (Arthur & Nazroo, 2003).

## **Owning One's Perspective**

Qualitative research acknowledges the impossibility of remaining completely objective to the research (Willig & Stainton-Rogers, 2008). The subjectivity of qualitative research can affect much of the decision making and interpretation of data. In describing my thinking and justifying my decision making, I have written in the first person, as opposed to using third person language and this can help to achieve the aim of owning one's perspective (Kalinowski et al., 2010). In order to acknowledge the subjectivity of qualitative research, Elliott et al., (1999) state that researchers need to explicitly describe their values, interests and assumptions and critically discuss how these could influence any findings. This is provided in the reflective statement below. As I used a reflexive approach to TA, reflection was particularly important to me during the research process. I used a research journal throughout the research process which enabled me to note down any thoughts and feelings that were evoked during data collection and in the analysis stage of the research (see Appendix F for reflective journal extract). In here I also made efforts to identify and document any of my own assumptions or beliefs I had around the experiences that participants spoke about in the interviews and the way in which they chose to describe them. I was then able to reflect on the origins of these beliefs, considering both personal and professional influences. Reflecting upon my own assumptions about self-harm and online behaviour was critical in acknowledging how my personal, societal, and cultural beliefs may affect or influence interpretation of the data. This process helps to defend the credibility of qualitative research (Hammarberg et al., 2016). Some of the content of my research journal went on to shape the following reflexive account below.

## **Reflective Statement**

As described above, in qualitative research, credibility is enhanced when researchers describe and interpret their experience throughout the research process (Koch, 2006). This is because the way in which we view the world is shaped by the many intersecting personal,

social, and cultural contexts in which we live. Within this, is the presence of conscious and unconscious bias and beliefs, which influence the way in which we make sense of the world around us. The risk here, when conducting qualitative research, is that this can bias findings and as put by Dodgson (2019), we find out what we set out to find. Therefore, it is important that I provide context to the reader about my own context and how I came to study online peer support for self-harm.

I am a 29-year-old white British female and I was brought up in the North East of England, where I have lived for most of my life. I have worked in various mental health settings since 2013 and am currently training to be a Clinical Psychologist. In my career I have worked with people across the lifespan who were self-harming. In these settings, it was my understanding that self-harm was generally viewed as a secondary symptom of a mental health problem (in adult mental health services, repeated self-harm was sometimes closely associated with having a personality disorder). Working with people with learning disabilities was pivotal in changing my perspective on self-harm. It was only in this setting where the multiple functions of self-harm were thoroughly discussed and appreciated, and here I gained a broader understanding of self-harm.

There has been little consideration in my professional career of online behaviour and how this contextually fits into people's lives if they self-harm. Where this previously has been considered (albeit briefly) is when working with children and young people. There is recognition that the online world is significant to children and young people and in relation to self-harm. When working with young people, I took a very cautious approach to discussing online behaviour, often only considering it from a risk assessment perspective, as a potentially harmful behaviour. I had never considered signposting the clients to online communities, both because I lacked awareness of them and also because I perceived the online world to be largely harmful in relation to self-harm. My age, and the culture I grew up in has also had an impact on these beliefs. I grew up in the era of "pro-anorexia" forums, where users encouraged each other to pick up, or continue with negative practices around food and therefore I was cautious about the harms of online peer support.

As an adult, who uses some social media platforms, this has also influenced my assumptions about the online world. When conducting interviews I noticed on some occasions I had a tendency to refer to the offline world being the “real world”, which perhaps suggests an unconscious preconception that I held that interactions online may be less legitimate or authentic than offline. This may be shaped by my own online behaviours. I have had limited experience of membership of online communities, although have often looked to forums and groups in relation to health advice. I held a general sense that these communities can be somewhat unreliable and have a preference to seek professional support if needed. I was brought up with a respect for professionals, in most fields and held beliefs that professionals generally “have the answers”. This belief has faltered through my own experience of interactions with other professionals (both personally and professionally). Over the last 12 months, I would consider myself to have a more balanced view, with a greater awareness of the limitations of professional spheres of knowledge and a greater appreciation of the value of lived experience.

In terms of the interviews themselves, there are several ways that my own personal experience may have shaped the way I conducted the interviews which I will now discuss. As a novice researcher, I lacked confidence in the early stages of interviews. This meant that at times, I did not ask relevant follow up questions which may have led to further clarity or a more in-depth response from the participants. As the interviews continued, my interview technique improved, and I felt less preoccupied with adhering to the interview schedule in a rigid way.

My identities as a professional and researcher were both relevant to the interpersonal processes that were present during data collection. Although I was taking the role of researcher, I could not separate from my identity as a Trainee Clinical Psychologist and this was sometimes an uncomfortable position. As the interviews continued and I started to hear stories of some the participants’ negative experiences with mental health professionals and services, I became increasingly aware of my role as a professional and that I could be seen as untrustworthy. This made me quite anxious as I was worried that it



would impact how open participants were with me. However, my dual role as a researcher almost seemed to mediate this and they held positive assumptions of my views on self-harm, with one participant stating: “The fact that you’re researching this probably means that you don’t think horrible things about self-harm”. It was true that I empathised a lot with many of the participants during the interviews and I was very aware of balancing wanting to be trusted by participants whilst ultimately conducting credible research. There were occasions during the interviews that I noted I did not follow up on certain relevant conversational topics (for example, I noted with one participant who was quite closed in her responses, I did not follow up or probe certain responses she provided). It is therefore possible that the depth of conversation was impacted by my worry about being untrustworthy and my concern with ensuring the participants felt listened to.

Furthermore, it is important to acknowledge how other aspects of my identity, such as age and gender influenced the research process. I chose to share a photograph of myself on the research advert and therefore all participants would have been able to make assumptions about aspects of my identity (such as age, gender and race) prior to deciding to participate in the research. As a female, I shared this demographic with the majority of the participants and this sameness between us went unvoiced. However, during the interview with the male participant, I was aware of the gender difference between us, and I brought up the impact of gender on his experiences. I had assumed that as a male he would find it more difficult to talk about his experiences, both in the interview and in accessing services due to his maleness. I was surprised to find that the participant was more open than expected with me, and perhaps had not considered the issue of his gender as relevant as I had in terms of his experiences. Two of the female participants who were a similar age to me also assumed that we would have similar interests and suggested I watch TV programmes, or live streams. It is true that it is likely we had similar interests and I found that with these two particular participants, the conversation felt more natural and less rigid than with others.

## **Chapter Three: Results**

In this chapter, the results of the analysis will be presented along with direct quotes from the participants to demonstrate the themes described. Pen portraits have also been included to provide the reader with a clearer description and understanding of each participant.

### **Participants**

All eight participants were adults (over the age of 18) who were members of the online peer support community. Participants' ages ranged from 20 – 55. Seven of the participants were female and one was male. The participants lived in various locations across the UK. All participants had been a member of the Facebook group from time periods ranging between two months and four years.

### **The Facebook Group**

The online peer support community being indirectly studied is a private group on Facebook, created and maintained by a peer-led self-harm charity. Only those accepted into the group by moderators have the ability to access, read and post content onto the space. The group is easy to access with group members simply having to agree to group rules before being permitted to join. At the time of writing, the group had over 3000 members. The Facebook group is peer moderated and a group of moderators read content and ensure that members are adhering to the group rules. The group rules include that no graphic photos be posted on the group and that members must post the relevant “content warnings” (to include but not limited to: “abuse, self-harm, suicide, “wound advice needed”) prior to posting content on the page. Users are also advised against contact outside of the group (through sharing of telephone numbers or directly private messaging one another).

## **Pen Portraits**

### Jane

Jane had been a member for four months and was quite active on the group. She was receiving therapy for her mental health whilst accessing the group but had found it difficult to talk to her health professional about self-harm specifically. She had previously accessed another online forum for self-harm but found the information was outdated and therefore found it unhelpful. She was attracted to the group because it was a closed (private) group, and she had privacy concerns. She came across as very positive and appreciative of the support she had received from the group so far. The interview with Jane felt quite formal as she was a little guarded in discussing her personal experiences.

### Harriet

Harriet had been a member of the group for approximately six months. She had self-harmed for approximately five years and was receiving NHS mental health support at the time of the interview. However, she was not completely open about her self-harm with professionals. She was very active on social media platforms and other online communities (unrelated to self-harm) which she found useful and she was receiving mental health support from professionals at the time she was interviewed. There was a sense with Harriet that she had conflicting thoughts around how helpful she found the group. Harriet was extremely open during the interview and very detailed in the way she shared her experiences and the interview felt quite informal because of this.

### Lisa

Lisa had been a member of the group for two years. Lisa had talked to some family and friends about her self-harm but had varying responses, which were not always helpful. She had previous experience of therapy and found it hard to open up to the therapist and articulate how she felt. She was attracted to the online group because of this - particularly because she could write her thoughts and experiences down. However, she had some negative past experiences of online peer support (receiving negative feedback from other

members) and this meant she was quite cautious about posting online. She was quite anxious about talking about her experiences with me, however she became more relaxed as the interview went on and as a result became more detailed and specific in her responses. She was reflective and able identify a lot of meaning in some of the experiences she shared with me during the interview.

### Gareth

Gareth had been a member of the group for approximately four years. He had a lot of prior negative experiences with mental health services, explaining that he struggled to find and access services that would provide him with support for self-harm. He had found third-sector organisations extremely helpful in understanding and managing his mental health and self-harm and was a member of another face-to-face mental health peer support group at the time of interviewing. He came across as passionate about bettering systems for people who self-harm. In the interview he talked candidly about his experiences and this meant that the interview flowed naturally.

### Samantha

Samantha had been a member of the group for two years. She lived in a rural location and had not disclosed her self-harm to many friends or family. She was reluctant to seek professional support due to living in a close-knit, small community so was actively looking for informal support for self-harm online. The Facebook group was her first experience of discussing self-harm openly as she had not disclosed self-harm to her GP, or other professionals due to privacy concerns. She had previously accessed online peer support for a health condition and found this experience helpful. Samantha used a lot of humour to share some of her experiences and came across as very personable in the interview.

### Colleen

Colleen was the first participant I interviewed and very active member of the group since joining approximately 18 months prior to the interview. She had limited experience of social media and online peer support prior to joining but had sought professional support for

self-harm through her GP and mental health services in the past. She was encouraged to join the online group after being involved with the charity and finding their support information useful. She was shielding for health reasons during the pandemic, which she had found difficult in terms of isolation. Colleen came across as knowledgeable about self-harm and was very honest in the way she shared her experiences, despite finding it quite challenging to talk about in the interview. She shared that she wanted to take part in the research in the hope it would improve others' understanding of self-harm, based on her own experiences of feeling her self-harm was misunderstood by others.

### Ashleigh

Ashleigh had been a member for three years. She shared that she had not used the Facebook page for some time, as she was feeling in a good place. She had been self-harming since she was a teenager and had difficult experiences of trying to hide her self-harm. She had accessed professional support in child and adolescent mental health services (CAMHS) but had found it difficult to access services as an adult, so the accessibility of the Facebook group was appealing for her. She had previously joined other online peer support groups for mental health, however not specifically for self-harm. Ashleigh came across as very mindful of others and this seemed to influence how she used the group and what she chose to share with other people. This meant that she was sometimes cautious about posting or interacting on the group. In the interview, Ashleigh was slightly more descriptive, than reflective about her experiences and seemed quite guarded about talking about the personal impact the experiences had on her.

### Rosie

Rosie had recently joined the Facebook group about three months prior to the interview taking place. She had no previous experience of accessing online peer support for self-harm and joined after struggling to find support that was specific for self-harm. She was receiving professional support at the time of the interview, which she had found helpful but worried about letting people down (including her therapist) by self-harming. The interview

with Rosie felt very comfortable and conversational. She came across as articulate and reflected often about where her own beliefs about self-harm had come from and the impact that talking about self-harm had on her.

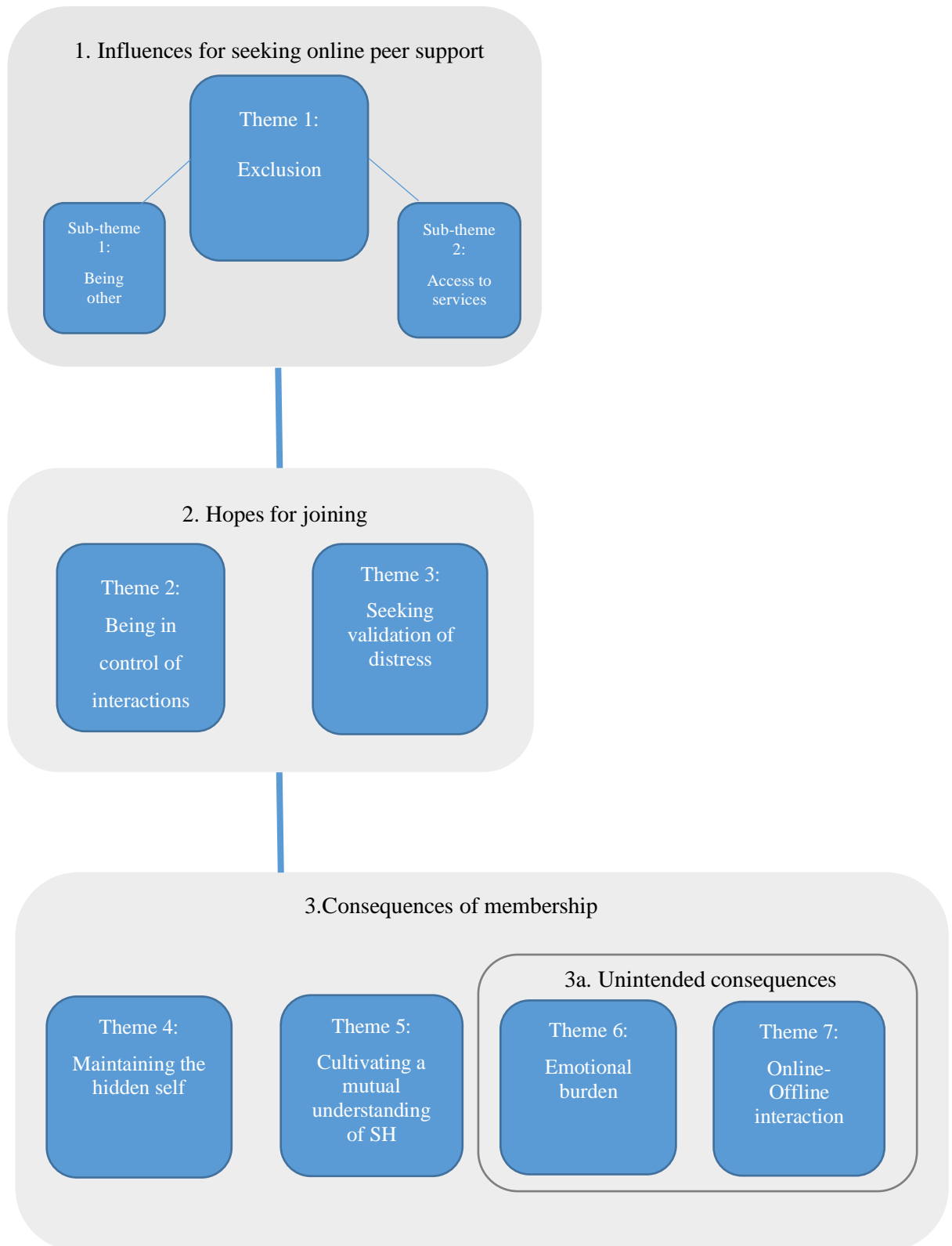
#### Further participant contextual information

Half of the participants found the Facebook group directly through actively searching online for self-harm support. Others had learned about the Facebook group through seeking support from the charity. Two of the participants were signposted to the charity by professionals (one GP and a support worker) and another had heard about it via a recommendation from another third sector organization (not specifically self-harm related).

Only one of the participants had never accessed professional support for self-harm. At the time of the interviews, three of the participants were concurrently accessing support through NHS services and had contact with professionals; this included a Psychologist, Mental Health Nurse, and a Therapist (unspecified). Other sources of support were being used by two other participants, including pastoral support and another mental health peer support group (not specifically self-harm related).

## **Qualitative Results**

The study aimed to explore the use of an online peer support group for adults who self-harm. The research questions considered the influences and hopes for joining online peer support for self-harm. The research questions also considered whether the participants' needs were met through their experiences of online peer support, which is understood through the consequences of membership. The analysis of the interview data yielded seven main themes and two sub-themes (see Figure 1). In this chapter I will present the themes and sub-themes. An initial summary of each theme will be provided with subthemes further described. Direct quotes from participants are used to illustrate the data and ideas presented in each theme.



**Figure 1. Thematic Map**

## Description of Thematic Map

Figure 1 presents a visual representation of the themes identified in the analysis, which I will now go on to describe in further detail:

Influences for seeking online peer support for self-harm were captured in the first theme (see Figure 1, box 1). Two associated sub-themes were also generated ( “Being Other” and “Access to services”). Exclusion was experienced by participants as they felt unable to access general mental health services due to their self-harm. They also highlighted negative perceptions of self-harm (both from self and others) that made accessing support more challenging for them.

When understanding participants’ hopes for joining, two themes were identified (see Figure 1, box 2). Theme two, “Being in control of interactions” refers to participants’ hopes that seeking support through an online medium would provide them with a level of control regarding interactions with others, which they were not able to exert offline. Theme three; “Seeking validation of distress” is self-explanatory and refers to participants’ hopes that the community would offer validation in response to their experiences of distress.

When understanding whether participants’ needs were met through the engagement with an online peer support community, four themes were identified (see Figure 1, box 3). Theme four; “Maintaining the hidden self” illustrates how participants maintained a degree of secrecy about their self-harm. Theme five describes how being part of a self-harm peer support community allowed participants to cultivate a mutual understanding of self-harm with their peers.

Figure 1, box 3a, presents the consequences that would be considered as unintended for participants (for example, not what they were looking for, or expecting when joining the online peer support community). These are presented in the final two themes. Theme six; “Emotional Burden”, refers to participants experiencing discomfort or distress as a result of group interactions. Finally, theme seven; “Offline- Online interaction”, refers to how



participants were able to integrate what they have learned or experienced in the group into their lives in various ways.

## **Description of Themes**

*Influences for joining an online peer support community*

### **Theme One: Exclusion**

This theme refers to the experiences of exclusion that participants have experienced in the offline world, specifically their experience of negative stereotypical perception around who self-harms and why, and also their difficulties in accessing mental health services. This main theme was then broken down into two sub-themes (“Being other” and “Access to services”).

#### **Sub-Theme One: Being Other**

Being Other refers to participants’ understanding of their identity in relation to their self-harm. Feelings of social isolation and experience of being different from groups of peers in the offline world has a symbiotic relationship with their drive to find other people they could relate to, because of their mutual experiences of self-harm. The more participants felt isolated and different because of their experiences with self-harm, the more they felt compelled to find others who they could identify with:

*“I just needed some more support other than professionals. I wanted to talk to people who have gone through similar things to me or other things...because, they (professionals) haven’t necessarily gone - although I wouldn’t know, but I believe they haven’t gone through injuring themselves” (Jane)*

The quotes above demonstrates Jane’s hopes to find people she could identify with. This was based on her previous experiences of talking to her health professional about her self-harm and feeling as though the professional was “repulsed” by her disclosures around self-harm.

Participants spoke about various experiences where they have felt excluded by societal beliefs of self-harm. Many participants described how they felt different from peers because of self-harm. The quote below describes how the participant considers self-harm as something that not only set her apart from peers but something that was not human:

*“And that I wasn't weird. Well I am weird but I'm not the only weirdo! Like hurting yourself when you don't want to die is just something that people...like it's completely against like what a human should do, you know?” (Samantha)*

Samantha's account above demonstrates her desire to connect with others who shared the same non-conforming identity. There were many uses of negative self-descriptive words such as “weird”, “abnormal” and “freak”, with participants being noticeably aware that it was their experiences of self-harm that engendered these negative labels of themselves. Because of their experience of self-harming, participants viewed themselves as different and that they did not “fit in” with societal norms. One participant described how the experience of finding out there was a group for adults who self-harmed normalised her experience of dealing with distress:

*“I think it's kind of how I felt when I first self-harmed, like this isn't normal, why can't I just deal with things like a normal person? But actually finding out that there are other people that feel the same and do the same things, that makes it kind of easier to deal with.” (Rosie)*

Alongside their own internal attributions of being “other”, participants also reflected on the societal stereotypes and negative assumptions of self-harm. Some reflected that their understanding of self-harm was shaped by their early experiences and the negative assumptions about the meanings of self-harm.

*“Like I remember from school, if anybody talked about self-harming it was like an attention seeking thing” (Rosie)*

Participants discussed assumptions about the characteristics of people who self-harm. For example, self-harm being seen as a childish or adolescent, female behaviour and being associated with specific music genres.

*“Like a lot of people say oh it’s just – what do people say? It’s just it’s a phase. That’s the one and like, oh it’s just a teenage phase, oh they’ll get over it, oh they’ll stop and it made me feel really alone I guess, because I was still really struggling and no one was really helping” (Harriet)*

*“...like it’s just emo teenage girls sitting in a corner with a razorblade, like listening to My Chemical Romance or something.” (Samantha)*

The quotes above describes both Harriet and Samantha’s understanding of the stereotypical “self-harmer”, and how they could not identify with these stereotypes. The lived experiences of the participants contrasted with the negative assumptions and stereotypes that they have been exposed to. Adulthood was a characteristic that challenged stereotypes of self-harm, leaving Samantha reflecting on how others perceived her self-harm scars, in the context of her being an employed 27-year-old woman.

*“If I was a teenage girl and people saw my scars they would assume that’s what it was but because I’m not, I’m a twenty-seven year old woman who seems pretty mentally stable, can hold down a job, is relatively happy...or seemingly. So people just...they don’t expect it”*  
*(Samantha)*

Another participant described her own surprise at the age of other group members, when she first came across the group:

*“...look at all these other people who do it, they’re like actual adults doing it. Like it’s not just a kid’s thing (Harriet).*

Harriet referred to “actual adults” on two occasions in the interview when she discussed her peers in the online group. When explored, this was an idiosyncratic term that she used to describe adults who lived fully independent lives (e.g. had jobs, families and responsibilities) and was used to indicate her surprise that adults, who were significantly older than her also self-harmed.

## **Sub-theme Two: Access to services**

Being unable to access professional support, and dissatisfaction with care were factors that influenced participants to seek online support. All of the participants spoke about their experiences of attempting to access professional support for their self-harm. Many of the participants spoke about finding and accessing the group in their journey of finding professional support for self-harm. Some struggled to access professional support or were seeking support that was specifically for self-harm, which was not readily available.

*“...finding somewhere that would take me or that sort of thing, was all totally new to me”*

*(Gareth)*

All but one of the participants had previously or were currently accessing professional support whilst also being a member of the group. Despite two positive accounts of accessing NHS mental health services, self-harming was mostly described as a barrier to receiving professional support. One of the participants discussed the conflict of feeling pressured to stop self-harming in order to access therapy, but needing to talk about how she was feeling, in order to stop self-harming.

*“And one of the experiences that people seem to have is that they can't access therapy if they admit they that they still self-harm. It seems to be a barrier to therapy which means that you can't get support until you stop. Well, very often stopping is something you need to build into your therapy, rather than – and hopefully when you feel better you won't need to self-harm, rather than stop self-harming before we'll talk about how you feel. That feels a*

*very unrealistic way around it.” (Colleen)*

Participants viewed the accessibility of the group as a factor that influenced them to join. The restrictions to accessing mental health services were highlighted in a number of the interviews. Some of these were related to physical barriers, with one participant who lived in a rural area finding it difficult to access support for self-harm. The receptionist at her

local GP surgery was a family friend, which made her reluctant to seek support through this route through fear of being exposed.

*“I live in a very rural area, it’s quite hard. It’s got a small GP surgery and everybody knows everybody and it’s just you have to go to your GP and be referred you can’t just refer yourself because there’s nowhere around to go.” (Samantha)*

Many participants described needing and valuing accessible, “in the moment” support in response to immediate distress or thoughts of self-harm, which they could not readily access via professional routes. Moreover, participants spoke about having difficult experiences late at night and needing out of hours support which limited the services they could access. The fact that the peer support community was a large group was encouraged participants to join, as they thought it would be more likely that they would receive support from other members. The impact of COVID and the pressure on services was also highlighted as a reason that offline peer support was seen as a more accessible route to getting support:

*“unfortunately the isolation of COVID has meant that a lot of people’s mental health has been put under pressure. But at the same time a lot of services have stopped, so it’s been quite difficult if people were struggling already because they’ve had a lot of their face to face support removed at the same time.” (Colleen)*

*Hopes for joining an online peer support community*

## **Theme Two: Being in Control of Interactions**

This theme refers to the importance of control for participants in accessing online peer support for self-harm, specifically, in terms of how they choose to access, engage with, and receive support. Participants cited the anonymity of being online, and the way in which the online world can mediate interactions between individuals, as ways they could control their experiences of discussing their experiences of self-harm.

Being online and sharing their experiences in an online peer support group allowed participants to feel in control of their interactions in relation to self-harm. Having the option to be able to type their thoughts and feelings made interactions feel easier for one participant who struggled with expressing herself in social situations:

*“I struggle talking face to face. I kind of get like - If I get anxious I’ll kind of get words all muddled up and all this and that. Being offline is a complete different feeling cause you haven’t got the security of like, taking two minutes to just get your thoughts together and then write things”. (Ashleigh)*

Similarly, another participant shared her conflict of wanting to share her experience of self-harm with others, but also feeling scared to disclose in person. Online peer support offered her a way of talking to others in a controlled way:

*“And I did want to share stuff but I were just too scared to and that’s kind of why that like got suggested and I thought, oh you know... maybe - maybe I might be able to start opening up, kind of thing a little bit. So that’s what I kind of thought I’d be able to do without like saying too much to people...” (Lisa)*

Having the option to engage or disengage from the group, or talk to different people also made participants feel more comfortable about discussing their experiences:

*“It’s like an online counselling session but you weren’t limited for time, you had a nice person or you had the option to change people if you needed to, or you weren’t restricted” (Ashleigh)*

Additionally, the impermanence of online interactions also added to the sense of control one participant had when considering joining the group:

*“I was like you know what people post venty [sic] stuff all the time about how bad everything is, like the worst that could happen is I’d just delete the post in the morning.” (Harriet)*

Anonymity and privacy were spoken of as particularly important for participants. Accessing support through an online peer support group gave participants a sense of control in who they were sharing their information with. Participants linked the online anonymity with being able to speak more freely, without potential perceived negative consequences.

*“You know that friends can't see it. You know that your family can't see it, so it feels safe in that respect of whatever you're typing” (Rosie)*

Another participant expanded on these ideas of anonymity and discussed this as being synonymous with safety. He explained that being in an online environment allowed him to share thoughts and feelings that he would not typically share elsewhere.

*“And a safe place just to be able to put your innermost deepest, darkest thoughts and feelings” (Gareth)*

The anonymity of the offline world created a sense of psychological safety that was discussed by many of the participants. This encouraged participants to post, as they felt that they could disclose to other people without receiving unwanted intervention:

*“I just needed someone to listen who wasn't gonna' do anything about it if you know what I mean” (Harriet)*

Harriet went on to discuss that she did not want psychological intervention in response to her disclosing her experiences relating to self-harm. This was also impacted by her previous experiences of contacts with the crisis team and discussion with her community psychiatric nurse. Her concerns were that intervention would lead to her not being able to continue her university studies:

*“I wasn't going to go to the crisis team cause I know that they'd do stuff. Like I don't want that, I don't need that, that's not gonna' be helpful for me, so I was like, Facebook it is.”*  
*(Harriet)*

### **Theme Three: Seeking Validation of Distress**

This theme refers to the way in which participants were seeking validation of their distress online, as a result of having their experiences of self-harm invalidated in the offline world. Participants' understanding of self-harm was influenced by their personal experiences, interactions with friends and family, and the depiction of self-harm in the media. They described how self-harm was largely understood in a negative context, commonly linked with attention-seeking and demonstrating an inability to cope. Participants did not feel that this understanding was reflective of their experiences and did not view it as helpful in understanding their own self-harm, or how to manage it.

Participants spoke about feeling misunderstood by professionals in the offline world. As a result, support and advice from professionals was seen as unhelpful, or outdated. They spoke about feeling as though their experiences with self-harm were invalidated in the offline world, through interactions with friends, family, and professionals:

*“There’s a lot of very sort of old-fashioned advice about substituting self-harm with effectively another form of self-harm, like holding ice cubes or flicking rubber bands on yourself. Both of which are ways of hurting yourself, they’re just ways of hurting yourself that upset other people less (laughs)” (Colleen)*

The use of the term “old-fashioned” suggests that the advice that participants were given in terms of how to manage their self-harm, was deemed outdated and unable to meet their current needs. Participants shared experiences of professionals focusing on getting them to try to stop self-harming but feeling unable to do this without being supported to understand the reasons they were doing it. This left one participant feeling misunderstood:

*“You know people just weren’t...they just weren’t getting it and medical professionals were saying stop” (Gareth)*

Participants perceived professionals’ responses to be overly focused on getting them to stop self-harming. When discussing experiences of accessing professional support, one



participant described her understanding of professionals' attitudes to self-harm and how this conflicts with her understanding of why people self-harm:

*“they’re actually doing it very often to help them deal with suicidal thoughts and to avoid suicide, rather than to get ready for it and that seems to be an attitude that is still prevalent with doctors and nurses within the NHS from having talked with the mental health specialist at my GP and having talked with GPs as well previously.”(Colleen)*

Participants generally rejected the ideas that self-harm was synonymous with suicide, however accepted that this was a common view held in society. To have their self-harm validated as an experience in itself was something participants were looking for when joining the group:

*“Just to be hopeful that I could be free to say what I wanted without being judged, to talk about - to be able to talk about how I was feeling, what I might have done and just be reassured by people that might have gone through similar things.” (Jane)*

One participant discussed that she was specifically seeking validation from others for her self-harm:

*“I know there's this place I can go and I can be like, oh these people are doing it it's fine, and have that validation that everything's okay. Even if it's not.. like because I'm not the only one in that situation.” (Harriet)*

This account was quite different from the others, in that Harriet was not seeking particular words of comfort, agreement or support. Here, Harriet suggests she was directly looking for others who responded to distress in a similar way, to validate her personal experience of self-harm. There is a procedural manner in the way Harriet describes wanting to access the group, suggesting that she viewed this validation as a potential way of counteracting feelings of shame or discomfort about past or future episodes of self-harm.

Being simply told to stop self-harming from professionals was viewed as largely unhelpful for participants. They felt they needed support to do that, through understanding

the reasons why they were self-harming and wanting to have their experience of distress validated. Being unable to access support because of self-harm did not allow participants to have their experiences validated and contributed to negative judgements they felt from professionals and their own negative attributions of being abnormal. As a result, participants did not feel their expressions of distress or ways of coping with self-harm were acceptable and were therefore seeking validation of this online.

#### *Consequences of membership of a peer support community*

### **Theme Four: Maintaining the Hidden Self**

The group acted as a platform for participants to discuss self-harm and share experiences that they typically chose not to share offline. This seemed to be a response to the tension that many participants spoke of; of wanting support, but not wanting or feeling able to be completely open with others offline about their self-harm. All of the participants spoke about ways in which they had hidden self-harm in the offline world. Samantha spoke about fabricating a story to explain her self-harm scars when she was asked about them:

*“I mean because I’ve only told the two people, my experience of the real world is quite limited. I mean people have commented on my scars. Generally they don’t assume that they’re self-harm scars because people don’t, unless you’re a teenage girl (laughs) for some reason. Although one person who - I tell everyone it was my cat generally cause they’re idiots (laughs). And he was like it looks like self-harm scars and I was like well it was my cat...” (Samantha)*

Many participants spoke about their self-harm as a distinct part of themselves, which they kept separate from the visible parts of their identity that they present to friends, family, or employers. Although some participants spoke of sharing their self-harm with friends, family, or professionals, they still chose to conceal it in other aspects of their life.

*“I mean I don’t, I am not, NOT going to talk to my mother because you know it’s just...there’s no need I don't think” (Samantha)*

Despite thinking there was no need to tell family or friends, there was a conflict in wanting to disclose or share their experiences of self-harm, but only with specific people, or certain groups.

*“But then because I know like they (family) don't get it, I don't tell them anything and then I – but then I knew that at the same time I had to try and find some way to like open up to people and that that's when they started suggesting like these groups (Lisa)”*

The account above describes Lisa’s conflict around wanting to open up to people about her self-harm but due to feeling misunderstood by her family, she made the decision not to do this. The online peer support group acted as a way she could manage this conflict, as she felt more comfortable that her true experiences of self-harm would be accepted by her peers.

One participant also described her self-harm as a concealed aspect of her identity that she had successfully kept hidden from certain people in her life for many years:

*“... if you've known someone for 20 years to turn around and say well actually this is part of my past and this is something that's going on at the moment. Cause’ that's just not part of you that they know. So finding a group of people that were...completely accepting of that was really helpful” (Colleen)*

The reference to Colleen’s self-harm being a part of her that others did not know suggests that her self-harm was a concealed aspect of her identity. As a result, she been able to maintain this secrecy in certain social situations, whilst also being able to maintain longstanding relationships in the offline world. Yet still, she sought some social feedback in relation to self-harm, which she was able to access online whilst also continuing to keep self-harm hidden offline. Similarly, other participants recognised that there was a desire to connect with others where they could be less guarded about revealing the part of themselves, they had typically concealed in society.

In relation to help-seeking, participants spoke about the group being a place where they were able to talk openly about their experiences of self-harm. Interacting online was associated with being free of some of the consequences that they perceived as negative (e.g. people offline finding out about self-harm, being hospitalised, career prospects, upsetting loved ones).

*“so whether it’s because they can’t do anything about it cause it’s anonymous or whether it’s just mutually agreed that even if you’re in crisis they’re not gonna’ do anything about that. I guess I find that pretty helpful cause then you don’t have to worry about repercussions or implications of saying anything... when I talk to my mental health nurse [name] there are certain topics which I just can’t bring up cause I just know they’re gonna’ result in her moving things along or changing the way things are done or changing the situation which I don’t want” (Harriet).*

The quote above describes how by seeking support for self-harm online, Harriet felt less concerned about the consequences of sharing details of her self-harm than if she were to disclose the same information to her health professional. She discussed how she purposefully withholds some information from health professionals through fears that this would negatively impact her education and future career prospects.

Many of the participants had privacy concerns and viewed the anonymity of the group as especially important to them. They were worried that Facebook friends who did not know they self-harmed would be able to see their posts on the group.

*“...there’s only certain people that know what I’m going through. And Facebook is such a big thing and you know depending on how you post. It depends on whether it’s worldwide, whether its certain friends you know, and I just want to keep you know things personal and private unless I decide to tell people what I’m going through”. (Jane)*

This theme captured the factors that contributed to participants going online for peer support for self-harm. There was a strong desire to connect with others, in a way that would simultaneously maintain the secrecy of self-harm offline. This partial disclosure process

protected participants from the perceived negative consequences of people finding out about their self-harm, such as impacting education and future prospects, but also perceived social consequences such as upsetting friends and family, or letting down professionals. The anonymity of the group and private nature helped participants feel protected from the intrusion of non-self-harmers.

### **Theme Five: Cultivating a Mutual Understanding of Self-Harm**

This theme explains how membership of the group led to participants developing a mutual and shared understanding of self-harm. In relation to participants' understanding of self-harm, interaction and membership of group had opened up a novel and welcomed perspective for many of the participants. This occurred through directly posting themselves, receiving responses and observing interactions between group members. A common experience amongst the participants was that their experience of self-harm had been validated, by the mutual understanding of considering self-harm as a coping strategy or mechanism. This contrasted with general views they had experienced from others offline.

*“Essentially what it is, is a coping strategy, it's just a coping strategy that a lot of people don't agree with” (Gareth)*

*“Because they understand the reasons behind it and it is a coping mechanism, it's a much broader approach to supporting you rather than just stop” (Rosie)*

This appeared to be a valued perspective of self-harm. Having a shared understanding of the reasons underlying participants' self-harm, strengthened the mutual understanding of self-harm within the community. It was recognised that this is not a view that is often advocated or appreciated by other professionals, or family.

Almost all of the participants spoke of the benefits of being able to be around other people who self-harm. There was an assumed level of understanding, which was grounded in other members' personal experiences of self-harm. Within this, there were also

assumptions that professionals did not self-harm and therefore could not completely understand how to support individuals who do.

*“[a counsellor] might be well trained and they might have read a million books but real life experience, real life know how and real life understanding them feelings... if you haven't experienced self-harm they just don't get it.” (Gareth)*

Another participant also shared a similar assumption that professionals do not or have not self-harmed and therefore believed they would not be able to truly understand the experiences that people who self-harm want to share. Jane believed that those who have not self-harmed would think that she was “repulsive” because they were unable to empathise with her.

*“Because, they haven't necessarily gone - although I wouldn't know, but I believe they haven't gone through injuring themselves.” (Jane)*

Part of the mutual understanding that was generated between group members was based on an assumed level of acceptance. One of the participants explained that there was a mutual level of acceptance underpinning the interactions on the group, which made seeking and receiving suggestions on management of self-harm easier:

*“I think part of it is being able to start from that sort of pragmatic approach, because there's a level of acceptance amongst the people who are on there – it's peer group, this is something that's touched all of us. So nobody's particularly shocked or taken aback or you don't have to explain yourself in the same way.” (Colleen)*

*Unintended consequences*

## **Theme Six: The Emotional Burden of Peer Support**

This theme refers to the negative feelings participants experienced as a result of being a member of the group. Participants explained that accessing the group (either to post themselves or reading other people's posts) was not always a positive experience and did

have the potential to evoke some difficult feelings. As a result,, participants sometimes felt more or less able to engage with the group at different times. This was influenced by participants' mood and emotional state in general.

*“– it’s kind of like a different way when you’re looking on it on a good day or bad day. Like you read it differently I think. I don't know, I see the group in a different way, so I sometimes like feel like two different people, like on a good day or a bad day and I don't know, like on a bad day like sometimes I just can’t even read through some of the like posts where people are like struggling, because it’s just too much to like read someone else’s struggle. So I probably don't go on it as much on bad days and when I’m actually poorly I should be posting on there myself but then I don't.” (Lisa)*

Being a member of the community also brought about a sense of responsibility for other members, either in terms of offering support, or by concerns of causing distress to others because of what they chose to post on the group.

*“I’m always scared of like how I would affect other people from what I might post if I’m like in a bad way, I mean.” (Lisa)*

Despite the anonymity of posting online, the quote above still suggests that some participants do worry about the consequences of disclosing their thoughts feelings and experiences in relation to self-harm. The reference to being in a “bad way” further suggests that participants' mood state plays a role in their decision to post online, with more caution being taken if they were in a negative mind set. In contrast, one participant suggested that the element of choice and control for peers, freed her from feelings of responsibility for others, which in turn, helped her feel more comfortable about posting:

*“So like people choose to read it, so you don't feel like you’re putting anything on anyone because if you want to read it you can.” (Samantha)*

There was an additional a sense of responsibility for participants to respond to other members of the group when they posted online. Being unresponsive when others posted evoked feelings of guilt if participants were then unable to or did not want to offer support.

*“it's supposed to be like a community where you're like supposed to support people and like you're supposed to support each other and like I just joined this group and then I was like I just didn't do anything.” (Harriet)*

A concern for some participants was that accessing the group to simply seek support, but not offer support for was seen as less community focused. Participants suggested that there is almost a “pay off” for members for seeking support (they had to feel as though they had earned the support they received, by volunteering their own support to others). One participant described how initially offering support to others made her feel more comfortable, as opposed to immediately seeking support herself, suggesting that she felt it necessary to earn her place in the group first.

*“Because I often put people before me, so me offering support out there was a way of getting trust for that page I suppose. And then that helped me if I needed help. I could put something out then. Cause' I knew, okay, well I've offered my support...” (Ashleigh)*

Interestingly, this was not a thought that any participants shared about their peers, and they did not question the legitimacy of others' support needs. But for some participants they were aware of “taking” more than they “gave” to the group, which resulted in feeling guilty. There was a common assumption that contributing positively to the group included both giving and taking support. However, one participant discussed the value in being able to simply observe interactions without contributing:

*“But I also find it useful, not from a posting point of view, although I do find it useful from a posting point of view, but just you know when other people post and read their comments and read the feedback that they get. So it's like, if somebody's put a post up and they're struggling and then the feedback that they get. I seem to find that useful as well myself, you know even if I don't comment on that post or anything.” (Gareth)*

Although Gareth did not share similar negative feelings about not responding to the posts himself, he acknowledged the value of interaction and feedback on the posts.

Some participants spoke about considering the wellbeing of peers and at times having to tolerate the uncertainty of not knowing how they were after they had posted.



Reading, but also responding to others' posts evoked a sense of responsibility for participants. Although posts are posted in "real time", there is no requirement for members to respond, reply or maintain conversation. In some cases, this was difficult for participants to tolerate. The quote below describes the emotional impact that the lack of follow up from fellow peers can have. In this instance Ashleigh was left worrying about a peer's wellbeing:

*"There's been ones where I've helped people and then you're like are they still alive? You don't hear from them again, so you're like, okay, what do I do now?" (Ashleigh)*

One of the participants spoke of being on the other side of this type of interaction, after receiving support and feeling as though she owed it to those who had supported her to not self-harm. The use of the word "forced" in her account suggests that she felt obliged to repay those who had offered her support.

*"having them almost be like rooting for me and letting me know like we're here and let us know how you're getting on like it kind of almost forced me to stay clean if that makes sense. (Harriet)"*

Almost all of the participants referred to the experience of being "triggered" by the content on the Facebook group. There was a shared understanding of what it meant to be triggered by a post, or content online. Being triggered referred to a state of being distressed as a direct result of the content that participants observed in the group. Some participants talked about an associated relationship with their mood state and whether they would be triggered by content. They described how they were sometimes more or less able to tolerate content that could be distressing, based on how they were feeling at the time of accessing the group.

*"if I'm feeling a little bit more kind of fragile, I won't scroll through them as much as I would sometimes or just stay away from them."*

Another participant shared similar feelings, explaining that he had actively exercised caution about what he was reading or viewing online. This was based on his previous experiences of finding some posts distressing:

*“I think when my moods lower and I’m more unstable, there’s a period of time when I have to be wary about what I do because some stuff I could find upsetting and could make me worse.” (Gareth)*

Participants discussed the group rules, which were outlined upon joining the group and then enforced by the moderators of the group (also peers who self-harmed). The rules acted as precautions were put in place to “protect” members from being triggered. This suggests that being “triggered” is a common peer- group experience. All of the participants spoke about one of the group rules that asked members to preface their posts with “TW” (Trigger Warning) if the poster believed that it contained information or content that could be seen as distressing. Graphic pictures of self-harm were also removed by the moderators. Most of the participants valued the group rules, although there was an acknowledgement that not all members adhere to the group rules, which can lead to inadvertently viewing content that was distressing. Additionally, despite the precautions put in place to moderate content, there was also recognition that the Facebook algorithm meant that this took away some of the control and choice around engaging with the group and its content:

*“...it'll just come up on your newsfeed sometimes, of like a post somebody's written and you kind of find yourself reading it without really noticing what you're reading and then you'll suddenly think, oh I didn't want to read that today, or that's made me think of something else. So it is sometimes quite difficult to avoid when it's coming up in your newsfeed as well”. (Rosie)*

Whilst some participants actively avoided posts and content that could be triggering, two of the participants spoke about actively looking for content that could be distressing. In these cases, seeing their peers’ experiences of distress helped participants regulate their own emotions.

*“I only click on groups and then [group name] if I either want to just feel like not alone or like - this sounds really bad, so don't take it like the wrong way, but almost like if I want to trigger myself. Because I'm just feeling bad” (Harriet)*

## **Theme Seven: Online – Offline Interaction**

Participants shared in various ways how their involvement with the group impacted areas outside of their lives, such as relationships with friends and family, their own sense of self and how they approached professional support. This affected participants differently, with some suggesting that membership and engagement with the group had been more influential offline than it had for others.

Participants spoke about the sense of self-acceptance they had gained as a result of membership of the group. Specifically, accepting and understanding self-harm as a result of the shared interactions they had experienced in the group. One participant recognised that the group had a significant impact on their understanding of self-harm.

*“I think without [group name] I’d have been probably still wrestling with myself and wrestling with why I do it and not understanding it and not accepting it.” (Gareth)*

The idea of wrestling with self-harm and the reasons why and the discomfort this evokes, suggests that the participant above was struggling to make sense of his self-harm as he was battling against accepting this as part of his identity, and was able to use the group to help him come to terms with this.

There were also clear changes to how participants approached some relationships or situations in their lives as a result of posting on the group or the advice or support they had experienced. Two of the participants talked about how posting on the group and the responses they received influenced them to want to have conversations with health professionals about their experiences of self-harm:

*“I haven't had like another therapy session since that post, but it's definitely made me feel like it's something I want to approach in therapy” (Rosie)*

In response to a difficult experience with her health professional, where she felt that her health professional was ignoring some of her disclosures, Jane went to the Facebook group

to “vent” about how she was feeling. The interaction that took place on the group resulted in Jane approaching the issue with the health professional, and consequently she felt this improved their relationship and was more satisfied with her care:

*“But with [group name] page and all the people that are on it, I could vent what I was feeling and knew that it wouldn't... you know that it would be fine to do that and since I said that to my health professional I think we've got a better relationship now and she's— the last appointment I had with her last week, she's actually started to address things”. (Jane)*

Similarly, another participant described how her experience of being a member of the group enabled her to be more open in other groups offline:

*“I definitely think it's helped me to like be more open in the other groups that I go to, like face to face groups.” (Lisa)*

Not only did interaction with the group influence interactions with health professionals, or other services for self-harm, but participants also shared how they felt more able to discuss self-harm with people who they had close personal relationships with, as described in the quote below:

*“being part of that group has made it easier for me to talk to people like my parents, my friends about self-harm, because it's almost a bit of an icebreaker....so I think I found it quite difficult to speak to my parents about self-harm but I said to them oh I'm doing...I found like an online peer support group for self-harm and it's helped me sometimes to explain to them like the reasons behind it” (Rosie)*

For some participants, there were clear, tangible changes in their lives (in relation to self-harm) as a result of engaging with the group. However one participant shared that she thought it was unlikely that the group would influence whether or not she self-harmed, however valued that the online peer support group gave her a place to share her thoughts and feelings, that she typically would not offline:

*“I wouldn't say it necessarily influences my experience of self-harm, because if I'm gonna' do it, I'm gonna' do it....But also like generally in terms of mental health I'd say like being a part of [group name] gives me a place to be heard.” (Harriet)*

## **Chapter Four: Discussion**

This final chapter will summarise the findings of the analysis and how these relate to the current literature. I will then discuss the implications of these findings for clinical practice. Finally, I will consider the strengths and limitations of the research and consider directions for future research.

### **Revisiting the Research Aims and Questions**

The aims of this research were to understand why individuals seek online peer support for self-harm and to understand what their experiences are of engaging with the community. Therefore, the following research questions were explored:

1. What influences users to seek online peer support for self-harm?
2. What do users hope to gain from engagement with an online peer-support community?
3. Are users' needs met through engagement with the community?
4. Are there any unintended consequences of engaging with the community?

The research questions were investigated qualitatively, and the qualitative analysis produced 7 main themes, which clearly link with the study aims and research questions. The 7 themes will now be discussed in relation to the existing literature within the field.

### **Discussion of the Findings**

#### **Influences for seeking online peer support for self-harm**

##### Exclusion

This overarching theme captured the role of societal exclusion in influencing participants to access online peer support for self-harm. Two sub-themes demonstrated how this was related to the experience of stigmatised attitudes and understanding of self-harm in society, which led them to feel different and find it difficult to access services.

### Being Other

The study found that participants viewed themselves as different from others who did not self-harm, and this was a motivating factor for accessing peer support online. Participants labelled themselves as being “freaks” or “weird” and seemed to be seeking others to either disprove or weaken these associations or in some cases alter the negative connotation with these labels. For example, rather than reject the label entirely, some discussed wanting to know that they “weren’t the only weirdo”. This demonstrated a sense of camaraderie in taking ownership of a negative stereotype. This is an example of internalised or self-stigma, which is the internalisation of perceived negative stigma towards marginalised groups (Corrigan et al., 2011). Similar negative self-labels have been identified more widely in the literature (Long, 2018) and specifically in relation to online peer support (Lavis & Winter, 2020), demonstrating the common experience of those who self-harm and suggesting that they may turn to these communities as a result of feeling misunderstood or different from other groups. There was a conflict, however, with participants agreeably labelling themselves as “abnormal” or “weird”, but clearly rejecting some of the societal stereotypes of people who self-harm, such as self-harm being associated with only teenage girls and for reasons such as “attention-seeking”. The stereotypes that were highlighted by participants (that people who self-harm are adolescent or childish, female or incapable) mirror previous findings and discussions that self-harm is often perceived to be associated with adolescence and associated with teenage girls (Chaney, 2017; Lavis & Winter, 2020). This may be due to the understanding that the common age of onset of self-harm is in adolescence, coupled with the lack of recognition or acceptance of self-harm in adulthood (and particularly in males). It was of particular note that it was the participants who recognised they did not conform to these characteristics of the stereotypes who appeared more consciously aware of them.

Another stereotype that was highlighted within the findings of this study was that of self-harm being associated with alternative sub-cultures and music relating to sub-cultures. One participant's reference to the band My Chemical Romance's music is a reference to the "emo" subculture of the early 2000s. The term "emo" is an abbreviation of the word "emotional" and is associated with a rock/punk hybrid style of music. Although difficult to define precisely, there is a very specific demographic emo stereotype; that of an adolescent who is "overly-sensitive" (Munteanu et al., 2011). Similar to the gothic sub-cultures, the emo sub-culture has frequently been associated with self-harm in the media (Millard, 2013), however, the empirical basis for this is weak and based on only a handful of studies (Baker & Bor, 2008; Trnka et al., 2018). Participants' awareness of the stereotypes associated with adolescence, coupled with the fact they did not conform to them meant that they thought others would not believe that they self-harmed. It also led to them believing that they were abnormal, weird, or unusual, in keeping with Adler and Adler's ideas of "deviancy" (2005; 2011).

These findings are important for two reasons; firstly, in adding to the literature that people who self-harm are aware of negative and stereotypical societal attitudes around self-harm. High levels of internalized stigma, experienced discrimination, and anticipated stigma are related to increased psychological distress (Quinn & Earnshaw, 2013). Therefore, awareness of stigma is likely to affect individuals' experiences of help-seeking in the offline world and this has been demonstrated elsewhere in the literature. It makes seeking help online from a specific self-harm community a more attractive option, given that participants are aware of unrepresentative stereotypes, which may make them feel more marginalised. Secondly, the results are suggestive that self-harm is more likely to go unnoticed in adulthood and more so, when considering how this is experienced by males, this issue is likely to be further compounded. This may mean that self-harm in adulthood is likely to be less recognised and understood.

Access to services



Exclusion was also experienced by participants who felt that they faced additional barriers to accessing professional support (specifically through NHS mental health services) because of their self-harm. This adds to existing findings that have noted poor access to services, specifically for people who self-harm (Quinlivan et al., 2021; McDonald et al., 2020, Samaritans, 2020). Participants spoke of not being accepted into services because of their self-harm or being told they must control or stop self-harming in order to access services. It was therefore a relief to find somewhere they could go to seek support for self-harm, without the preconditions they had met elsewhere.

A report by the Samaritans (2020) documents similar challenges faced by people seeking NHS mental health support following self-harm. Of those who were able to access support from NHS mental health services, many described that they felt excluded from services and were unhappy with the care they received (Samaritans, 2020). Similar experiences to these were echoed by the majority of participants, when they were describing their journeys into services and experiences with professionals. Five participants who had experiences of professional support through their GP, or mental health services shared stories of feeling misunderstood, having their self-harm dismissed or ignored, being negatively judged and having to hide details about their self-harm.

The experience of exclusion is significant when considering the risk for adults who self-harm. Shame and rejection elevates risk for marginalised groups (Cawley et al., 2019) and can negatively impact future help-seeking. Seeking help from an online peer support community was viewed as a way of meeting a need that could not be entirely met by services in the offline world; a place where they would be accepted immediately and without restrictions and limitations or stigma. This is clearly an attractive and important option for people who have been used, or are anticipating rejection and exclusion when attempting to access support.

### **Hopes for membership of an online peer support community**

#### Being in control of interactions

This theme highlighted the importance of maintaining a sense of control for participants when joining and participating in an online peer support community. Previous research has demonstrated the barriers that exist for adults in disclosing their experiences of self-harm, including shame and rejection and difficulty accessing services (Nada-Raja et al., 2017). It is reasonable, then, that participants seek support online, to retain a sense of control in how they chose to disclose, as this further impacts the consequences of disclosing self-harm.

Being in control was linked to the practicalities of online interactions. For example, being able to disengage or engage at times or in places that suited them, carefully consider wording during interactions and being able to delete posts retrospectively were all seen as attractive features for participants. The impermanence of online interactions offered a way for participants to retain a sense of control over their interactions. Participants found it reassuring to know that they could just delete posts retrospectively, for example, if they were unhappy with the response they received from others. Being able to carefully consider thoughts and responses prior to posting was also helpful for those who found it difficult to articulate their thoughts and feelings.

Physical proximity was also linked to being in control. An attractive feature of online peer support was being able to access it in the comfort of participants' own homes. For those who lived in rural areas, and where support options were limited, this had obvious benefits as it gave them options for support that they would not have had access to otherwise. For others who described having social anxiety, this was viewed as particularly helpful, as it meant avoiding potentially stressful situations. This could be viewed both positively and negatively in terms of the benefits of online support. Lawlor and Kirakowski (2014) argue that the lack of physical proximity in online peer support may contribute to increased isolation and discourage people from accessing support elsewhere. On the other hand, Naslund et al., (2016) suggest this is a benefit of online peer communities for people who have mental health difficulties. It could be seen as a "stepping stone", for people to seek support in a way that feels comfortable and measured. This gradual process of

disclosure can be seen in previous findings by Nada-Raja et al., (2003) who found that young adults who first seek informal support from friends and family are more likely to seek professional help thereafter.

Participants sought a place to be open with their thoughts and feelings, and the attraction of online anonymity enabled this. The anonymity afforded with being online acted as a protective mechanism from potential perceived negative social and personal consequences. Anonymity has been highlighted as key for young people who self-harm in previous studies that have explored experiences of peer support online (Jones et al., 2011; Whitlock et al., 2006). It contributes to how freely, and openly people feel able to discuss or disclose information about themselves. Discussed in literature as the online disinhibition effect (Suler, 2004) it is understood that the anonymity of being online enables users to be more open and honest than they would be in offline interactions. However, this alone does not completely explain why users may seek help from a specific self-harm community, rather than posting anonymously elsewhere online. Taking into context the experience of shame and stigma, and poor access to services for people who self-harm, being in control of interactions about self-harm seems to be an important and protective strategy in terms of managing the stigmatised identity. Being able to disengage or engage at various times, on their own terms, is a unique online experience to seeking support online and empowering for those who may fear stigma and rejection (Naslund et al., 2016). It is also a stark change from being rejected by others and having to conform with pre-requisites of services or social expectations.

#### Seeking validation of distress

This theme captures how participants joined the online peer support community hoping to receive validation from others “like them”, in the absence of validation from other sources. Despite having little knowledge about what to expect from the group, participants were hopeful that members of the community would be able to validate their distress, based on the fact that they shared a fundamental similarity; that they identified with self-harm in

some way. Participants frequently cited wanted to be around others who were “like them” because they would simply “get it”. Lending support to the communicative and interpersonal theories of self-harm, the participants were hoping to have their experiences of distress authenticated, by finding others who they could relate to. Previous research has suggested that seeking validation of distress is a primary motivator of accessing online peer support for mental health problems and self-harm (Boyce et al., 2018; Rodham et al., 2007). This is often due to previously experienced stigma, or because of receiving invalidating responses from those in other social groups or professional groups.

In their sociological discussion of the communicative and interpersonal nature of self-harm, Steggals et al., (2020) put forward that self-harm is both an attempt to communicate and also authenticate a kind of “inner experience”. Communicating self-harm to others can be challenging because of the associated stigma, which can result in people hiding their self-harm and therefore struggling with feelings of inauthenticity (Newheiser & Barreto, 2014). This creates a challenging tension for those who worry about disclosing their self-harm, but also simultaneously wanting to have their distress validated. Participants reported feeling ignored, dismissed, and being seen as repulsive by professionals because of their self-harm and wanting to find a place where they could be accepted for who they were and what they did. In these accounts of encounters with professionals, participants felt that their self-harm was seen as an inappropriate or unacceptable presentation of distress, that did not warrant validation and in some cases treatment.

Given the difficulties participants noted in accessing services and having their experiences of distress invalidated or dismissed, it is understandable that people may look elsewhere for more positive experiences of support. It seems participants viewed this as more likely to occur in a large group of similar others who they perceive to share the same experiences. Anticipatory stigma affects those with stigmatised identities, which means they anticipate negative responses from others who are not associated with that identity (Quinn & Chaudoir, 2009). It seems that here, there is a converse effect, where those with stigmatised identities anticipate a positive response from people with the same shared identity. Even

without having any sense of the helpfulness of the interactions on the group, the sense of community authenticated participants' experiences, and many spoke of the importance, and sense of relief they felt when finding a community of people who were just like them. This can be understood due to the common cognitive process of categorisation. As humans, we unconsciously categorise things based on sameness and difference and the perception of group homogeneity is a process of social categorisation (Turner, 2010), whereby people tend to see themselves and members of the same group as being more similar than they are. Therefore, identifying with others on the basis of a stigmatised identity can be accompanied by assumptions that others hold a similar set of values and beliefs. For participants in this study, this meant that they believed they would be generally viewed positively and be understood by other members.

In terms of help-seeking, telling others about self-harm is an important step in the recovery process (Hasking et al., 2015) and if responses from the disclosure are negative, or invalidating this may hinder people in continuing to disclose or seeking further help or professional support (MacDonald et al., 2020). Participants joined the community in the hope that they would be able to have conversations about their experiences and receive positive validation from other members. This was based solely on participants' perceptions of assumptions and beliefs about self-harm, and did not appear to be mediated by prior negative experiences of online peer support. Perhaps this is because the community was advertised as specifically focused on self-harm, as opposed to general mental health conditions and therefore it had a strong sense of group identity and participants were able to identify more closely with the group.

### **Consequences of membership of an online peer support community**

#### Maintaining the hidden self

This theme highlights how participants were able to maintain a level of secrecy regarding their self-harm, by discussing their experiences of self-harm online. People who self-harm can be understood as having concealable stigmatised identities, as self-harm is

often a covert and hidden behaviour that occurs as a result of stigmatised attitudes in society. This was reflected in participants' concerns about privacy online, and their self-harm being inadvertently revealed to people outside of the online community.

Many of the participants anticipated negative consequences if they were to reveal their self-harm to certain groups of people in the offline world. There were varying levels of disclosure, with some participants openly discussing their self-harm to friends, family and professionals and others discussing self-harm vaguely to family and friends, or omitting details when discussing with professionals. Previous research has considered the potential harmful impact of how online peer communities can encourage users to conceal self-harm and therefore reduce help-seeking (Lewis & Baker, 2011). Concerns also suggest that online peer support may actually increase feelings of isolation and distance people from face-to-face interactions in the offline world (Lawlor & Kirakowski, 2014). This is an interesting consideration in the context of the COVID pandemic, whereby at the time of writing there were significant restrictions in place that limited face-to-face interactions in the offline world. In this study, participants viewed being able to maintain the secrecy of their self-harm as a helpful feature of online peer-support, and as something that enabled them to manage the complexities of disclosing self-harm. They were able to get their needs met (such as validation and acceptance from others) without having to experience perceived negative consequences of disclosing more widely, to other social groups. Participants worried about having to deal with the emotional responses of others if they disclosed their self-harm. Being aware of the negative societal stereotypes of self-harm can lead to people who self-harm to anticipate negative future stigma, and this is further compounded if they have previously experienced discrimination in relation to aspects of their identity (Quinn & Earnshaw, 2013). This can go on to affect how people view themselves and how or whom they choose to be open with about self-harm.

Secrecy was a common response to the perceived experience of stigma and some participants explained how they had made up stories, or wore specific clothing to conceal their self-harm from people offline. Similar findings by Hodgson (2004) point towards this

being a common response to perceived stigma; in their study, they found that when people are confronted with having to explain their self-harm scars to others, individuals often make up stories to avoid having to disclose. In keeping with the literature around concealable stigmatised identities, which suggests that individuals may try to conceal their membership to a stigmatized group as a means of avoiding future rejection from those outside of the group (Link, Yang, Phelan, & Collins, 2004; Newheiser & Barreto, 2014). Participants in this study also chose to conceal their self-harm from others offline, through fear of negative consequences and further stigmatisation.

The tension between wanting to conceal their self-harm to some groups of people but also wanting to seek connection and validation from others was managed through the anonymity of online peer support. This online anonymity enabled participants to engage with others and disclose their thoughts, feelings and experiences relating to self-harm in a way that freed them from perceived potential negative consequences, whilst also simultaneously hiding self-harm from certain people offline. This particularly important for those who had not previously disclosed to others offline, as self-expression can protect against the harmful effects of stigma (McKenna & Bargh, 2004).

Participants were comfortable sharing this aspect of their identity online, with little concern of the presence of 3000+ anonymous members, but still for most of the participants, disclosing self-harm offline was a much more sensitive issue. This lends support to ideas that people use the online world to “test out” aspects of their identity (Code & Zaparyniuk, 2009). Camacho et al., (2020) go on to discuss how the process of concealment can be regarded as a coping strategy to protect against stigma for those with concealable stigmatised identities and it appeared as though this was an aim for participants in maintaining their secrecy offline, whilst also discussing it openly online. It suggests that participants may be using the community as a way of coping with stigma, whilst also developing and accepting their identity, by presenting the “part of the self” that they struggle to share in the offline world.

How people manage their online vs offline identities in relation to self-harm is a complex and personal process and one that is influenced by shame and stigma. Whilst it is clear people continue to conceal self-harm to specific individuals or groups of people whilst accessing online peer support, it also enables them to seek support through a trusted, or perceived “safe” network. It may also encourage, but not force people to disclose or reveal their self-harm to others offline. Those who may not seek support from friends and family, or feel unable to access professional support through their GP, or mental health services benefit from the anonymity of the online world in terms of gaining confidence to disclose elsewhere.

#### Cultivating a mutual understanding of self-harm

This theme highlights how being part of an online peer support community fostered a mutual understanding of self-harm between members. Shared understandings between participants were highlighted in the research. It is less clear whether participants already had these understandings of self-harm prior to accessing the group, however, it did appear that discussions between members strengthened particular narratives. Predominantly, that self-harm was understood to be a coping strategy. There were also associations with addiction, with participants discussing the concept of “staying clean”, a term often used for sobriety. In a study of self-harm posts on Instagram, Shanahan et al., (2019) reported similar findings, that self-harm was commonly referred to as an addiction. Here, it was understood that the sharing of posts was something users did as a part of the recovery process.

There was a sense with participants that this understanding was a helpful way of personally conceptualising self-harm. It could be hypothesised that the understanding of self-harm as a method of coping, also acted as a way to validate individuals’ experience of distress, whilst also acknowledging their efforts toward recovery. Having self-harm recognised as both an addiction and a coping strategy acts as an acknowledgement of recovery and points toward the addictive nature of self-harm. This potentially reduces blame and distances people from the common negative stereotypes of “attention-seeking” and



“manipulation”. Adler and Adler (2005) discuss a similar theme in their study of social deviance within self-harm, noting that participants often referred to their self-harm as a way of “developing a personally acceptable view of their deviance”. The idea of self-harm being functional and used as a way of coping with distressing experiences is something that is also noted in existing literature (Lindgren et al., 2011; Nixon et al., 2002) suggesting that this is a common experience of people who self-harm, yet this is not something that is always clinically recognised (Macdonald et al., 2020).

This mutual understanding of self-harm being a coping strategy, encouraged participants to be open and able to discuss their experiences, without feeling the need to justify their actions. This contributed to a non-judgemental environment. Fostering this mutual understanding between members also highlighted differences in understanding within the group and then outside of it. They acknowledged that understanding self-harm as a coping strategy was not a widely accepted view from professionals. Similarly, in a qualitative study of individuals who self-harm, Adler and Adler (2005) discuss how those who participated were well aware of how unacceptable self-harm was in wider society and used a deviant sub-culture (others who self-harmed) to rationalise or legitimise their acts. Harris (2000) suggests that people who self-harm understand their actions through situated internal logic, whereas professionals tend to use a more rational logic in their understanding. This seemed to be echoed in participants discussions of how other members of the community were able to “get it”, whereas professionals tended to overly-focus on getting participants to stop self-harming, despite them also acknowledging that this was a goal. Understandably, professionals focus on the reduction of self-harm is a logical approach to risk management and is in keeping with NICE guidelines for the management of self-harm (NICE, 2011). However, this type of rational approach was mostly rejected by participants, who recognised the risks associated with self-harm, however, felt that in order to reduce or stop their self-harm, they needed to understand the underlying reasons they self-harmed and wanted others to acknowledge this too. They also wanted others to acknowledge that their self-harm was something that they did that helped them avoid suicide, rather than being an

isolated symptom. The lack of clear understanding of the functions of self-harm is cited as one of the barriers to effective healthcare for service users by Edmondson et al., (2016) and the value of professionals looking beyond physical injury and aiming to understand the personal reasons of self-harm has also been documented by people accessing services (Macdonald et al., 2020). Indeed, in this study the participants valued a perspective that looked beyond symptom management and sought to consider relationships and inclusion in the world.

It could be argued that although the mutual understanding developed by the participants enabled free and open speech, the perceived differences in understanding could be seen to perpetuate an “us” and “them” narrative. In line with theories of social identity (Tajfel, 1974; Turner, 2010), individuals are more likely to identify with and pay attention to members of their in-group, and may reject ideas from the out-group (in this case, “non self-harmers”). In the context of peer support and help-seeking, an application of this theory could suggest that help received from an in-group source is more welcomed and less threatening than from an out-group source, such as that of a mental health professional. In-group and out-group formation can contribute to the strengthening of ideology within groups (Jhangiani & Tarry, 2014). If participants viewed professionals as unhelpful, and if that is a consistent message between users, it is possible that this may also contribute to reduced help-seeking. However, this was not evident with the participants who were interviewed, and many were continuing to access professional support for self-harm at the time (however, a larger sample of group members may have provided a wider perspective on this).

#### The emotional burden

This theme captured the unintended emotional consequences of being part of the online peer support community. None of the participants anticipated this burden being consequence of membership of the community and acknowledged that at times it could be difficult to engage with the group as a result. The nature of online peer support involves a

reciprocal interaction between members and this is understood to be a key component of online peer support (Lavis & Winter; 2020; Naslund et al., 2016). Daine et al., (2013) suggest that communities that allow the reciprocal sharing of information are seen as having a more positive influence on users. However, in this study, participants suggested that posting content themselves and responding to others' posts had the potential to evoke difficult emotional responses for participants, such as anxiety, frustration, and rejection. There was also a sense that some participants felt they needed to "earn" support, by providing support for other people. Linking back to the literature on shame and stigma, it seems that even in peer support contexts, it can be difficult to accept and receive support, due to previous negative experiences, such as having to meet pre-requisites or thresholds to seek help from services, or anticipating negative responses from others.

Although participants were keen to avoid perceived negative social consequences (experiencing stigma/upsetting friends and family) by posting online, it seems that posting online is not necessarily free of consequences entirely. Participants spoke of the emotional burden that occurred because of posting. This impacted their decision to post and led them to consider what impact the content of their posts would have on other members. Participants spoke of limiting the amount of information they shared, in case it was perceived as "triggering" for other members. The emotional burden experienced also sometimes resulted in participants deleting their own posts if they did not receive the desired response from other members, leaving them feeling invalidated. Regardless of the anonymity of being online and being amongst other people who self-harmed, being a member of the group had perceived social consequences, similar to those they described in the offline world.

Both reading others' accounts and providing emotional support to other members could also be challenging for participants and many discussed being "triggered" by content. Previously, "triggering content" has mostly been discussed in relation to viewing visual content of self-harm (Jacob et al., 2017; Shanahan et al., 2019) and associated with self-harming in response (Arendt et al., 2019). However, in this study, the participants were not

discussing the emotional impact of viewing images of self-harm, but the emotional impact of offering support to other people in distress and reading about others' distress. The specific emotional responses that participants reported were worry, feeling low in mood and frustration. This finding suggests that even with the censorship of graphic images on the peer support community, the description of self-harm (and extending more widely to descriptions of distress in general) can lead to an increase in distress for users (it is of note that the distress experienced was not always linked to self-harm for the participants in this study). This finding may broaden the understanding of the word "triggering" in the media, as participants regarded triggering content more broadly; as content that provoked distress, which did not always accompany urges to self-harm or actual self-harm. Despite the acknowledgement that content could be triggering, the participants in this study found this to be manageable, and the benefits of membership outweighed the potential negatives. They were able to disengage with the group easily which was noted to be helpful. Nonetheless, these findings are consistent with previous findings by those such as Lavis and Winter (2020) and Rodham et al., (2007) who highlight the reciprocity in peer support communities, as a potentially harmful factor.

Recognising the emotional burden that accompanies membership of an online peer support community suggest that users should take a cautious approach when engaging with these groups. The emotional burden is both nuanced and complex, and affected by several factors. The different responses about the level of distress from participants suggest that this is not a universal experience and is likely to vary from person to person. However, what was highlighted in the study, was how the participants responded when they were faced with emotionally challenging situations or viewing content that had the potential to cause distress. The benefit of peer support being facilitated on an online platform means that participants can exert their own level of control about how much they engage in the group and are able to easily disengage from it when needed. Most participants found this an easy process to do and spoke of choosing not to access the group at certain times. It is recognised though, that this may not be a representative reaction of all users and it is possible that other

users who were not interviewed as part of this study had different reactions; for example, leaving the group entirely.

#### Online – Offline interaction

This theme highlighted some of the ways that interaction with the online peer support community impacted participants' lives offline. This happened through sharing and observing interactions between peers online. None of the participants indicated that this was what they were hoping for, or actively seeking, through engagement with an online peer support community and therefore this is regarded as an unintended consequence of engaging with online peer support for self-harm.

It has been queried previously whether the benefits of online peer support do translate into meaningful improvements in the offline world (Brotsky & Giles, 2007; Naslund et al., 2016). However, findings from this study suggested that participants were able to do this. By referencing the group as an “ice-breaker” to start conversations, participants were able to have more conversations with friends and family about their self-harm or wellbeing. Membership and engagement with the group also facilitated conversations with professionals and gave participants the confidence to discuss issues that they were unlikely to have discussed otherwise. This finding suggests that participants were able to apply their new understanding and improved confidence in discussing self-harm and topics associated with it to situations in the offline world. Some participants reported that they had reduced episodes of self-harm as a result of their engagement with the community. Therefore, there were clear interactions between participants' online and offline behaviours.

This finding challenges previous thinking about the online vs offline distinction (Lawlor & Kirakowski, 2014) whereby it has been argued that engagement with online peer support can actually increase social avoidance and reduce help-seeking offline. Participants were able to report positive and meaningful changes outside of the group, including feeling more able and confident to disclose and discuss issues about their self-harm offline and these changes were attributed to group membership. In addition, some

participants shared that being a member of the group helped them understand their self-harm and accept that this was part of their identity. This was seen as a meaningful and positive experience. Linking back to the ideas of McKenna and Bargh (1998) around demarginalisation of stigmatised identities, it is suggested that the experience of positive social interactions within the online community helped to increase both self-acceptance and self-esteem, whilst also reducing social isolation and feelings of shame around the stigmatised identity. There is great significance in going on to have conversations about self-harm offline, as this can work towards breaking down some of the barriers to help-seeking for self-harm, and open up a narrative about self-harm in a society that has a lot to learn.

## **Strengths**

Few studies have qualitatively explored adults' experiences of online self-harm peer support communities. The current study therefore contributes to the literature around self-harm and online peer support in the adult population. It also adds to the confusion of literature around the helpful vs harmful debate of online peer support more generally.

A number of steps were taken to improve the validity of this piece of research (Elliott et al., 1999). As discussed in Chapter 3 (Conducting robust qualitative research), several measures were put in place throughout the research process, which improves the validity of the analysis. Checks were undertaken by myself and my research supervisors, who are both experienced qualitative researchers. I received regular supervision throughout the research process, whereby decision making was discussed, and ideas were shared. I also made the decision to transcribe the interviews personally, which enabled me to become thoroughly immersed in the data from an early stage in the analysis. This also meant I was able to begin reflexively documenting my thoughts and ideas from a particularly early stage. I wanted to ensure that reflexivity was a priority within this study. I kept a reflexive journal from the outset and have also provided a reflexive account of my positioning as a researcher.

## **Summary of Findings**

In relation to the research questions for this study, there were several interesting findings. Research question one considered the influences for joining online peer support. Exclusion in the offline world was a significant influence for participants seeking support offline. Research question two asked what users hoped to gain through membership with an online peer support community. This included being able to exert a sense of control during interactions about self-harm and seeking validation of distress.

With regards to research question three, which asked whether the participants' needs were met through engagement with the community; this was less clearly answered than the other research questions and there were understandably differences in participants' experiences. Most participants regarded the group and community as a positive place, as it enabled them to maintain privacy offline whilst having helpful conversations about self-harm online. Further, the majority of the participants found the mutual understanding of self-harm validating, however some worried that this normalised self-harm to a certain extent. There was recognition that the platform of Facebook sometimes made it difficult to follow threads of conversation and that the algorithmic presentation of posts on Facebook sometimes contributed to participants seeing unexpected or unwanted content, which could be triggering. Some participants had left and re-joined the group for this reason.

Finally, with regard to research question four, whether there were unintended consequences; these were positive and negative. Participants were able to translate some of their interactions on the group into positive offline experiences, such as improving their experience of therapy and having helpful discussions with friends and family. There was recognition that peer support could be emotionally burdening, and participants reported experiencing negative emotions as a result of some interactions.

## **Limitations**

Research question three aimed to explore whether participants' needs were met through membership of the community. This was a difficult question to fully address, as it is recognised that it is less likely that participants would have been a member of the page if they were not in some way satisfied by the content of it. This may have been a limitation of the recruitment strategy, by recruiting directly through the Facebook page.

The sample studied was predominantly female, with only one male participant responding to the online advert and going on to participate in the study. Possible explanations for the gender disparity include gender differences in reporting self-harm. Males report less self-harm than females, and also experience more stigma with regards to reporting (Lloyd et al., 2018; O'Connor et al., 2020; Whitlock et al., 2011). There are also differences in online social activity, with males being less active online (Rollero, Daniele, & Tartaglia, 2019) and possible gender differences in peer support more generally. Previous studies of peer support have also encountered groups that consist of only female members, or that have a very minimal male representation (Boyce et al., 2018; Murray & Fox, 2006). Therefore, it is possible that this gender disparity is somewhat reflective of the population of those who are members of the group, however this is not clear and the lack of male voices in this research is a clear limitation of the study. Alongside this, the ethnic diversity in the sample is limited and it is unlikely that this is a true representation of the population this study aims to represent. Therefore, the results are less likely to reflect the experiences of individuals who would identify as BAME. Further research gathering a more varied sample would therefore be valuable.

A further consideration of the limitations of this study is related to the differences in administration of the interviews. Participants were given the choice of completing the interview either via telephone or via videoconferencing. Four participants completed the interview over the telephone, and this may have limited the quality of some of the interviews, as the interview was unable to consider important cues in verbal conversation,



such as body language and eye contact. However, considering participants' wishes and ensuring they felt comfortable was an important ethical consideration and this may have also enabled them to feel more able to express themselves.

The experiences that were shared by the participants all acknowledge that they were generally active members of the community (although some, more so, than others). Of those that were very active, (e.g. posting, responding, and sometimes having a role in the group itself) there appeared to be a greater level of satisfaction with the group than those who were perhaps more distant. This poses an interesting question about whether active participation, as opposed to passive participation provides a different experience for users.

Additionally, participants' experiences can only be considered to be reflective of that particular online space and therefore cannot be generalised to all online peer support communities. As is discussed, the group had its own sense of group rules and norms and is a highly moderated space. Other peer support communities are likely to have different rules and norms which are likely to shape membership and discourse. It is recognised that this is a small-scale qualitative study and therefore the results cannot be generalised to other online peer support communities.

## **The Current Context: Conducting Research During the COVID- 19 Pandemic**

It is important to situate research within context and therefore consideration of the impact of the COVID-19 pandemic is needed in order to understand the impact this may have had on those participating in research, the way in which the research was conducted and any ensuing findings. A UK lockdown was first implemented by the government on the 23rd of March 2020 in response to the COVID-19 pandemic. The radical societal changes that ensued as part of the governmental response to public health concerns, lead to an increase in social isolation, deprivation, and a significant change in healthcare delivery (Kapur et al., 2021), with many services withdrawing face to face support and relying on

online delivery of services (Byrne et al., 2021). It should be noted that data collection took place during the lockdown and therefore it is important to consider the context around this.

With consideration of the wider social impact of the lockdown, including financial stress, unemployment, and bereavement, it would be intuitive to consider that these significant stressors may have led to an increase in the rates of self-harm and therefore presentation to health services. Although research on the impact of COVID-19 is still in its infancy, data from the University College London COVID social study suggests that rates of self-harm actually remained fairly constant in the general population (Kapur et al., 2021). Conversely, further findings following the first lockdown suggested approximately a 30% decrease in the average weekly presentations to services at this time (Hawton et al., 2021). Although participants did not explicitly mention COVID in terms of their influences for joining online peer support, it is entirely possible that their experiences of online peer support were impacted by COVID, due to the wider systemic impact this had. The participants did refer to the challenges of the COVID – 19, which had affected their mental wellbeing and ability to access support, citing that shielding had increased loneliness and decreased social support. They also reported that they had noticed that the community was more active during the lockdown. It is possible that those who self-harm may have been more engaged in the online world, in the absence of face to face social support. Some of the participants joined the group during the UK lockdown, whilst others had been members for significantly longer. However, it is unclear in this study, whether the UK lockdown impacted the decision to join or the overall use of an online peer support community. The current research does provide a much-needed insight into the alternative support structures available for people who self-harm, in the absence of face to face, formal support.

## **Clinical Implications**

Online peer support for those who self-harm remains a neglected issue in clinical settings. Professionals may be reluctant to promote online peer support communities, due to

the lack of formal regulation of these spaces or uncertainty of what type of content is posted in these communities. The lack of consideration in clinical practice could reflect the distrust or lack of knowledge about these spaces more generally. It is also in line with the mainstream media ideology, which argues that online spaces focusing on self-harm are typically associated with increased risk, opposed to the alternative perspective; that online peer support may contribute to or facilitate positive wellbeing.

Clinicians also may have concerns that by encouraging the use of online peer support communities, some might view this as a substitute for seeking professional support for self-harm. No participants in this study suggested that they used the community as an alternative for professional support and this is not a recommendation of the study. In fact, the participants highlighted the helpfulness of receiving support from the peer support community and utilising professional support together, with some describing how the community had a positive influence on their experience of therapy, by giving them a space to reflect outside of the therapy room. This suggests that there could be some positive bearings for professionals, in learning about the values of these spaces and working alongside them, to improve overall experiences of professional support.

The findings from this study are evidence to question the concerns and reservations around the value and benefit of online peer support for self-harm. It is argued then, that professionals should take a broader view of online peer support for self-harm, and routinely consider the role of the online world for adults who self-harm during assessment and intervention. An interesting question is then posed, as to whether online peer support for self-harm should be integrated into formal mental health settings (for example, using professionally moderated online peer support groups). On one hand, it could be argued that this could provide professionals with greater understanding. This could also work toward meeting the needs of people who self-harm that were identified in this study, whilst providing a “safety-net” of formal regulation of the space. However, there is also argument to suggest that the value of these spaces is in the empowerment of peers supporting each other, which includes the mutual giving and receiving of support and the perceived safety of

being with like-minded others (Naslund et al., 2016). These features of peer support may not be able to be maintained successfully, if the patient-professional relationship was then introduced.

The study highlighted some of the challenges for participants when accessing professional support. Participants perceived their self-harm as a barrier to getting support. Consideration of self-harm as a coping strategy to deal with distress, as opposed to viewing it as a challenging behaviour in isolation, could be a useful approach for clinicians to take. Participants appreciated this view as it validated their experiences and were able to recognise that it was not a healthy coping strategy. This was one of the core shared ideas within the group, which meant that participants were more open to taking suggestions about alternative ways to cope. Clinicians should be aware of and open to alternative perspectives about the function of self-harm and work collaboratively with service users to manage self-harm. Increased knowledge about self-harm in professionals is associated with more positive attitudes to those who self-harm (McHale & Felton, 2010; Pintar Babič et al., 2020). This is particularly important, as this study suggests that people who self-harm perceive negative attitudes towards them from professionals and can find interactions with healthcare professionals invalidating and dismissive of their needs.

There are concerns that by talking and listening to others discuss their self-harm, members will be encouraged to learn potentially more damaging ways to hurt themselves (Lewis & Baker, 2011; Whitlock et al., 2006). However, the findings from this study were not supportive of these concerns, as talking and sharing experiences with peers were crucial features that facilitated members' awareness and ability to find alternative ways to live with and manage self-harm. When considering the potential benefits of online peer support for those who self-harm, it is necessary for both clinicians and policymakers to better understand these communities.

## **Implications for Future Research**

The literature on adults' experiences of the use of online peer support communities for self-harm is sparse, with much emphasis being placed on adolescent use. Adults have been largely neglected from this area of research, despite self-harm remaining a public health concern for all age groups. This study provides an insight into the experiences of the use of online peer support communities for adults who self-harm. The topic of self-harm and online social media use is current and can be controversial. The concerns raised in the media and shared in public policy amplifies the importance of understanding these communities and how they can be both helpful and harmful to users. Learning about these differences is imperative in understanding the overall risks associated with online peer support.

## **Future Directions for Research**

Self-harm in adulthood should continue to be studied because the adult population remain both understudied, and at risk from self-harm. Further research that is specifically focused on the experiences of men who self-harm is needed, as they remain a neglected and at-risk population, whose voices are lesser heard in the field of self-harm research. This could provide much-needed insight into the experiences of help-seeking for men.

Future research should consider the boundaries between helpfulness and risk within online peer support communities. Each social media context should be explored within its own right, to understand the complexities and nuances of interactions that take place across different platforms. Finally, given some of the positive experience heard in this study of using online peer support alongside accessing professional support, future research could explore professionals' views of online peer support communities. There is much to be learned by professionals' from online peer support communities and this could help to enhance understanding around the use of online peer support communities in a clinical context and may also help to resolve the question as to whether the two should be integrated.

## **Conclusion**

There is limited research on adults' experiences of online peer support for self-harm. Therefore this study provides an original contribution to knowledge around the influences and experiences of using online peer support for adults who self-harm. There were several interesting findings, and the study highlighted some key issues within this field of research. There was a clear motivation for people who self-harm in accessing online peer support for self-harm; the societal stigma experienced by participants meant that the online world was viewed as a safe space to interact with others about self-harm. Whilst participants were not always consciously aware of what they are seeking when going online, there is a protective element to the online world, in that it affords people the anonymity to freely discuss self-harm in a way that felt measured and comfortable. This met participants' needs of receiving validation of their distress from peers, in the absence of this offline. Conversely, through this process of almost compartmentalizing the disclosure of self-harm in online and offline environments, this enabled participants to maintain privacy of their self-harm offline if they were not comfortable fully disclosing their stigmatized identity.

As discussed in much of the research in self-harm, this is an extremely complex area of study. Self-harm can be an incredibly personal experience and therefore it is difficult to draw strong conclusions from the current study. Ultimately the findings from the study demonstrated that people are influenced to seek support online, due to some of the barriers to help-seeking that exist in the offline world; such as stigma, and access to services. This highlights the role of shame and stigma in help-seeking for adults who self-harm, which has been found in many other studies, particularly in the adolescent population. The study demonstrated that there was value for participants in accessing online peer support for self-harm, allowing adults who self-harm to feel less isolated in their experiences. The study also highlighted some of the unexpected outcomes of being a member of an online peer community. It can also have some negative consequences, and the relational nature of online peer support can lead to an unwanted emotional burden. There is a complex interaction that takes place online and offline and people use online peer support communities in a way that

helps them translate their online experiences into positive experiences in the offline world. This can lead to opportunities for disclosure and help-seeking in both informal and formal settings. Gaining further understanding of some of the intended and unintended consequences of accessing online peer support can help clinicians be better informed when discussing online behaviour and self-harm.

The study provides helpful insights in response to the prevailing narrative that self-harm content online is generally harmful. Based on the findings in relation to wider literature in the field, I would argue that this is a narrow lens from which to view online self-harm content, which neglects to account for the wide range of benefits and risks associated with the online world for people who self-harm. There are differences between those who are vulnerable and are seeking help online and those who are inciting dangerous advice and practices to others. Censoring all content related to self-harm on social media platforms would include recovery-focused online peer support communities, which, as the current study and others mentioned in this study present; act as places for those who self-harm to be accepted when they do not feel accepted in other places in society.

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## **Appendices**

### **Appendix A: Risk Protocol**

#### **Participant risk protocol (including escalation procedures)**

##### **Pre-interview discussion**

Researcher will check whether participant has any concerns ahead of the interview and will suggest that when interview takes place, if possible, participant could let a member of household or friend know that they are participating.

##### **Responding to distress during the interview**

- All participants who take part in interviews will be reminded that they can decline to answer any questions or pause the interview at any time, should they feel upset or distressed.
- All participants who take part in interviews will be reminded that they can end the interview at any time, should they wish to, without needing to offer an explanation.
- The researcher will offer the participant the opportunity to make a safety plan together in case the participant found the interview distressing or becomes distressed later. The plan will follow the structure outlined in the Connecting With People website:  
(<https://www.stayingsafe.net/sites/default/files/BlankSafetyPlan.pdf>).
- The researcher conducting the interview is a qualified mental health professional and Clinical Psychologist in training and therefore is equipped, by means of her clinical experience and training, with the skills to offer emotional support should the participant become distressed during the interview.
- Participants will be given the contact details for agencies whom they can contact for additional support after the interview. This will include:

##### ***Mental Health support contacts***

MIND- The Mind team can provide information on a range of topics such as different mental health problems, where to get help, medication and alternative treatments and advocacy Phone: 0300 123 3393/Text: 86463/

<https://www.mind.org.uk/information-support/helplines/>(Out of hours support)

Connect Helpline – Emotional support and information between the hours of 6pm-2am. Phone: 0808 800 12 12

Samaritans – available 24 hours a day for anyone struggling to cope and provides a confidential and safe space to talk. Phone: 116 123

NHS 11 is available 24/7 for anyone requiring immediate advice regarding their mental health. Phone: 111

### ***Emergency contacts***

Participants will be reminded that they can contact their GP, or present at A&E if they feel immediately unsafe

*(All of the above contacts are open and continuing to offer support during the COVID-19 pandemic)*

### **Risk escalation protocol for participants**

The participants are members of the public who have volunteered in response to an online advertisement. They are being interviewed about a topic with which they are familiar – their use of an online support group – and will not be questioned about experiences likely to provoke particular distress. However, they may choose to bring up distressing experiences and this protocol is designed to outline the steps taken if a participant discloses information that puts them at a significant risk to themselves (such as active suicidal ideas) or others during the interview.

1. Suspend research interview and explain reasons for doing so. If interview is taking place over the telephone/video conferencing participant will be encouraged to stay on the line.
2. Discuss the relevant issues with the participant (where possible) and ask them if they have plans to see their GP or another identified health care professional, or contact other relevant organisations detailed above. Ask if they regard these plans as adequate to keep them safe and explore their own feelings about personal safety. If the plans seem adequate, offer to make a follow-up call (timing will depend upon the plan) to check how the plan went.
3. If they have no plans or won't discuss them, or if the plans seem inadequate, seek permission to contact their GP or other identified health professional on their behalf.

4. If they do not grant permission and the risk is judged to be sufficiently high to justify such action, then inform the participant that due to concerns around the risk the meeting can no longer remain confidential and that advice on how to proceed will now be sought.
5. The researcher will speak to supervisors (Professor Allan House/ Dr Kate Farley) and seek advice from the study's identified mental health contacts. Clinical Psychologists from the University of Leeds (Dr Gary Latchford & Dr Fiona Thorne) have been identified as mental health contacts, who are willing to offer additional advice to the researcher around managing distress and/or risk if needed. They will be made aware of the time of the interviews taking place to ensure support is accessible if required.
6. If the participant poses an imminent danger to themselves the researcher will call 999.

## **Appendix B: Participant Information Sheet**

Participant Information Sheet

**Project Title: Exploring the use of an online peer support community for self-harm.**

*Researcher: Bethany Douglas (University of Leeds)*

*Supervisors: Professor Allan House & Dr Kate Farley (University of Leeds)*

You are being invited to take part in a research study. Before you decide whether or not you want to take part in the study, it is important that you know what the study is about and what it will involve. Please take some time to read the following information.

### **Purpose of Study**

The purpose of the study is to understand how and why people use online peer support groups for self-harm. I am interested in what people are hoping for when they turn to online peer support for self-harm and also whether their hopes are met through joining in the group – by posting, responding, or simply reading posts.

### **Why have I been chosen?**

You have been asked to take part as you have identified yourself as a user of an online peer support group for self-harm. You do not have to self-harmed yourself to take part in the study.

### **Do I have to take part?**

You do not have to take part. If you agree to take part and then decide later at any time that you do not want to take part anymore you can withdraw at any point up until the results are finally prepared and presented for publication.

### **What it involves**

I would like to interview you for no more than an hour about your experience of using online peer support groups for self-harm. The interview will take place either in person, telephone or video conferencing, depending on your preference.

### **Will I be recorded, and how will the recorded media be used?**

The interviews will be audio recorded. The audio recordings of your activities made during this research will be used only for analysis. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings unless you consent to this.

### **Potential Risks**

There is a possibility that you may find the topics discussed in the interview distressing or too personal. You do not need to answer every question, you do not need to talk about things you don't want to discuss and you can withdraw from the interview at any time, for any reason and you can ask for your interview not to be used up, at any time until the research is submitted for publication.

### **Potential benefits**

You will be reimbursed £10.00 for the time you have given to take part in the research. There are no other direct benefits, however by participating in this study you will be contributing to research which will help us understand the impact of online peer support communities for self-harm.

### **What will happen to my personal information?**

All the personal information that we collect about you (for example your name or email address or phone number) will be kept strictly confidential and will be stored separately from the other information you give during the interview. The information you provide in the interview will be transcribed (typed out) and all identifiable information will be removed. Direct quotes from the interview may be used in the write-up of the research and subsequent publication but you will never be personally identified. This data will be stored securely by the University of Leeds, for 3 years after the point of data collection.

In normal circumstances only the researcher and their supervisor will be allowed to see your information. No information will be disclosed to your GP or other health professional. However, in exceptional circumstances, if during or after the interview the researcher has concerns regarding your wellbeing or somebody else's then

confidentiality may have to be broken. If this is the case, the researcher will discuss this with you where possible.

**Who is organising the research?**

The researcher is a Clinical Psychology Doctorate student at the University of Leeds and this project is being undertaken as part of their qualification to become a clinical psychologist. It will be written up as a doctoral thesis and may be submitted for publication.

The project is overseen by research supervisors at the university and had received Ethical approval from the School of Medicine & Health Ethics review committee.

**What happens now?**

If you are interested in taking part, you will be given a copy of this information sheet to keep. I will also ask you to complete a consent form to ensure you fully understand and accept the potential risks. After this you will be given more detailed instructions and we will arrange the interview for a time best suiting you.

Thank you for taking the time to read this information. Please feel free to ask questions and if you want more information, my contact details are:

[umbd@leeds.ac.uk](mailto:umbd@leeds.ac.uk)



## Appendix C: Consent Form

**“Exploring the use of an online peer support community for self-harm.”**

Add your initials next to the statement if you agree

I confirm that I have read and understand the information sheet explaining the above research project and I have had the opportunity to ask questions about the project.	
I understand that my participation is voluntary and that I am free to withdraw at any time, up until 31.12.2020, where by this time the data will be fully integrated into the final research report. I understand I can do this without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.	
I have been provided with the contact details for the lead researcher (details on participant information sheet) should I wish to withdraw from the research.	
I understand that my name or other means of identifying me will not be linked with the information I provide at interview, and I will not be identified or identifiable in the report or reports that result from the research. I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my responses.	
I agree for the data collected from me to be stored and used in relevant future research [in an anonymous form with all my personal details removed].	

I understand that other genuine researchers will have access to my responses only if they agree to preserve the confidentiality of the information as requested in this form.	
I understand that other researchers may use my words in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.	
I understand that relevant sections of the information collected during the research study, may be looked at by auditors from the University of Leeds. I give permission for these individuals to have access to my records.	
I agree to take part in the above research project and will inform the lead researcher should my contact details change during the project and, if necessary, afterwards.	

Name of participant	
Participant's signature	
Date	
Name of lead researcher	
Signature	
Date*	

\*To be signed and dated in the presence of the participant.

Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the letter/ pre-written script/ information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be kept with the project's main documents which must be kept in a secure location.

## **Appendix D: Interview Topic Guide**

Project Title: Exploring the use of an online peer support community for self-harm

- Can you tell me about your experience of using the group?  
(prompts)
  - When did you join?
  - Why did you join?
  - Experience of other groups?
- How do you use the group?  
(prompts)
  - How frequently do you access/use it?
  - What do you typically do when you access the group?
  - Can you give me some examples of recent occasions when you have used the group?
- Has the way you use the group changed over time/Do you think the group has changed over time?
- What were your hopes when joining the group?
- How has your experience of using online peer support met or differed from initial expectations?
- What is most important to you about online peer support for self-harm?
- Would you change anything about it?
- Has online peer support had an effect on you in any way? (Helpful/unhelpful?)
- Anything else?

## Appendix E: Ethical Approval

Email confirmation of ethical clearance statement received by the School of Medicine Research Ethics Committee (dated 04/06/2020):

Dear Beth

**MREC 19-052 - Exploring the use of online peer support communities for self-harm**

***NB: All approvals/comments are subject to compliance with current University of Leeds and UK Government advice regarding the Covid-19 pandemic.***

I am pleased to inform you that the above research ethics application has been reviewed by the School of Medicine Research Ethics Committee and on behalf of the Chair, I can confirm a conditional favourable ethical opinion based on the documentation received at date of this email and *subject to the following condition/s which must be fulfilled prior to the study commencing:*

- **The exclusion criterial should include those who may be considered to be at risk**

The study documentation must be amended where required to meet the above conditions and submitted for file and possible future audit.

*Once you have addressed the conditions and submitted for file/future audit, you may commence the study and further confirmation of approval is not provided.*

*Please note, failure to comply with the above conditions will be considered a breach of ethics approval and may result in disciplinary action.*

***Please retain this email as evidence of conditional approval in your study file.***

Please notify the committee if you intend to make any amendments to the original research as submitted and approved to date. This includes recruitment methodology; all changes must receive ethical approval prior to implementation. Please see <https://leeds365.sharepoint.com/sites/ResearchandInnovationService/SitePages/Amendments.aspx> or contact the Research Ethics & Governance Administrator for further information on [FMHUniEthics@leeds.ac.uk](mailto:FMHUniEthics@leeds.ac.uk) if required.

Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

*Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, risk assessments and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.*

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

The Chair wishes you good luck with the study and I too hope the study goes well.

Best regards

Rachel

***On behalf of Dr Anthony Howard, co-Chair, SoMREC***

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**Rachel de Souza, Lead Research Ethics & Governance Administrator**, The Secretariat,  
Room 9.29, Level 9, Worsley Building, Clarendon Way, University of Leeds, LS2 9NL, Tel:  
0113 3431642, [r.e.desouza@leeds.ac.uk](mailto:r.e.desouza@leeds.ac.uk)

## **Appendix F: Extract from Reflective Journal**

Extract from reflective journal (after 4 out of 8 of the interviews were completed, and before analysis took place).

“...I’ve never really considered self-harm to be a coping strategy. It keeps coming up in the interviews which has surprised me. I think I was expecting people to talk about self-harm as this uncontrollable addiction-like behaviour, not something they actively choose to do as a way of coping with their difficulties. I talk about coping strategies at work and it made me think when [participant] was talking, it would feel completely against what I’ve been taught to suggest someone self-harms as a way of coping! When I think about it, the way I’ve always understood coping, as it being associated with overcoming problems, almost like you should be doing something to make you feel better. Yet, this is exactly what participants are doing. It’s really hard to pull away from my professional identity when participants talk about self-harm as a coping strategy. Self-harm in my clients often makes me feel quite anxious, is that why I find it difficult to view self-harm as a coping strategy?

It made me wonder too- , to say something is a coping strategy, is this just a defence? Does it allow you to continue with a behaviour that you know is unhelpful? It reminds me of alcohol addiction. It is true that I think it’s more acceptable to use alcohol as a way of coping than self-harm. In my social circle, it’s generally acceptable that people have a glass of wine after a hard day. That’s understood as coping, but in a very middle-class way! There also seemed to be a clear contradiction in the ways that participants then viewed this coping strategy, stating that they knew it wasn’t healthy, or they would prefer to use other means of coping. Perhaps this group ideology fosters a sense of immediate forgiveness and acceptance - something that is not easily sought without a group ideology. Yalom’s idea of being held in a group and their being a sense of universality in groups comes to mind.”