The Use and Perceptions of Social Media of Young People who have Self-harmed

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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ABSTRACT

Background: Research suggests that young people who self-harm spend more time on social media than those who do not self-harm. Social media has been considered a double-edged sword; on the one hand providing support, but on the other posing risks such as self-harm being 'normalised'. To further our understanding, it is essential that up-to-date research considers the voice of those who self-harm and use these platforms.

Aim: This study aimed to explore the use and perceptions of social media in relation to self-harm from the perspectives of young people who have self-harmed.

Method: 15 participants (aged 18-29 years) were recruited via social media. Semi-structured telephone interviews were conducted and analysed by Thematic Analysis.

Results: Four themes were identified: 'Offline/Online Relationships', 'Regulating Feelings', 'In Group', and 'Control'. Participants were drawn to social media, due to unhelpful responses they received offline when discussing self-harm. Being online offered a space to feel accepted, not alone and to regulate emotions. However, social media could form part of the self-harm process and could perpetuate self-harm. There were different demands, pressures and responsibilities with being online, such as self-harm comparisons and encouragement. Participants discussed the internal and external controls in place to protect them from these. The external censoring of social media content was considered silencing and shaming - leaving participants to again feel misunderstood. Participants considered the control and choice they have about engaging with content or not and about keeping their offline/online worlds separate.

Discussion: This study highlighted the need for greater collaboration between young people who self-harm, professionals and social media. This could create opportunities for open discussions around self-harm and for the creation of accessible, safe and helpful practices to be fostered to support young people who access self-harm content online.

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CHAPTER ONE: INTRODUCTION

Self-harm is considered a global health problem (Vega et al., 2018). A suggested 18% of people are thought to have engaged in self-harm at one point in their life (Swannell, Martin, Page, Hasking, & St John, 2014). Research has identified an increase in the prevalence of self-harm worldwide with the most notable increase being in young people (e.g., McManus et al., 2019). Despite the rise in prevalence, the amount of people who self-harm and seek support has decreased (McManus et al., 2019). It is suggested that young people who self-harm are spending more time on social media than with health professionals meaning that social media presents a platform on which discussions around self-harm are likely to occur (Hilton, 2017). The potential risks of using social media related to self-harm include issues around bearing witness to 'graphic' content, self-harm competition or 'contagion', and the encouragement and normalisation of self-harm (Lewis, Heath, St Denis, & Noble, 2011). Conversely, social media can be a support for those who self-harm, providing advice, a sense of community, and a space for self-expression (Duggan, Heath, Lewis, & Baxter, 2012; Dyson et al., 2016). Due to the constantly evolving nature of social media, there is need for updated research which takes into consideration the reality of those who use these sites and not just our own assumptions of what is helpful or harmful regarding online content (e.g., Marchant et al., 2017; Lavis & Winter, 2020). It is important to ensure that research considers the voice of those who self-harm and use these platforms. This study aimed to explore the use and perceptions of social media in relation to self-harm from the perspective of those who have self-harmed. This bolsters the evidence base from which we can progress our understanding and develop policies relating to online content to better support and protect those who use social media in relation to self-harm.

This chapter provides a critical overview of the evidence that frames this study and introduces the current investigation.

Definitions and Prevalence of Self-Harm

Definitions of self-harm are varied and there is little consensus in the literature regarding definitions and terms (Straiton, Roen, Dieserud, & Hjelmeland, 2013). Definitions can include deliberate harm to self, e.g., via cutting, burning, ingesting toxic substances or objects, without intending for a fatal outcome (Madge et al., 2008). The concept of intent differs between definitions; some consider self-harm both with and without suicidal intent whereas other definitions exclude behaviours with any level of suicidal intention (Muehlenkamp, Claes, Havertape, & Plener, 2012). Other definitions consider that intent behind self-harm is fluid and

that there can be numerous motives for self-harm (O'Connor et al., 2018). Self-report regarding intent adds to the lack of clarity, as the individual may be unclear on what the intent of the act was, especially if it was impulsive (e.g., Silverman, 2011). Additionally, definitions vary in relation to how inclusive they are regarding the method of self-harm; for instance, Cooper, Murphy, Jordan, and Mackway-Jones (2008) included overdoses of alcohol and recreational drugs in their definition. Attempts to define self-harm by intent and/or method only allow for a classification of the individual act rather than the individual. One individual could use multiple methods, intent could vary both within and between acts of self-harm and the reasons someone starts to self-harm may be different to why they continue. A broader definition of self-harm was adopted in this study and formed part of the inclusion criteria outlined on the study adverts. This definition included any act of self-harm (including self-poisoning) regardless of the individual's motivation (National Institute for Health and Care Excellence [NICE], 2013). NICE (2013) guidance excludes harm from over or under-eating, alcohol or drug use, accidental harm, body piercing or tattooing from this definition. This definition allows for a comprehensive inclusion of different self-harm behaviours without considering intent, an unclear concept.

The existence of varying definitions of self-harm affects investigations into its prevalence. McManus et al. (2019) found an increase in self-reported lifetime self-harm (self-harm occurring at any point in life) from 2.4% to 6.4 % in England between 2007 and 2014 (for those aged 16-74 years). McManus et al. (2019) used a definition that defined self-harm as harm without suicidal intent and included self-poisoning. The reasons for the increases in self-harm rates are unclear but could be linked to an increase in mental health concerns, pressure on mental health services (meaning that people could be more likely to self-harm as a way to cope in the absence of other support) or an increase in willingness to disclose self-harm (Gunnell, Kidger, & Elvidge, 2018).

Rates of self-harm could be higher than those published due to the secretive nature of this concern and the issues raised by estimating self-harm rates on hospital admission and self-report data alone (Borschmann & Kinner, 2019); rates of self-harm can be variable dependent on the population also. The difficulty in estimating rates is reflective of the 'iceberg model' of self-harm (e.g., Hawton, Saunders, & O'Connor, 2012). This model outlines the common but largely hidden prevalence of self-harm in the community and the common and overt self-harm presented to services. The tip of the iceberg represents suicide which is overt but less common (Geulayov et al., 2018).

Self-harm and gender.

Rates of self-harm vary with gender. The mean age of onset of self-harm has been reported as 13 for females and 13.5 for males (Morey, Mellon, Dailami, Verne, & Tapp, 2017). The

definition of self-harm used here included ingestion of substances over the prescribed/recommended dose and recreational drug use that the individual regarded as an act of self-harm. Carr et al. (2016) used the NICE (2004) self-harm definition (akin to the definition in NICE, 2013) and found that annual self-harm rates in the UK were consistently higher for females than males: 12.3 per 10,000 males compared to 17.9 per 10,000 females. However, these are rates based on accessing support via a GP and are likely to be an underestimate given that many people do not tell anyone about their self-harm. McManus et al. (2019) found the most notable increase in self-harm prevalence, from 6.5% to 19.7%, in females aged 16-24 years. It must be acknowledged that this study only looked at male and female gender and other studies have shown that rates may be higher in transgender/non-binary populations (e.g., Butler et al., 2019).

Regarding the reasons for the gender difference, Griffin et al. (2018) highlighted higher, and increasing, rates of internalising symptoms for females, which are linked to self-harm such as presentations of depression and anxiety. This difference could also be attributed to men not disclosing self-harm due to feeling stigmatised and marginalised on the assumption that 'only women self-harm' (Taylor, 2003). The gender difference in self-harm rates is mirrored in self-harm research, with women being overrepresented in qualitative studies. This could reflect a true difference or could be a reflection of men being more reticent to speak about self-harm or take part in research. I have remained inclusive of gender (and other participant characteristics) in my investigation to provide another opportunity for a diverse range of voices to be heard.

Self-harm and age.

Across the lifespan, rates of self-harm are reported to decrease with age; for instance, McManus et al. (2019) observed self-harm prevalence of 13.7% for 16-24 year olds, 2.9% for 45-54 year olds and 1.1% for 65-74 year olds. O'Connor et al. (2018) reported self-harm prevalence (for self-harm occurring in the past year at time of study) of 6.6% for 18-23 year olds, 4.7% for 24-29 year olds and 2.4% for 30-34 year olds. However, O'Connor et al.'s (2018) observations could be limited by the use of self-report measures and as the recruitment was only from Scotland.

It has been suggested that self-harm rates in young people are increasing overall; Griffin et al. (2018) reported an increase in self-harm rates of 75% for 10-14 year olds, 25% for 15-19 year olds and 39% for 20-24 year olds. This data was based on young people who presented to hospital so it is likely to only show part of the picture. However, these increasing rates point to a need for further research and understanding into what is influencing self-harm in young people.

The rates of mental health concerns and self-harm within young people could be due to the tumultuous periods they face between adolescence and young adulthood. In this period, there is

still a level of reliance on parents which conflicts with the desire for increasing independence (Vaterlaus, Patten, Roche, & Young, 2015). Transitions between child and adult mental health services, increased stress, and greater drug and alcohol consumption in recent years could be contributing to the exacerbation of self-harm in young people (Griffin et al., 2018).

Understanding Self-Harm

Reasons for self-harm can be multifaceted, so it is difficult to classify an act of self-harm, but a number of models have attempted to do so. For example, Nock's (2009) integrative model suggests both intrapersonal and interpersonal motivations for self-harm. Intrapersonal reasons include relief from intense cognitions or emotions, and interpersonal reasons could be to communicate with or influence others. The experiential avoidance model (Chapman, Gratz, & Brown, 2006) outlines how an individual experiences a stimulus which creates an emotional response, the motivation to avoid this response is influenced by pre-existing difficulties in distress tolerance and emotion regulation. This avoidance is managed through self-harm, which creates a temporary relief and means self-harm is reinforced. There is clear overlap regarding functions across the models of self-harm.

Other reasons for self-harm include it being a form of punishment (e.g., Wadman et al., 2017), or providing a sense of mastery which relates to holding a level of control over one's feelings (Edmondson, Brennan, & House, 2016). Bryant et al. (2021) used a Q-methodology study and recruited participants from NHS and third sector organisations to explore the functions of repeated self-harm. They found four distinct functions: to manage one's mental state, communicate distress, to distract from suicidal feelings/thoughts and to produce positive feelings. Bryant et al.'s (2021) findings evidence the importance of considering the multi-functional reasons behind an individual's self-harm - an individual is likely to have different reasons for self-harm which can fluctuate over time. This creates challenges for the individual when seeking help as they have to try and articulate these dynamic functions to another. In turn, others may find this reasoning challenging to understand and be uncertain as to how to support the individual (Bryant et al., 2021).

The Impact of Self-Harm

Self-harm is considered transdiagnostic (Vega et al., 2018). It has been associated with a number of mental health concerns, such as: eating disorders (e.g., Koutek, Kocourkova, & Dudova, 2016); borderline personality disorder; depression; substance misuse and anxiety disorders (Guerra, Ferreira, Moura, & Silva, 2013). This presents a complex bidirectional relationship, with mental health concerns being a risk factor for self-harm and vice versa (e.g.,

Lundh, Wångby-Lundh, Paaske, Ingesson, & Bjärehed, 2011). This could be a result of a 'vicious cycle' - self-harm could help an individual cope with a mental health concern but the individual may feel a level of shame or regret related to the self-harm, which then exacerbates the mental health concern (Lundh, Wångby-Lundh, & Bjärehed, 2011).

Self-harm and suicide.

Self-harm has been associated with suicide for children, adolescents, and adults (e.g., Hawton et al., 2015). However, the relationship between self-harm and suicide is complex. NICE (2013) suggest that those who have engaged in self-harm are 50 -100 times more likely to end their life in the 12-month period following self-harm compared to those who do not self-harm. Carroll, Metcalfe, and Gunnell (2014) identified that one in 25 individuals who present at hospital for self-harm will die by suicide within the following five years. Whilst self-harm is used to regulate certain emotions (e.g., depression and frustration), individuals can experience shame, guilt and disgust after self-harm (Laye-Gindhu & Schonert-Reichl, 2005). Laye-Gindhu and Schonert-Reichl (2005) suggested that as self-harm becomes more pervasive, individuals may find it harder to manage those feelings (shame, guilt, and disgust) resulting in suicide becoming a more likely option.

On the other hand, there is suggestion that engaging in self-harm creates an intense physical feeling that reduces suicidal ideation (Wilkinson, 2013). This is supported by Klonsky (2009) who identified that prior to self-harming, individuals felt overwhelmed and frustrated whereas after they reported feeling relieved and calm. However, Klonksy (2009) argues that whilst self-harm may provide a method of affect regulation, this regulation can reinforce self-harm. The detrimental outcomes related to self-harm, including its link to suicide, add to the argument that further research in this field is essential.

Interventions for Self-Harm

Although it is a frequent concern for mental health services, the efficacy of treatment for self-harm is varied. NICE (2013) guidance is unable to recommend a specific treatment protocol, merely stating that "three to twelve sessions of a psychological intervention" (p. 30) should be offered. One psychological intervention is Dialectical Behaviour Therapy (DBT), which focuses on distress tolerance skills and chain analysis to understand what led to self-harm occurring and therefore what strategies could have been implemented to stop someone engaging in self-harm (e.g., Chapman & Gratz, 2009). However, Whitlock, Eells, Cummings, and Purington (2009) noted that clinicians often feel they lack effective knowledge to treat self-harm, and although they favour DBT approaches, these are not wholly effective. Furthermore, Hawton et al. (2016) conducted a systematic review evaluating the evidence for interventions for self-harm. They

found that the majority of interventions were based on low quality evidence so findings are inconclusive. Additionally, a reduction in self-harm repetition is not the only important outcome and people who self-harm may be more concerned with the intervention improving their quality of life, rather than focusing on cessation (House, 2020a).

Self-Harm and Help-Seeking

There is concern over whether support, regardless of its efficacy, is actually being accessed. Rowe et al. (2014) identified that one third to a half of adolescents who self-harm do not seek help and Hawton, Rodham, Evans, and Harriss (2009) note that many people who self-harm never come to the attention of health professionals. Barriers to accessing professional support could include fearing a negative reaction e.g., being labelled 'attention seeking', or fear of confidentiality being breached, e.g., to family members (Rowe et al., 2014).

Rickwood, Deane, Wilson, and Ciarrochi (2005) considered that the help-seeking process is where "the personal becomes increasingly interpersonal" (p.8). Their help-seeking model involves appraising the 'problem' as something needing intervention. Secondly, the 'problem' needs to be expressed so others can understand it. The third component relates to accessible sources of support, and the final aspect relates to the individual being willing to disclose their inner state to the helper. This model raises concerns in relation to self-harm help-seeking as individuals may value it as a coping strategy (i.e., they do not see it as a 'problem'). In support of this, Brown and Kimball (2013) found that participants viewed self-harm as an important and reliable coping mechanism for distress. Additionally, support for self-harm can be hard to access and not wholly effective (e.g., Hawton et al., 2016). Self-harm is also stigmatised which could impact on disclosure willingness (e.g., Rosenrot & Lewis, 2020). Having to disclose means the individual is required to express self-harm and how they are feeling. Research suggests that this can be difficult for those who self-harm as these individuals may lack the words to describe how they feel (Norman, Oskis, Marzano, & Coulson, 2020). Individuals who self-harm face the issue of worrying about reactions to their disclosure; responses can be unpredictable, ranging from being understanding and accepting to invalidating or avoidant (Rosenrot & Lewis, 2020).

Fortune, Sinclair, and Hawton (2008) constructed a potential model of help-seeking specifically related to self-harm based on interviews with young people. This model identified 'push and pull' factors that influenced help-seeking behaviours. Initially help-seeking is thought to be influenced by gender, ethnicity and age, followed by the individual's perception of their self-harm, that is, whether it was viewed as someone's choice, an impulsive act, 'not that serious,' or someone had a shift in their mood or a problem was resolved, all of which made someone less

likely to seek help. The third aspect of the model relates to whether the person felt something could be done or not, linking to fears of people not understanding them, feeling that they should cope on their own or just not wanting help. The motivation to act was influenced by an individual's emotional state, fears that help-seeking could hurt others, that it would create more problems, or they would be labelled as attention-seeking. If an individual had decided to seek help, this could be affected by being unsure what to say or being unsure how to approach getting help. Finally, the model outlines the potential sources for help including friends, parents, and professionals, with each of these sources linked to its own costs and benefits, varying between the participants. This help-seeking model was based on a self-report questionnaire which means that the experiences reported may be inaccurately recalled. The responses could not be followed-up or clarified and not all participants completed every question. Finally, the sample used was of 15-16 year olds which may limit generalisability of the model.

For those that do seek help this is predominantly from family and friends, the latter of which is something considered to be developmentally appropriate for young people (Fortune et al., 2008), as opposed to professional support-seeking. There is a distinction made between formal and informal help-seeking; the former being delivered by professionals with a recognised role in providing support and the latter relating to help sought from social networks with a personal connection to the individual (Rickwood & Thomas, 2012). Informal support can work alongside or in place of formal support and is important in helping those who self-harm and could assist in the prevention of self-harm (Tham, Ibrahim, Hunt, Kapur, & Gooding, 2020). De Choudhury and Kiciman (2017) identified that social support and self-expression can improve an individual's mental wellbeing; therefore, resources that allow for this, such as social media, could act as a support for those who self-harm. In this expanding area of social media, others are involved in providing assistance, but may be unknown to the individual and not have a 'personal' relationship with them. Social media is considered to be an important source of social support for those who self-harm (e.g., Record, Straub, & Stump, 2019) and is often a first port of call for those seeking health related advice (e.g., Beaunoyer, Arsenault, Lomanowska, & Guitton, 2017). Therefore, it is important that such initial contacts are beneficial for the individual, prompting the need for further examination into this area in relation to self-harm.

Social Media and Help-Seeking

Ofcom (as cited in Mitchell, McMillan, & Hagan, 2017) reported that 33% of 18-29 year olds used the internet to research a mental health concern. It was identified that only 11% of young people sought self-harm information from professionals, compared to 73% who did so via websites, radio, television, and social networks.

Harris and Roberts (2013) suggest that help may be sought online by those who feel unable to seek help offline, perhaps as offline sources are perceived as judgmental. The ease of access, flexible use and anonymity of social media are cited as other potential benefits of online help-seeking which can reduce fears of stigma (Mitchell et al., 2017). This is contrary to NHS services that have funding issues, lengthy waiting lists, and are time limited (Naslund, Aschbrenner, Marsch, & Bartels, 2016). In support, Carey et al. (2018) suggest that young people who self-harm can feel more comfortable using social media to discuss self-harm due to the anonymity it provides, so exploring and understanding self-harm can be done without the knowledge of parents and friends or peers. However, there are risks in online help-seeking, which will be discussed in following sections.

The relationship between offline and online help-seeking requires consideration. Social media has the potential to be a 'steppingstone' or a barrier to seeking offline support (Daine et al., 2013). Frost and Casey (2016) conducted a survey on young people and reported a paradoxical relationship where those who self-harm and seek online support are less likely to have sought help offline, however they report that in future they would be more likely to seek professional support. Perhaps it is online resources that suggest how offline help could be sought. This has support from Mars et al. (2015) who identified that individuals who used the Internet in relation to self-harm were more likely to seek professional help than those who did not use it for this purpose. The pathways to care model suggests that online help-seeking for those who self-harm can be considered the primary intervention or an introductory step to seeking help offline (Frost & Casey, 2016). On the other hand, Lewis, Heath, Michal, and Duggan (2012) suggest that some online activity could 'glamourise' self-harm and present the view that nothing can be done to stop it, leading to people perceiving that their self-harm does not warrant help. In support, Lewis and Knoll (2015) examined first aid tips for self-harm depicted on YouTube, they suggested that this material could reinforce the belief that professional help is not needed. However, the focus here was the content of the video, rather than considering the direct impact the videos were having on viewers. Additionally, there could be a difference between seeking support for how you are feeling versus more specific information seeking, e.g., about caring for wounds; individuals may use the internet for one but look for professional help for the other.

Online help-seeking is common for those who have self-harmed. Whilst this is not the only motivation for social media use in this group, it holds a complex relationship with offline support-seeking. If social media is a likely first port of call for help-seeking for young people who self-harm, it is important that we develop a better understanding of the nuances of self-harm content on social media.

Social Media

Social media is an umbrella term, defined as interactive platforms and applications that enable user-generated content to be created, discussed, modified, or exchanged (Kaplan & Haenlein, 2010). Aichner and Jacob (2015) outlined the existence of thirteen different types of social media, including social networks, blogs, forums, social gaming, and video/photo sharing sites, such as YouTube and Instagram. Social networks, such as Facebook, have been defined as a media type that connects others with shared interests (Aichner & Jacob, 2015). In 2020, 70% of UK households used the internet for social networking and 66% used it for video watching and sharing sites (Office for National Statistics, 2020). In 2020, Facebook and YouTube were the most dominant platforms used in the UK (Revive Digital, 2020). The landscape of social media is ever-changing. Where once forums, message boards and dedicated websites were commonly used, this has evolved to social networks and video and photo sharing sites (e.g., Harris & Roberts, 2013).

My investigation adopted a broad definition of social media (akin to Kaplan & Haenlein, 2010; Aichner & Jacob, 2015) and allowed participants to stipulate what social media platforms they used rather than pre-defining this as an inclusion criterion. This enabled recruitment to be broad and allowed for an examination of the perceptions of self-harm content across different sites. The literature review that follows focused on social media, rather than general internet use.

Social media and young people.

Social media is of particular importance and relevance to young people, sites are increasingly accessible with most young people owning a smartphone (Frost, Casey, & Rando, 2016) and the Pew Research Centre (2019) reported that 90% of internet users aged 13-29 years held at least one social media account. In the UK in 2020, over 90% of 16-34 year olds reported using the internet for social networking (Office for National Statistics, 2020).

Social media has become the norm in youth and young adult life and may be helping individuals manage the transitions characteristic of this life stage (Vaterlaus et al., 2015), such as, when peer groups relocate for higher education or employment. It holds a key role in adolescent development meaning it is paramount for us to remain up to date about its effects (Shafi, Romanowicz & Croarkin, 2018). It is thought to contribute to identity development as young people shape their online worlds and interact with each other on social media (e.g., Subrahmanyam & Šmahel, 2010; Berryman, Ferguson, & Negy, 2018). Online activities are key mechanisms to achieve connectedness, figure out one's identity, and decrease isolation, perhaps also in a less intimidating way than face-to-face interactions (e.g., Callahan & Inckle, 2012).

Periods of development for young people can give rise to distress. Social media offers a platform where this can be discussed with peers as coping strategies transition away from being linked to a young person's parents (e.g., Bokhorst, Sumter, & Westenberg, 2010). This is of particular importance for young people who self-harm, as not only are they going through similar changes as their peers, but they are also faced with the stigma attached to self-harm (Lloyd, Blazely, & Phillips, 2018).

Social media and mental health.

There has been much discussion and difference of opinion regarding the link between mental health and social media. Best, Manktelow, and Taylor (2014) systematically reviewed research relating to social media and young people's wellbeing. Among the benefits reported were increases to self-esteem, safe identity exploration, and social support. Best et al. (2014) suggest that these benefits indirectly could improve wellbeing. In support, from an interview study, Davis (2012) asked young people about the impact of their online interactions. Thematic analysis identified that these interactions were important for self-disclosure and a sense of belonging. However, the generalisability of these findings is questioned due to the specific and small sample size. Naslund et al. (2016) commented that those experiencing serious mental illness benefit from social media encounters; they feel empowered, can learn coping strategies and gain insight for making health related decisions.

A conceptual model explores how those with mental health concerns use social media support and what opportunities from engaging in this could be (Naslund et al., 2016). Using social media support is seen as a result of experiencing distressing symptoms, feeling isolated and scared to reach out, and fearing stigma. In turn, using online networks is seen as a method of challenging stigma, and increasing the potential to seek healthcare information and access interventions for wellbeing. However, this is a conceptual model and understanding the nuances of online support could best be considered with the view of the individuals who are accessing it in mind.

On the other hand, Lin et al. (2016) examined social media use and depression in young adults, a high frequency of visits to social media sites was associated with an increased risk of depression. Kelly, Zilanawala, Booker, and Sacker (2018) used questionnaire data from the UK Millennium Cohort study. They found that more time spent on social media related to poor sleep and body image, low self-esteem, and harassment online, and these factors related to higher depression scores. In support, O'Reilly et al. (2018) found from focus groups of adolescents, that social media was thought to cause depression and anxiety disorders and left the user open to cyberbullying.

However, Berryman et al. (2018) outlined that, for young adults, social media use was not associated with mental health concerns. It must be acknowledged that these cross-sectional studies (Lin et al., 2016; Kelly et al., 2018; Berryman et al., 2018) cannot impute causation. Coyne, Rogers, Zurcher, Stockdale, and Booth (2020) conducted an eight-year longitudinal study examining social media and mental health (depression and anxiety). Data was collected through a once-yearly questionnaire. Coyne et al. (2020) found no association between time spent on social media and mental health concerns. Another longitudinal investigation (Heffer, Good, Daly, MacDonnell, & Willoughby, 2019) examined social media use (based on hours of use) and depressive symptoms (measured by questionnaire) in adolescents and young adults. Heffer et al. (2019) found that social media use did not predict symptoms of depression. While these longitudinal investigations can provide more evidence for lack of causality, they are still not free from the effects of confounding variables.

It is important to note that survey questions here were related to general social media use rather than specific sites. Methodological concerns in these investigations should be acknowledged. The use of self-report measures to assess for mental health concerns and social media use can be inaccurate forms of measurement and the varied findings could be attributed to differences in the outcome measures used. The investigations focus on depression and anxiety and do not explore other mental health concerns. It must be recognised that the majority of research in this area relates to time spent on social media, which does not account for the content or context of social media use and its impact on mental health (Coyne et al., 2020).

Papamichail and Sharma (2019) commented in their Barnardo's report that a causal link between social media use and mental health concerns in young people is not conclusive. They suggest that more research is needed to understand the impact of social media use on young people. We must be careful to not make assumptions based on what we think is helpful or harmful to young people. Despite the lack of clarity between social media and mental health, the media frequently associates social media use with poor mental health outcomes (e.g., Barr, 2020). Timpano and Beard (2020) suggest the need for further research to explore the link between social media and mental health beyond just considering the frequency/duration of social media use to considering types of use and motivations for use.

Explaining the link between social media and mental health.

The links between social media and mental health are unclear. Three potential mechanisms are considered: i) those experiencing mental health concerns could spend more time online, ii) time online could displace other 'healthy' activities, and iii) harmful interactions or content are experienced online which affects an individual's mental health.

Firstly, people already struggling with their mental health may spend more time online (Timpano & Beard, 2020). Those experiencing depression may be more likely to access social media to gain social communication that may be too challenging in person given the impact of depressive symptoms (Radovic, Gmelin, Stein, & Miller, 2017). Similarly, individuals with high anxiety could access social media more as a form of communication due to fears of rejection and evaluation that feel too overwhelming in-person (e.g., Valkenburg & Peter, 2009). There is also the question of congruency of content; people with mental health concerns could be more likely to seek out content that is aligned with how they feel. In support, Oksanen et al. (2016) suggest that vulnerable individuals, who already hold negative self-beliefs, are more likely to be at risk of accessing harmful online content, which could feedback into these self-beliefs. This links to the information processing error, that individuals struggling with mental health concerns may be more likely to attend to content that fits with their pre-existing beliefs about the world, and other information that does not fit is filtered out (e.g., Lang, Blackwell, Harmer, Davison, & Holmes, 2012).

Secondly, time on social media could displace other activities and this is where the 'harm' stems from (e.g., Brunborg & Andreas, 2019). This relates to the "shallowing hypothesis," (Carr, 2010) which states that social media activity can lead to a decline in ordinary daily reflective thinking which impacts on wellbeing. Social media could also be displacing face to face interactions. Timpano and Beard (2020) suggest that if social media use is passive then this can mean that someone's sense of belonging is reduced, which can lead to lower mood. Social media could reduce the link with more positive coping strategies and augment more maladaptive ones, such as avoidance and suppression, although further research is needed to examine this (Timpano & Beard, 2020).

Sleep and exercise play key roles in the wellbeing and general development of young people (Milojevich & Lukowski, 2016; Mandolesi et al., 2018). Social media can lead to poor sleep and increased sedentariness (Timpano & Beard, 2020). Hökby et al. (2016) conducted a longitudinal investigation, using questionnaires, to explore young people's mental health and internet use. They found that lack of sleep, as a consequence of internet use, had a notable detrimental effect on mental health (measured using a depression, anxiety and stress scale) at four month follow-up. However, Hökby et al.'s (2016) investigation had a high dropout rate, which reduced the power of the analysis. They also excluded participants at risk of suicide, meaning that those with more severe mental health concerns were not represented in the findings.

The third mechanism relates to 'online harms'. This refers to the fact that there may be content or mechanisms online that are harming people's mental health. In support, George (2019) outlined that time online does not affect mental health, but the content of what people are viewing does. There is a distinction within this between harmful interactions such as

cyberbullying or the encouragement of damaging behaviours versus witnessing harmful content (e.g., HM Government's Online Harms White Paper, 2019).

The interactions people are having on social media could cause the adverse impact on mental health. Behaviours such as bullying or being actively encouraged to take part in harmful behaviour are present in 'offline' life and have a detrimental impact on young people. This detrimental impact is likely to be mirrored when these behaviours are enacted online also. It is well-established that bullying affects mental health in the short and long term (e.g., Takizawa, Maughan, & Arseneault, 2014). Bullying could be exacerbated online due to the anonymity being online affords, meaning online abuse can go unnoticed or unreported. Cyberbullying has been associated with depression, substance abuse and suicide (Bottino, Bottino, Regina, Correia, & Ribeiro, 2015). In support, Kim, Colwell, Kata, Boyle, and Georgiades (2018) explored cyberbullying and mental health concerns in young people using surveys. When controlling for traditional forms of bullying, Kim et al. (2018) found that cyberbullying significantly predicted behavioural and emotional problems in young people. Incitement, or being encouraged to engage in criminal or risky behaviour, could also impact upon a young person's mental health; for instance, existing vulnerabilities could be worsened through the encouragement of self-starvation, self-harm or suicide (Dosani, Harding, & Wilson, 2014).

Another explanation suggests that online harm relates to the exposure to harmful content online, e.g., images of risky behaviour, or to the social comparisons made with online content that can leave individuals feeling inferior. This points to the difference between someone being actively told to harm themselves versus them being exposed to stories and images of individuals engaging in risky behaviours.

Branley and Covey (2017) explored exposure on social media (an inclusive definition akin to Kaplan & Haenlein, 2010) to content portraying 'risky behaviour' (e.g., illegal drug use, self-harm, violence). To assess for risky content, they asked about viewing material that is supportive of risky behaviours, provides instruction regarding these behaviours or depicts these behaviours positively e.g., presenting them as 'fun' or 'cool'. They found that online exposure was a significant predictor of offline risky behaviour. However, the direction of the relationship is unclear. Branley and Covey (2017) suggested an alternative explanation - that individuals who have a desire to engage, or already engage in 'risky' behaviours, may be more likely to seek 'risky' content out. Their finding could therefore just be a mirror of what is already going on in society, a result of social learning and modelling another's behaviour viewed online, or a combination of these.

Brunborg and Andreas (2019) also suggest that social media could expose individuals to role models who engage with harmful behaviours. This is important in adolescence and emerging adulthood where peers and the media, rather than parents or caregivers, are the likely sources

for role models (e.g., Gorrese & Ruggieri, 2012). This has connections to social learning theory (Bandura, 1971), which outlines how observed behaviour is repeated, and behaviour can be reinforced through reward or punishment (e.g., Branley & Covey, 2017). Therefore, 'risky' behaviour is more likely to be enacted when witnessing both the behaviour and favourable reactions/attitudes towards the behaviour on a platform such as social media (Branley & Covey, 2017).

Keipi, Oksanen, Hawdon, Näsi and Räsänen (2017) suggest that 'harm-advocating' online content (a term used to describe the intention of the person posting the content as opposed to the effect of the content on viewers) includes pro-eating disorder, pro-self-harm, and pro-suicide content. They collected survey data from 1587 American and Finnish young people (aged 15-30 years), asking them about exposure to harm-advocating content, subjective wellbeing and social media activity. Questions around exposure to harm-advocating content asked participants whether they had seen sites about ways to harm/kill oneself or 'be very thin', or whether they had seen sites showing death or murder in the last year. They found that exposure to this content was associated with lower subjective wellbeing. However, the direction of this relationship was unclear due to the cross-sectional design, and the authors did not determine whether content had been sought out or encountered accidentally. Furthermore, the length of exposure and the frequency were not measured, limiting the interpretation of the findings.

Social comparison theory (Festinger, 1954) suggests that, as people, we want to gain accurate evaluations of ourselves. To do this we compare ourselves to others to work out where we measure up in terms of our opinions and abilities, so uncertainty about the self is reduced and we have an understanding of how to define ourselves (Vogel, Rose, Roberts, & Eckles, 2014). This relates to comparisons made by young people on social media. Brunborg and Andreas (2019) suggest social media content is selective to give a perfectionistic view of life which is envied. These comparisons impact on young people's wellbeing if they perceive others to have a 'better' life than they do (Chou & Edge, 2012; Orth, Robins, & Roberts, 2008). Social media comparisons are suggested to cause an increase in symptoms of depression (Radovic et al., 2017). In support, Nesi and Prinstein (2015) used self-report questionnaires at two time-points with 619 students. They found that technology-based social comparison was associated with increased depressive symptoms. However, this link could be explained by extraneous variables, and the accuracy of self-reporting must be questioned.

Social media and self-harm.

Rodham, Gavin, Lewis, St Denis, and Bandalli (2013) noted that as internet use is becoming more pronounced, the way self-harm is communicated has changed, from being once secretive to now shared online. There is suggestion that those who self-harm may prefer social media as a

means to communicate about their concerns (Lewis & Knoll, 2015; Pritchard, Lewis, & Marcincinova, 2021). However, a systematic review implicated social media in the escalation and maintenance of self-harm in young people (Dyson et al., 2016). The increase in self-harm rates can be linked in a causal way to the increase in social media use. This can hinder our understanding of the motivations behind self-harm related social media use, fails to consider extraneous factors and is potentially an over-simplistic view on a complex relationship.

Motives for using social media.

Kaukiainen and Martin (2017) suggest that self-harm related social media use allows the user a level of self-validation and enables access to social support. Jacob, Evans, and Scourfield (2017) used interviews with young people and explored participants' motivations for going online in relation to their self-harm as part of their results. Participants cited a variety of reasons for going online, including: to find support, to make sense of their self-harm, or to discover new self-harm practices/techniques. The social media site Tumblr was cited as commonly used due to the ability to share images, which allowed people to document their self-harm journeys. The use of images also evoked physical reactions which could be associated with the functions of self-harm for some young people. However, recruitment was only through Facebook so it may have discounted those young people who use other sites.

Pritchard et al. (2021) analysed self-harm related posts from a social network app and suggested that those who self-harm are using social media to vent, discuss self-harm urges, to distract themselves, or get support to prevent self-harm. However, the app they examined was specifically mental health focused and may not be representative of content shared on more general social media. Additionally, the absence of demographic information means there is limited transferability.

Potential motives for why individuals who self-harm start, continue, and cease the use of e-communities have been explored (Lewis & Michal, 2016); e-communities here referred to YouTube channels and Facebook groups, among others. Lewis and Michal (2016) used online questionnaires (including three open-ended questions and the 'Inventory of Statements about Self-Injury,' Klonsky & Glenn, 2009) to explore motives. Thematic analysis of questionnaire responses showed that motives for using e-communities included getting help for self-harm, helping others and to understand self-harm. However, further research should consider what else exactly social media offers that other sources cannot to support those who self-harm. As the questionnaires were online, Lewis and Michal (2016) were unable to ask follow-up questions to ascertain what aspects of e-communication each participant's answers related to – exploring this in more depth would develop our understanding of the motivations behind e-community use.

Lavis and Winter (2020) analysed self-harm related posts on Instagram, Reddit and Twitter and completed 10 semi-structured interviews. They suggested that individuals may go online to make sense of their self-harm, to seek crisis support or to manage self-harm urges, and to get help from others with shared experiences, among other motives. They highlighted how individuals who self-harm are motivated to go online due to feeling misunderstood or ignored offline by parental figures and professionals. Lavis and Winter (2020) also explored the motives behind posting images, including to alert others to someone's need for support with images becoming more graphic as a way to maintain support due to increasing need, rather than as a result of competition, which is often the assumption.

While the motives for self-harm related social media use have been acknowledged, as with mental health more generally, there are concerns regarding the impact of social media on self-harm.

Social media and self-harm: the risks.

There are risks associated with self-harm related social media use, some of which will be discussed here. These risks include: self-harm being normalised, triggered or exacerbated, the potential for online abuse or rejection, and the impact of helping others.

Firstly, a key concern is around the normalisation of self-harm, which is argued to increase the risk of engaging in self-harm (e.g., Gooseens, Cleator, Dziurawiec, & Chen, 2016). From a systematic review, Dyson et al. (2016) argue that viewing self-harm content on social media can affect the young person's perception of the behaviour and reinforce their belief of it as an accepted coping strategy, preventing less damaging alternatives from being considered. Normalising self-harm can reduce the threshold for this behaviour (Smithson et al., 2011) and can mean that the severity of self-harm acts is minimised (e.g., Dyson et al., 2016). When self-harm is minimised, through interactions on social media, it can reduce the likelihood of someone seeking support (Daine et al., 2013).

Lewis et al. (2011) reviewed self-harm related videos on YouTube and suggested that regular viewing of these could normalise the behaviour and reinforce it. However, Lewis et al. (2011) only assumed that the videos could 'normalise' self-harm. This assumption was based on the suggestion that the popular videos (videos with more views and positive ratings) were artistic and could be attractive to those who self-harm and 'normalise' the behaviour. This was as opposed to asking the viewers their opinions on the videos and normalisation of self-harm. They also did not operationalise 'normalisation', so a link between self-harm maintenance and the videos was unable to be considered. These results were also based only on a subsection of videos, giving an incomplete picture, and lacking generalisability to other videos.

The concern that online exposure to self-harm content normalises self-harm and prevents the individual from stopping self-harming (Lewis & Baker, 2011) relates to cultivation theory (Gerbner, Gross, Morgan, Signorielli, & Shanahan, 2002). This outlines how messages can become normalised when they are common and repeated and with repeated exposure this can become reinforced and contribute to continued self-harm (Lewis & Knoll, 2015).

Research suggests that viewing self-harm content online can be triggering, with young people imitating self-harm (e.g., Arendt, 2019). In one study, 18% of young people outlined that their decision to self-harm was directly influenced by social networking site use (O'Connor, Rasmussen, & Hawton, 2014). Cavazos-Rehg et al. (2017) analysed self-harm related posts on Tumblr, some posts were suggested as giving harmful advice regarding how to self-harm secretly. They expressed concerns that the posts 'glorified' self-harm, and they identified the glorifying nature of self-harm posts as a concern for young people who are easily influenced by their peers. However, it is unclear which posts they classed as 'glorifying', and the term 'glorifying' was undefined.

Arendt, Scherr, and Romer (2019) found that exposure to self-harm on Instagram predicted self-harm one month later. This related to accidental and intentional exposure which is important for understanding the impact of "coming across" content. Yet their analyses do not prove causality, as third factor variables are likely to be involved in the relationship between Instagram exposure and self-harm. Arendt et al. (2019) also based these findings on a niche sample, with participants recruited from online gaming sites, limiting transferability of the results. Additionally, Harris and Roberts (2013) raise the issue of causality, not only was self-harm a concern prior to the evolution of social media, individuals reported self-harm related internet use (including forum use) after self-harm rather than preceding it. However, the relationship is likely to be complex with a combination of self-harm both preceding and following social media use.

Lavis and Winter (2020) outlined that self-harm can be exacerbated, as one interviewee noted that this was a mechanism by which online support was maintained. The authors also found that gaining support on social media can fuel the separation between online and offline worlds and prevent help-seeking. Young people may access support online due to feeling isolated offline but a reliance on online contact can reduce confidence to socialise offline, thereby making it harder to integrate into offline worlds. This is compounded by sites (in this instance, YouTube) not discussing recovery from self-harm, which could perpetuate the problem in some, by not offering them a different perspective (Lewis, Heath, Sornberger, & Arbuthnott, 2012).

Cyberbullying relating specifically to self-harm can also be counted as a risk of using social media. Hilton (2017) discusses the propensity for those who share self-harm material on social media to be ridiculed by the public, who often misunderstand the behaviour. This can hamper

the recovery process and evoke more distress. Additionally, Niwa and Mandrusiak (2012) examined posts via content analysis in four self-harm Facebook groups and found that a highly prevalent type of post related to harassment and verbal abuse directed at those who self-harm. They suggest that the anonymity of social media sites means that these posts are likely. Niwa and Mandrusiak (2012) distinguished between trolling, posts intended to attack or provoke, and flaming, posts intended to encourage or mock self-harm. These posts have the potential to cause emotional and physical distress (if self-harm results due to encouragement or perhaps a way to cope with the abuse itself). However, this presents a partial picture as only Facebook groups were explored, and many abusive posts may have been removed by moderators prior to being available for analysis. Additionally, it does not account for the impact of these posts on those just observing, rather than commenting, and no demographic information was collected, limiting transferability of the findings.

Whilst there is the acknowledgment of the harm that can be caused by interactions online, there is also the concern that individuals can face further rejection online with posts not gaining responses, perhaps akin to the rejection they have felt offline (Harris & Roberts, 2013). Furthermore, the reproduction of self-harm related images can reinforce stereotypes of self-harm being a young white female problem, whilst this can foster connection in those identifying with this image, it can also silence others who do not (Lewis & Seko, 2016).

It is well established that people who self-harm seek support from others on social media. However, being in the helper role can take its toll emotionally, with young people feeling responsible for another's welfare (Lavis & Winter, 2020). There is also the impact of vicarious trauma, being distressed by bearing witness to another's distress, either described in text or picture form (Lavis & Winter, 2020).

Social media and self-harm: the benefits.

Social media can provide a sense of community, support, and a space for self-expression, it gives individuals a sense of purpose by helping others and gives hope for recovery. These areas will be discussed in more detail here.

Dyson et al. (2016) outline that social media sites offer a sense of community and belonging; the latter a basic human need universal to all (Maslow, 1943), but of special importance for those who self-harm, a behaviour perceived negatively by society (Baker & Fortune, 2008). This relates especially to adolescence and young adulthood where feeling accepted is highly important. Duggan et al. (2012) outline that informal web resources (e.g., social media sites, YouTube) make users feel less judged, which is important to those experiencing shame, distress or isolation linked to self-harm. Hilton (2017) explored the presentation of self-harm on Twitter by analysing posts. Twitter was considered a helpful platform to express yourself when you

have been let down by other sources and it was suggested to be a useful source of support and a sense of community for those who self-harm. Additionally, as friendship groups for young people exist increasingly online, these resources could provide a source of peer support that is more acceptable to young people. However, there are limitations to how much can be understood about self-harm and social media using this method, where participants are not directly engaged with and using Twitter which limits the number of characters of a post, meaning that posts only show an edited representation of self-harm.

The support received on social media may reduce self-harm. Dyson et al. (2016) reviewed studies examining social media sites used to discuss self-harm. They noted that connections made on these sites could have therapeutic potential and sites were used to encourage people to seek treatment and to give advice on stopping self-harm. In support, Lewis and Seko (2016) offered that social media can reduce feelings of isolation and self-harm urges, encourage self-expression, and promote recovery. Sites have also been used as an alternative to self-harm by serving as a distraction, a coping strategy, or a way to express oneself, the latter two mirroring self-harm functions (Baker & Fortune, 2008). In support, Duggan et al. (2012) examined the scope and nature of self-harm on social networking sites and YouTube by analysing the content of the most popular sites. They acknowledged that the sites provided information and allowed users to express themselves.

Social media offers an opportunity to help others who self-harm and to feel competent in doing so (Dyson et al., 2016), showing the switching of roles between helper and the one being helped. However, these conclusions may not be representative of all social media as Dyson et al. (2016) did not include some of the more popular sites used now e.g., Instagram. Sternudd (2012) used a questionnaire to examine the reasons for and reactions to producing and viewing images of self-harm online. Sternudd (2012) found that the images were thought of as alleviating rather than triggering and allowed people to give or receive help from others. Lavis and Winter (2020) also identified that the process of helping can manifest in many ways, for instance, people showed care via emojis and shared first aid tips. They also virtually ‘sat’ with others in distress and people had opportunities to discuss the context of self-harm. Adler and Adler (2013) noted from posts on online self-harm communities (including MySpace) that helping others gave individuals purpose and value, they wanted to reciprocate the help they had received online and helping others could also motivate the helper to continue their recovery (in this case to not self-harm).

The portrayal of recovery on social media can have a beneficial impact on those who self-harm. Individuals have been praised and encouraged when sharing how long they have been ‘clean’ of self-harming (Lavis & Winter, 2020). Lewis, Seko, and Joshi (2018) conducted an experimental study to compare the impact of hopeful versus hopeless messages regarding self-harm recovery

on YouTube. Participants were randomly assigned to view either the hopeless or hopeful fictional comments, and questionnaires were taken pre and post exposure. Exposure to hopeful messages was linked to a significant increase in positive attitudes towards recovery. It was notable that the hopeless comments did not link to a significant decrease in these positive attitudes. Lewis et al. (2018) concluded that exposure to such comments could foster a sense of recovery being possible and that the hopeless comments may not be as harmful as assumed. However, the sample was small, no control group was used, and the investigation was based on exposure to only six hopeless or hopeful comments, limiting generalisability of the findings. Additionally, the assessment of participants reading the comments was based on time taken to read the comments. This is not an accurate measure as participants may not have actually attended to all the messages in this time. Furthermore, Seko and Lewis (2018) conducted a visual narrative analysis on Tumblr posts. They reported the use of pro-recovery images, such as healed scars. They suggested that the scars represented resilience and strength for some and were considered an adaptive way to understand themselves and build self-worth.

The reaction from social media.

Whilst research has acknowledged the pros and cons of social media use related to self-harm, a reactive response to the negative side of this relationship has resulted in controlling the content of sites. The pull to exert control has resulted in certain images or posts being banned; for example, Instagram have censored images of self-harm (Hern, 2019). However, Gabriel (2014) noted that banning or filtering content or blaming social media for adverse events fails to consider the reasons for the person's social media use. Banning content shuts conversations down relating to why and how such content is accessed. Therefore, there is a need to open this up for discussion, akin to the Samaritans' (2019) call for a collective approach to understanding self-harm and suicide online content by bringing together the government, social media companies and those with lived experience. The 'Online Harms' white paper suggests that sites should be clear about what is acceptable content and consistently enforce this, but freedom of expression is central and a proportionate approach to dealing with online harm should be adopted (HM Government, 2019). However, it also faced criticism as it merged discussion regarding suicide and self-harm content with content relating to terrorism, child pornography and dark-web drug dealing (House, 2020b).

Instagram has faced criticism from users for censoring images, as it has been suggested that self-harm scars allow others to see their recovery progress (Bramwell, 2019). Lavis and Winter (2020) outline the difficulty when platforms ban hashtags linked to graphic and supportive content as, while the former is the intended target, both kinds of content are lost. There is also the query regarding what determines 'graphic' content and the concern that it is 'outsiders' who do not use the platforms that are determining what content is 'graphic' or 'harmful'. Again, the

opening up of discussions about self-harm content with young people is essential (Moreno et al., 2016). Additionally, restrictions on content imposed by social media platforms can be overcome by users such as via changing hashtags, as was done with Instagram (e.g., Vega et al., 2018; Record et al., 2019).

Lloyd (2014) points to the importance of understanding the nuances and adopting a more dynamic approach to protect young people on social media whilst acknowledging the potential of social media. In sum, it is clear that this area needs further exploration as the instant reaction has been to ban content, not only can this cause harm to those using social media for self-harm purposes, but there are also ways around posting banned content, and doing this prohibits us from exploring the impact of such content on those who have experienced self-harm.

The Current Study

The benefits and harms of social media for self-harm purposes have been explored. The view presented to the public often relates to the perceived harms of social media on young people who self-harm (Dyson et al. 2016). Yet there is query regarding whether it is too simplistic to consider social media as just 'good' or 'bad' (e.g., Marchant et al., 2017; Lavis & Winter, 2020). Additionally, platforms are likely to hold both protective and harmful characteristics making it more challenging to classify any one site as beneficial or a risk (Till & Niederkrotenthaler, 2014). Therefore, this study aimed to build on our understanding of the nuances of self-harm related social media use from the perspectives of those who self-harm and use social media.

Research aims/questions.

This study aimed to explore the use and perceptions of social media in relation to self-harm from the perspectives of young people who have self-harmed. This will aid the understanding of the relationship between social media and self-harm. This project created a space for those who have self-harmed (an often-marginalised group) to be heard. This encompassed an exploration of the following questions:

1. How have young people who self-harm used social media to view, share, and discuss self-harm material?
2. What are the motivations for using social media in relation to self-harm?
3. What are their perceptions of social media as a vehicle to discuss self-harm/seek support?

Addressing the limitations of existing research.

Due to the ever-evolving nature of social media, investigations quickly become outdated (Lavis & Winter, 2020; Daine et al., 2013). Therefore, there is a need for research itself to keep up with the changes in social media. Studies in this field can be based upon an analysis of social media posts or online surveys; this is helpful for reducing researcher bias, but it prevents direct engagement with those who use social media for self-harm purposes (Mars et al., 2015; Jacob et al., 2017). Research based on posts prevents the collection of demographic information (e.g., Lewis & Knoll, 2015) and without this contextual information, limited conclusions can be drawn. It also fails to account for the individuals who self-harm and use social media but do not post. We are unable to learn about some social media sites from posts alone, such as Snapchat, where posts are automatically deleted after a time (Carey et al., 2018). Researchers may also be unaware of the more secretive search terms that can be used to identify certain posts which means a more complete picture of self-harm related social media use cannot be gathered (e.g., Cavazos-Rehg et al., 2017).

Lavis and Winter (2020) speak about the importance of considering the context and complexity of self-harm and of self-harm related social media use. Rather than making assumptions about the direction of this relationship and perceived benefits and harms there is a need to include the voice of those who use these platforms. Picardo, Mckenzie, Collings, and Jenkin (2020) outline the need for more qualitative research about social media and self-harm from the users' perspective "to obtain reliable users' information, and better understand what in their view constitutes self-harm content online, why they engage with it, how it affects them, and relates to them offline" (p.13). Hence with this study I aimed to tackle the concern that less has been done to examine self-harm related social media use directly from the perspectives of those who have self-harmed. I have conducted interviews to do this, which also allowed for the collection of demographic information to contextualise the findings.

Whilst the absence of demographic information means that often participant age cannot be specified, those investigations having direct involvement with participants focus on adolescents or those in emerging adulthood which fails to acknowledge social media use in young adults (e.g., Jacob et al., 2017). It is important to consider the views of young adults as social media has been around for upwards of 20 years (Lavis & Winter, 2020) and social media is likely to have played a role in the developmental periods of their lives, especially for those who have self-harmed, similarly to adolescents. I have included the views of a wider age range of individuals and remained inclusive of gender and ethnicity to give voice to those, e.g., men, young adults and ethnic minorities, whose voices are less apparent in research regarding self-harm and social media. One theory suggests that self-harm can take two paths: beginning in early adolescence and declining in early adulthood or remaining a concern from childhood

through to older adulthood (Whitlock, Powers, & Eckenrode, 2006; Nixon, Cloutier, & Aggarwal, 2002). Therefore, encapsulating a proportion of adolescents and young adults in this study allowed for consideration of how social media is used for both profiles, considering how social media use fluctuates with changes in self-harm.

I kept a broad view of social media for this study rather than focusing on one or two sites as there are often differences and overlaps between sites and how they are used which can be lost in investigations with a narrower focus (e.g., Lewis et al., 2012). In support, Jacob et al. (2017) discuss the importance of understanding young people's interactions with a variety of mediums on different sites.

Potential implications.

Adding to the evidence base and developing a clearer awareness and understanding of the nuances of social media use in those who self-harm could help to guide policies in this area for the benefit of young people. This is further supported by Lloyd (2014) who suggested that "with proper engagement, policy makers and health professionals could use social media to connect with young people on issues like mental health" (p. 340). Additionally, Radovic et al. (2017) noted that when young people became more aware of the consequences of social media, they engaged in more 'positive social media activities' such as gaining social support and were more aware of what they were posting and the implications of posts.

Cavazos-Rehg et al. (2017) further support the need for us to understand how to balance the freedom of expression and support offered by social media whilst using social media to support those who may need more formal intervention. This further nuanced understanding could facilitate the creation of more tailored social media support systems, as current supports are suggested to be generic and less able to meet the needs of young people who self-harm (Pritchard et al., 2021).

CHAPTER TWO: METHODOLOGY

In this chapter, I will explore the qualitative research design, its rationale and my epistemological stance. I will then consider my decision-making surrounding the choice of semi-structured telephone interviews, the use of Thematic Analysis, the study sample size and participant criteria.

Design

This project employed a qualitative design and took the form of an individual interview study. Qualitative research can allow for a thorough understanding of the research topic (Howitt & Cramer, 2007) and, as such, fitted well with this projects' aims.

Qualitative Research

Qualitative research methods allow for the collection of rich, descriptive data which emphasises the individual's perspective (Howitt, 2019). They also allow for the exploration, description and interpretation of participants' personal and social experiences (Smith, 2015). These methods facilitate the understanding of diverse perspectives, and through them, underlying assumptions, beliefs and values can be probed (Choy, 2014). In support, Mack, Woodsong, MacQueen, Guest, and Namey (2005) outline a key strength of qualitative research is its ability to obtain complex descriptions of a person's experience of the research topic and allows the 'human' elements of difference and contradiction to be explored. Data collection in qualitative research can be wide ranging. Willig (2008) discussed four main approaches: semi-structured interviews, focus groups, observation, and diaries. However, other methods are also employed, such as the use of images and videos (Redlich-Amirav & Higginbottom, 2014). The flexible nature of qualitative research means that participant responses can be meaningful, spontaneous and explanatory as opposed to participants feeling forced into choosing predetermined responses which can feel a less meaningful way to discuss their experience (Mack et al., 2005).

Hilton (2017) suggests that qualitative approaches are favourable when exploring self-harm as they can capture the subjective nature of self-harm rather than only a universal understanding. Research regarding social media and self-harm can be focused on online surveys or analyses of online posts (Jacob et al., 2017), Branthwaite and Patterson (2011) argue that the use of 'social media monitoring' (the observing of posts on social media), may not be a reliable expression of an individual's experience. It also removes beneficial attributes of other qualitative methods

such as the ability to probe answers, develop a shared understanding between researcher and participant and to add context to the data. They suggest that social media monitoring is not an adequate substitute for in-depth qualitative research. There is also discussion about the ethics of social media monitoring as essentially data is taken without permission (on the assumption that it is in the public domain). This is not always seen as appropriate – especially if the data (and therefore the poster) can be identified in the results (e.g., Henderson, Johnson, & Auld, 2013). With all of this in mind, my study offers an opportunity for the voices of those who self-harm and use social media to be heard and explored.

The disadvantages of qualitative methods should be acknowledged, such as it being labour intensive and for interview studies, the data collected can be impaired if the interviewer has poor interviewing skills (Choy, 2014). Choy (2014) outlines the risk of important issues being overlooked as the researcher's experiences and knowledge will affect the research processes. There is the potential for the interviewer to become too involved with the interviewee resulting in difficulties separating their views and perspectives from the participants' (Schonfeld & Mazzola, 2013). While these issues were acknowledged, a qualitative method was still considered the most appropriate option for my investigation. The potential disadvantages are considered through my reflexive statement and quality checks detailed at the end of chapter three.

Qualitative approaches can take different epistemological stances; epistemology relates to the nature of knowledge and the justification of claims to knowledge (Carter & Little, 2007). In this study, I adopted a social constructionist position, viewing experience as a reading of environmental conditions rather than a direct reflection of them (Willig, 2008). This encourages a critical stance of my assumptions about the nature of the world and offers an opposing view to other stances, for instance positivism which deems that what we observe reveals the true nature of the world (Park, Konge, & Artino, 2020). Social constructionism offers the view that there are 'knowledges' not just 'knowledge' (Willig, 2008). In relation to my study, Fylan (2005) suggests that less structured interview formats are well aligned with social constructionist stances. This stance also allows for an appreciation that knowledge is constructed by both interviewer and interviewee and as the interview progresses, perspectives are likely to unfold. Additionally, it acknowledges that the circumstance of the research interview and the social pressures associated inevitably affect the interview's content (Koro-Ljungberg, 2008).

Methods of data collection

Semi-structured interviews.

For this project, I collected data via semi-structured interviews using a topic guide (Appendix A). The topic guide outlined potential questions to ask the interviewee, this acted as a foundation, but the conversation could also flow freely, allowing the participant to lead the conversation's direction (King, Horrocks, & Brooks, 2019). The topic guide was constructed based on the research questions and existing literature. Using a topic guide means that similar questions can be asked to each participant, so some cross comparison can occur, but also means that different areas of importance for individual participants can be considered in more depth (e.g., Hill et al., 2005).

Semi-structured interviews can be used effectively for the exploration of complex and sensitive issues. As discussing self-harm is a sensitive topic, this type of interview provided opportunities for participants to ask questions about the study, and to be debriefed and their wellbeing to be assessed at the end of the interview (Fylan, 2005). This supports why focus groups were not used in this investigation; while focus groups are useful for establishing consensus and identifying differences, they can also prevent deeper and more personal disclosures due to them being a more public forum (DiCicco-Bloom & Crabtree, 2006). Semi-structured interviews also allow for clarification and elaboration of questions and answers (Howitt & Cramer, 2007); for example, contradictions in a participant's account can be explored through probes (King et al., 2019). This is particularly relevant when considering the social constructionist perspective, which assumes that an individuals' response is not pre-determined and fixed but likely to emerge and change during the interview (Fylan, 2005). While more structured interview approaches can reduce the effects of the interviewer, they can also hinder understanding the interviewee's unique perspectives (Knox & Burkard, 2009).

A draft of the topic guide was discussed with the supervisory team. The topic guide focused on: i) understanding participant's activities on social media in relation to self-harm across time and different sites, ii) understanding what using social media for this purpose afforded them, iii) what challenging experiences on social media were like, and iv) the impact of social media on self-harm behaviours and its relationship with professional support-seeking.

Telephone interviews.

Initially, I considered online interviews as this acknowledges the preference for those who self-harm to communicate online (e.g., Lewis & Knoll, 2015). I contacted the University of Leeds Learning Technology team to discuss what platforms enable online chat interviews. The 'Blackboard Collaborate Ultra' platform was explored and tested out with peers. This was found

to be confusing to use and the security of the data collected from this platform could not be confirmed with the Learning Technology team or the manufacturers of the software. From further supervisory discussions, it was felt that online chat interviews would alter the data collected, as typed responses can be more moderated and less free-flowing than oral responses. Additionally, Opdenakker (2006) outlined that achieving in-depth interviews can be more time consuming online and the interview could be affected by the typing abilities of the interviewee/interviewer.

For the above reasons, it was then felt that telephone and face-to-face interviews (for local participants) would be more appropriate. This is supported by Hamilton and Bowers (2006) who identify that cues and opportunities to clarify responses can be lost with text-based interviews. Research also outlines the differences between oral communication, likely to be closer to the individual's real experience, and written communication, likely to be more objective and less abstract (e.g., Hawkins, 2018). Telephone and face-to-face interviews provide synchronous communication, where there is no delay so responses are spontaneous (Opdenakker, 2006). However, the 'real-time' nature of these types of interviews places demand on the interviewer to be holding questions in mind, listening to responses and making notes (Opdenakker, 2006). Due to Covid-19 pandemic restrictions and from further supervisory discussions, it was decided that telephone interviews only would be conducted.

Novick (2008) outlined concerns when implementing telephone interviews, including the absence of visual cues and contextual data that could affect data quality. However, there is a lack of evidence to support this concern (e.g., Sturges & Hanrahan, 2004; Novick, 2008). Sturges and Hanrahan (2004) note that telephone interviews afford the interviewee a level of anonymity when compared to face-to-face interviews and for sensitive topics, they suggest that this could improve data quality. King et al. (2019) suggest that telephone interviews can facilitate research participation, especially important for marginalised groups. Holt (2010) also suggests that the absence of non-verbal cues with telephone interviews means that everything has to be articulated which potentially increases the richness of the data collected. Additionally, Opdenakker (2006) argued that the visibility of the interviewer could unwittingly guide the interviewees responses.

Choosing Thematic Analysis

I chose Thematic Analysis (TA) as the framework for my analysis as it allows for a wider view in exploring the use and perceptions of social media of those who self-harm. TA is a qualitative technique used to identify, analyse, and report patterns within data (Braun & Clarke, 2006). It involves searching across the data set to find repeated patterns of meanings.

Some of the central characteristics of TA include its ability to be used across a range of epistemologies and research questions (Nowell, Norris, White, & Moules, 2017). There has been debate over classing TA as a standalone method rather than a process which can assist analysis (Nowell et al., 2017). It has been suggested that the flexible nature of TA could mean that it is liable to inconsistencies and lack of coherence in themes developed (Holloway & Todres, 2003). Yet these issues can be mitigated by employing checks such as considering others' interpretation of the same data and giving examples to demonstrate the analysis (Willig, 2008).

Although some of the disadvantages have been considered, TA offers a thorough yet accessible form of analysis. Additionally, guidelines have been produced to assist the production of more rigorous TA (e.g., Nowell et al., 2017), which fuel the need for it to be considered as a method in its own right. King (2004) also note that TA offers the opportunity of a well-structured approach for data analysis which in turn can produce a clear final report. In support, Guest, MacQueen, and Namey (2012) argue that TA is effective at encompassing the complexities of meaning within the data.

Different qualitative analysis methods with varying theoretical backgrounds were considered for this project. Two such methods are Interpretative Phenomenological Analysis (IPA), which is concerned with how individuals make sense of their own experiences (Smith, Flowers, & Larkin, 2009), and Grounded Theory, which employs inductive strategies in data collection and analysis to develop theory (Charmaz, 2014).

TA was chosen as it allows for a more flexible approach and for larger amounts of data to be analysed. This is as opposed to IPA which is focused more specifically on a few people's experiences and is argued to be constrained by its theoretical roots (Braun & Clarke, 2006). TA was also chosen over Grounded Theory as my project is interested in the views of social media of those who self-harm rather than developing a theory. A more flexible approach was preferred and Grounded Theory has been argued to be over prescriptive in its guidelines (Hodkinson, 2008). It has also been suggested that Grounded Theory results in the production of small-scale theories which fail to consider the wider world impact on participants. Additionally, the lack of initial hypotheses and prescriptive processes mean that the researchers subjective experiences are not considered (Hodkinson, 2008).

Sample

Sample size.

There is the need to balance having enough participants to develop a rich understanding of the topic whilst ensuring that the amount of data collected is manageable (Robinson, 2014). Three

issues were considered in deciding this study's sample size: data saturation, qualitative interviews, and publication. The concept of data saturation has been suggested to aid decision making surrounding sample sizes; saturation being defined as the point at which no further themes are found from repeated reviews of the data (e.g., Malterud, Siersma, & Guassora, 2016). Guest, Bunce, and Johnson (2006) and Ando, Cousins, and Young (2014) suggest that qualitative studies typically need a sample size of 12 to reach saturation. However, this threshold can be impacted by factors outside the researchers' control, such as, the project timescale and budget, how homogeneous the sample is, and the researchers' experience in assessing saturation (Dworkin, 2012). Others argue that true saturation is not possible, as due to the uniqueness of each participant there will always be new concepts to discover (Wray, Markovic, & Manderson, 2007).

For studies using qualitative interviews, a broad range of sample sizes has been suggested. Terry, Hayfield, Clarke, and Braun (2017) recommended that for Professional Doctorate programmes, a sample size between six and 15 (for an interview study) is appropriate. Terry et al. (2017) emphasise the need to maintain data quality rather than focusing solely on the quantity of participants. In the literature, interview studies related to self-harm and social media use sample sizes ranging from 10 (Baker & Fortune, 2008) to 21 (Jacob et al., 2017). The potential for publication also needs consideration; 30 participants was suggested by Charmaz (2006) as an appropriate size for publication.

My project aimed for 12-15 participants as an appropriate number to balance the issues of publication, saturation and the typical sample sizes of interview studies in this field, whilst ensuring a thorough analysis could be undertaken.

Inclusion criteria.

Participants were eligible for the study if they were UK-based English-speakers, aged 16-29 years who had self-harmed and used social media in relation to self-harm. In this study I used the NICE (2013) definition of self-harm which outlines self-harm as "an act of self-poisoning or self-injury, irrespective of motivation" (p. 11).

The age range of 16-29 years was selected for three reasons. First, this age group is likely to be more homogeneous (i.e., experiencing similar life stages). A homogeneous sample can lead to estimates which can be transferred more accurately to the population (Jager, Putnick, & Bornstein, 2017). There have been changes over time in UK society with a higher proportion of young adults living with their parents for longer, marrying and having children later (Office for National Statistics, 2019). This is perhaps due to the rising cost of rent, first-time home buying and a higher number of young people remaining in education (Office for National Statistics, 2019). Second, adolescents to young adults make up the majority of social media users (e.g.,

Office for National Statistics, 2020). Third, this age range encompasses stages from late adolescence, emerging adulthood, and young adults (Oksanen et al., 2016). Whilst self-harm in adolescence has been the primary focus of research, it is important to consider self-harm rates for those in emerging and early adulthood, too (e.g., Griffin et al., 2018), as these are significant periods of transition. The instability in these life stages can lead to less settled lives, unemployment, and mental health concerns (Schulenberg & Zarrett, 2006; Griffin et al., 2018). For example, Kessler, Chiu, Demler, and Walters (2005) identified that by the age of 29 years, more than half of young people surveyed had experienced mental health concerns. Self-harm prevalence among adolescents and young adults is also high (Lloyd-Richardson, Lewis, Whitlock, Rodham & Schatten, 2015).

I kept the inclusion criteria broad and inclusive for other participant characteristics, such as gender and ethnicity, to allow for a diverse range of voices to be heard. A summary of participant demographics is provided in the results section.

Exclusion criteria.

The NICE (2013) definition of self-harm excludes harm from over or under eating, alcohol or drug use, accidental harm or body piercing or tattooing. Exclusion from the study applied if these methods were the only reported self-harm.

Both recruitment adverts (Appendix B) and information sheets (Appendix C) included the specified inclusion criteria and were confirmed when individuals completed the Background Questionnaire (Appendix D). Confirmation of a participants' age being 16 years or over was included on the consent forms (Appendix E).

CHAPTER THREE: METHOD

This chapter will outline the procedures involved in carrying out my investigation. This includes details regarding recruitment, the overall procedure, participant involvement, data collection and analysis along with associated quality checks, followed by ethical considerations, reflexivity and dissemination plans.

Recruitment Strategy

Opportunity sampling was used to maximise recruitment. Participants were recruited through free social media posts using a recruitment advert. The moderator of the National Self-harm Network forum was contacted via private message on the forum and agreed for the advert to be posted in the research section of the forum. I contacted PAPYRUS (a national charity for the prevention of young suicide) via email who agreed to advertise the study by posting it to their Instagram story. On my Twitter account (used only for research purposes), I posted the study advert and tagged relevant organisations in order for them to 're-tweet' the advert and reach a wider audience. On Reddit and Facebook, I located 'subreddits' (for the former – relating to pages regarding a specific topic) and groups related to self-harm and messaged the group lead/moderator privately through the site to request permission to post on the page. The majority of groups/pages contacted gave permission for the advert to be posted, no adverts were posted to pages where permission had not been given. On Facebook I ensured to disable the ability for viewers to comment on the post as the posts were not monitored. It is notable that some groups/subreddits related to specific mental health concerns e.g., eating disorders, did not give permission for the advert to be posted. This could have meant that the sample was potentially not representative of a more clinical population.

The advert gave brief details of the study and my contact details. I re-posted the advert regularly until the appropriate number of interviews were completed. To acknowledge the time taken to complete the study, participants were entered into a prize draw for a £20 gift voucher.

Procedure

Participants interested in the study contacted me using my secure university email address detailed on the advert. On receipt of this email, I provided participants with the data privacy notice and information sheet. The information sheet included details of what was required of the participant and any associated risks or benefits to taking part. I encouraged potential participants

to ask questions about the study via email. Participants who expressed continued interest after reading the information sheet were sent an electronic consent form via email. The consent form had a tick box option to indicate their consent to taking part in the study. The consent form included an agreement to be audio recorded and gave information on withdrawal.

When the completed consent form was returned, I asked participants to complete a short background questionnaire (sent via email). The questionnaire allowed for the collection of demographic and background information. Information regarding how they heard about the study, the type of social media they use and which sites self-harm content is discussed or shared on was gathered in this questionnaire. Using this questionnaire meant that interview time was freed up for me to focus on topics directly relevant to the research questions. After receiving the completed questionnaire, I arranged a telephone interview with participants. Prior to the interview, the debrief sheet, containing support service details, was emailed to participants.

I was based at home when calling participants for interviews due to Covid-19 pandemic restrictions. Interviews were conducted in a private room using a mobile phone with a withheld number. Interviews were recorded using the loudspeaker phone function and a Dictaphone. As the participants' environment could not be controlled (e.g., Opdenakker, 2006), I asked participants if they had enough time and privacy to speak freely at the start of each interview. I also clarified consent verbally. There was a discussion regarding management of risk, the remit of confidentiality procedures and construction of a safety plan (Appendix F), which I emailed to participants after the interview.

At the end of the interview, I asked participants whether they would like to be contacted to review preliminary themes and regarding the project's findings.

Participant Involvement

The information sheet was developed in consultation with LifeSIGNS, a user-led self-harm charity, and with input from a young person with experience of self-harm involved in the Patient and Public Involvement (PPI) group with which one of my supervisors is involved. This was to ensure that the information sheet was written clearly and sensitively. A draft was emailed to both parties for review and the feedback was used to make improvements. The risk escalation procedure was also reviewed by the young person from the PPI group (Appendix G).

For further involvement, I asked participants whether they would be interested and consent to being contacted to review the themes from the preliminary analysis of interviews, 14 out of 15 participants consented to this. When I had developed the initial set of themes I contacted these 14 participants by email to ascertain if they were still interested in taking part. Eight out of the 14 responded. I sent them the thematic map and a summary of the themes and asked them for

their thoughts; all communication was via email. I was clear in stating that the themes were from the early stages of analysis and stated that the participants may not recognise themselves in all themes as they were an amalgamation of 15 interviews. Of the eight who indicated interest, four replied with their thoughts which were used to amend the themes.

Data Collection

I conducted 15 phone interviews, the first on 3rd September 2020 and the final on 14th December 2020. Interviews lasted between 42 and 90 minutes with the average interview length being 59 minutes. Interview times varied which allowed for flexibility in the preferences of participants. I did not conduct late evening interviews due to the absence of support available for myself if needed at this time. One of my thesis supervisors was contactable by phone for daytime and early evening interviews, but this support was not required.

Interview procedure.

I called participants at the pre-arranged time, introductions were given, consent was checked verbally, and I offered them the opportunity to ask questions. DiCicco-Bloom and Crabtree (2006) outline the importance of developing rapport with interviewees to facilitate sharing of their experiences; the quality of the relationship between interviewer and interviewee affects the depth of information gathered (Knox & Burkard, 2009). I established rapport initially through easing the participant into the interview, which is likely to have felt like an unusual experience (DiCicco-Bloom & Crabtree, 2006). As all participants had completed the background questionnaire prior to the interview, this allowed for a starting point to discuss how they were using the social media sites that they had indicated on the questionnaire. This created a natural start to the interview, and I felt it helped the participants relax and become more comfortable with the process.

The interviews were structured using the topic guide. To manage the interview, I asked one question at a time and used open-ended questions. I also asked follow-up queries, such as “tell me more about…?” to explore topics more thoroughly (Mack et al., 2005). I clarified answers I was unclear about and tried to reflect back what the participant had said to check my understanding. As the interviews were conducted on the phone, I had to be more mindful to overtly make affirming sounds and phrases like ‘mmm’ and ‘yeah’ to encourage the participant (Irvine, Drew, & Sainsbury, 2013). Throughout the interview I made notes to aid my memory and allow me to keep track of the participant’s answers so I could ask appropriate follow-up questions.

To bring the interview to a close, I asked if the participant had anything else to add that they felt was missed. At the end of the interview, I checked how participants were feeling and asked if

they had any questions about the interview or the investigation itself. At this point, participants were also offered the opportunity to be contacted to discuss the themes following the preliminary analysis or to be provided with a summary report.

I transcribed the first few interviews and sent one anonymised transcript to my supervisors to gain feedback. This feedback was incorporated when I completed the remaining interviews. For example, my supervisors encouraged me to ask more follow-up questions to understand whether the participant was actively seeking out self-harm content or had accidentally come across this content. After each interview I spent time considering how it had gone and wrote down my initial thoughts and feelings in the reflective journal to discuss in supervision. I was aware that in the first few interviews I listened back to I asked some leading questions. Leading questions invite the risk of leading a participant down a particular direction in line with the interviewer's assumptions instead of inviting the participants unedited perspective (Mack et al., 2005), as such, I tried to avoid using these in later interviews.

Data Analysis

I transcribed four interviews myself and the remaining 11 were transcribed by a university approved transcriber. The interview data collected was analysed by myself using a form of TA (Braun & Clarke, 2006). Throughout the analysis process I maintained notes in my research journal which allowed me to make sense of and track the evolution of my thinking.

Data were analysed using a combination of inductive and deductive reasoning. Inductive reasoning is a bottom-up approach derived from the data itself (Braun & Clarke, 2012). I attempted to stay close to the participants meanings so that codes/themes were generated inductively and not by attempting to fit the data to a pre-existing theoretical framework. Deductive reasoning is a top-down approach and involves the researcher bringing concepts, topics or ideas to the coding and analysis that inform this process (Braun & Clarke, 2012). I reviewed the literature in this field and used this to inform the research questions and topic guide, which is more akin to the deductive approach. Braun and Clarke (2012) suggests that this combination speaks to the reality of qualitative research as it is not possible to be wholly inductive as we are always bringing something, such as prior knowledge and experience, to the data when we analyse it. This is supported by Joffe (2012) who acknowledged that researchers bring preconceptions to the data but that they should also remain open to new concepts during the analysis.

Another choice I made was between semantic or latent themes. Semantic themes take more explicit, descriptive and surface-level meanings from the data, this is in comparison to latent themes which explore the underlying concepts, ideas and assumptions of the data (Braun &

Clarke, 2006). Both semantic and latent level themes were explored with my analysis as I stayed close to the participants perspectives but used supervision to encourage me to consider the more conceptual level and to understand deeper interpretations of what the participants were saying.

For my analysis, I followed Braun and Clarke's (2006) six phase approach to TA. This involved firstly becoming familiar with the data. I did this by listening back to the interview recordings and re-reading interview transcripts actively by making notes throughout. I made notes on each interview individually and then considered general notes with all the interviews held in mind (Braun & Clarke, 2012). These notes were discussed in supervision to share my initial thoughts.

Secondly, initial codes were generated. Codes allow for the identification and labelling of data features that are relevant to the research (Braun & Clarke, 2006). This process also allowed for data to be organised into meaningful groups (Tuckett, 2005). In this phase, I manually coded the transcripts line by line considering what was important and relevant to this study (Appendix H). I opened a word document for each interview to lay out what codes were associated with certain extracts of data; Table 1. shows an example of data extracts and codes.

Data Extract	Code Assigned
"…because I'm not sure that's really what Tumblr did but it provided me a framework for it… a framework of like shared experiences of intensity and shared experiences of distress and shared experiences of what I think became actually aestheticized and not necessarily in a straight forwardly helpful way but not … I'm loath to just frame it as unhelpful either because I don't think that's necessarily true…"	Making sense of experience using others' accounts Feeling not alone Complexity in relationship with social media – not black and white
" like a feeling of complete desolation that was really a feeling that I had in my own life and a feeling that was shared amongst these blogs that were all blogging their own material like quotes about darkness or difficulty wrapped up usually in a sense of gender … like broken girls and what it meant to feel like you were failing all the time or feel like you are unloved or unlovable …"	Shared pain/distress Normalised/validated feeling Creation of own worlds – which interact Echo chamber
"…the way in which Tumblr particularly, because it has this re-blog function, has an ability to …I wouldn't have described it this way at the time, but in hindsight what I would describe it as is like a circulation of affect that this intense distress got passed around between different blogs…"	Identifying with another – using their content Distress fostering distress

Table 1. *Example of data extracts and assigned codes*

When reviewing the codes, I noted that some codes were similar to one another. I manually sorted these by grouping similar codes together; Appendix I shows this process of sorting duplicate codes. I then gave the groups of similar codes an over-arching code name. As the coding process was iterative, I kept track of how the codes were evolving by maintaining a codebook in Excel (Appendix J). The codebook showed the over-arching code name, the similar codes grouped under this and data extracts (across all interviews) that related to this code. Saldaña (2021) recommends the use of a codebook due to the propensity for codes to amass quickly and change as the process progresses. Saldaña (2021) also argues that maintaining a codebook means codes can be re-organised and the evolution of codes is transparent. The codebook was shared periodically with my supervisors. Braun and Clarke (2006) identify the need to stop re-coding when no substantial, meaningful additions are made.

Phase three involved searching for themes by analysing codes and considering how different codes can be grouped to form themes. 'Overarching' codes from the codebook were manually organised and grouped into preliminary themes (Appendix K). Thematic maps were used to aid

this process. Thematic maps are visual representations of the relationships between codes and themes (Castleberry & Nolen, 2018). Terry et al. (2017) suggest that thematic maps allow the researcher to see how themes work together to produce a convincing narrative of the data. In this phase, I considered the relationships between codes, sub-themes, and over-arching themes. For example, the codes 'ensnared in online echo-chamber', 'distress fostering distress' and 'surviving not thriving online' were initially grouped under the theme of 'circularity of distress'. I also kept a 'miscellaneous' theme category to hold the codes that did not initially fit into other themes. This process aligned with Braun and Clarke (2006) who suggest that remaining inclusive at this point is important and decisions on whether these miscellaneous themes will be incorporated with another theme, refined or discarded, can be made later.

The fourth phase was a review of potential themes. I assessed whether a theme had enough evidence to standalone or if it needed to be combined with another. To assist with this decision making, Patton's (1990) dual criteria for judging categories was used. Patton (1990) outlines the need for internal homogeneity where the data within each theme corresponds meaningfully and external heterogeneity, meaning that themes are distinct from one another. For example, the preliminary themes of 'sense of community' and 'accepted' were combined into the single sub-theme 'community'. Additionally, in the 'regulating feelings' theme, the 'extension of self-harm act' sub-theme was split to form a separate sub-theme 'comparable to self-harm.' This allowed the difference between social media being part of the self-harm process or social media being used as an alternative to self-harm to be distinguished. The credibility of themes was checked against the whole data set by re-reading it, which allowed any data items missed to be coded and to check for confirmatory bias. Interview quotes for each theme were checked to ensure they provided a clear narrative.

Phase five involved defining and naming themes. I provided them with a working title and decided what facet of the data the theme encapsulated. These initial themes were discussed with supervisors and participants. The member checks gave rise to changes in the themes. For instance, two participants queried the use of the sub-theme name 'splitting' (under the 'Control' theme). One participant recommended that the term 'compartmentalising' was used instead, this was due to the connotations the term 'splitting' has when associated with borderline personality or dissociative disorders. Another participant spoke of the importance of linking the 'Offline/Online Relationships' and 'In Group' themes as they particularly connected the sub-theme 'abandoned/misunderstood offline' to the sense of 'community' that they sought online. It was recommended by one participant that the theme 'Regulating Feelings' was clarified in terms of highlighting how social media can allow this process of regulation through both 'healthy' and 'less healthy' mechanisms. 'Healthy' mechanisms related to allowing the validation of feelings and space to feel. On the other hand, 'less healthy' mechanisms outline how the relationship between feelings and self-harm content can form part of the self-harm

process. Initially, the sub-theme “stuckness” encapsulated the disconnection some participants felt towards other users which was fuelled by the lack of diversity represented online. However, both supervisors and one participant felt that this sense of disconnection and lack of diversity was better placed in its own sub-theme, the ‘out’ group. The participant explained that “stuckness” to them was more related to self-harm being normalised, rather than feeling distant from other users. In the final stage, I produced a report which formed the Results chapter.

Quality Checks

Credibility and dependability.

It has been argued that the terms reliability and validity can only be applied for quantitative research (e.g., Corbin & Strauss, 2008), alternative terms have been suggested for use in qualitative research. Lincoln and Guba (1985) outline the term credibility (akin to ‘validity’ in quantitative research), which refers to the degree to which the findings represent accurately the participants’ original views. Dependability (synonymous to ‘reliability’) relates to the research findings being consistent and repeatable (Lincoln & Guba, 1985). In order for this to occur, the research protocol needs to be logical, thorough and clear (Tobin & Begley, 2004). Guest et al. (2012) suggest ways in which the research design can be augmented to improve credibility and dependability, I will discuss these below:

Accuracy of transcripts.

I reviewed the transcripts whilst listening to the recordings to check for accuracy and amended any mistakes, this simultaneously allowed me to immerse myself in the data.

Audit trail.

For my project, dependability was enhanced by maintaining a clear audit trail of processes and decisions made (Nowell et al., 2017). Joffe (2012) suggests that outlining a ‘transparent trail’ is key for providing the reader with convincing evidence regarding the study findings. To aid this, I have outlined my epistemological position and have explained how I adhered to each stage of TA. I maintained a reflective research journal throughout and thoughts from this were shared in supervision. Reflective journals allow the researcher to consider their own assumptions and beliefs that are likely to impact upon the research (King et al., 2019). Vaismoradi, Turunen, and Bondas (2013) suggest that this can be a useful way to enhance rigor in TA. I kept my own notes from supervisory meetings, a codebook (with different versions to show its development) and notes related to the development of themes (as suggested in Nowell et al., 2017). I also maintained an Excel decision making log to track my thinking and rationales for decisions.

Supervision.

Results can be checked with colleagues to assess the credibility of findings and interpretations (e.g., Nowell et al., 2017). I shared a transcript from one of the initial interviews with my supervisors to gain feedback for conducting subsequent interviews (e.g., Guest et al., 2012). At the start of the analysis process, I shared an anonymised coded transcript with my supervisors to discuss initial ideas. Further supervisory discussions were held periodically throughout the analysis and write up process to assess the credibility of codes and themes and to seek advice on written work.

Providing context and examples.

The background questionnaire allowed for contextual information to be gathered, this is summarised in the results section. Providing this information means that others can make an informed judgement about the transferability of my results to their own context (Nowell et al., 2017). Participant quotes have been provided in the results section and example quotes with associated codes have been provided in this method section, enabling the accuracy of codes and themes to be assessed by the reader (Braun & Clarke, 2006; Guest et al., 2012).

Member checks.

Four participants provided feedback for the initial themes. Nowell et al. (2017) suggest this as a way to test out the findings and interpretations and enhance the credibility of them. Guest et al. (2012) further suggest that this is a helpful way to stimulate critical thinking.

Ethical Considerations

Ethical approval.

Ethical approval was obtained from the University of Leeds School of Medicine Research Ethics Committee (application reference: MREC 19-078; Appendix L).

Informed consent.

For participants who expressed an interest in taking part in the study, I provided them with an information sheet outlining the nature of the project and they had the opportunity to ask questions. Consent was gathered via an electronic form emailed to the participant prior to the interview. This was also verbally confirmed at the start of the interview.

Confidentiality and anonymity.

Lloyd-Richardson et al. (2015) reflect on the complex situation of confidentiality in self-harm research, some researchers suggest that all contact details need to be taken, regardless of

geographical coverage of the investigation, in case of situations of imminent risk. On the other hand, this extent of management and intervention may not be possible and asking for this level of information from participants is likely to impact upon engagement (e.g., Sharkey et al., 2011). Therefore, a balance needs to be struck between these two positions.

Participants' real names, email addresses and phone numbers were kept strictly confidential. I discussed the remit of confidentiality with participants at the start of the interviews in that if there was a disclosure of criminal activity it would have to be reported.

I conducted the interviews in a private room. Participants were informed at the end of the interview that their contact details would only be retained until the prize draw had been drawn or if they had granted permission to be contacted regarding themes from the interviews, or to be sent the summary report. Contact details were destroyed after the above reasons were actioned.

During transcription of the interviews, all identifiable information was redacted and my thesis supervisors only had access to these redacted transcripts. I completed the transcription of four interviews and the remaining 11 were completed by a University approved transcriber who had signed the Data Processing Agreement. Participant numbers were used for the write up of this project to maintain participants' anonymity.

Withdrawal.

Participants were able to withdraw at any point during the interview without providing a reason. After completing the interview, participants had up to ten working days to withdraw from the study. To withdraw, participants were asked to contact myself and were not required to provide a reason for their withdrawal. After this time, participants could not withdraw their responses as they had already been accounted for in the transcription and analysis. Participants could request, up to March 2021, that their quotes were not used in the report. However, no participants requested this or withdrew from the study.

Data collection and storage.

Participant email trails expressing interest and arranging the interview were deleted after the interview. Participants' names, email addresses and phone numbers were stored on a secure server on the University drive (with password protection) accessible only to me. The consent forms and background questionnaires were saved onto the secure University server and consent forms were held in a password protected folder.

I conducted the telephone interviews at home in a private room. The interviews were recorded on a Dictaphone. Immediately after each interview, the recording was transferred onto a secure server on the University drive and deleted from the Dictaphone. Recordings were shared with the transcriber via the encrypted OneDrive at the University of Leeds. Once transcribed, the

audio files were deleted. As participants were referred to by number, the paper document linking participant names and number was stored in a locked drawer at my home. Paper notes made during the interview were typed up and saved onto the secure University drive, the paper notes were then shredded.

After three years all respective research related documentation will be shredded and electronic files will be deleted from the server at the University, in line with University of Leeds data management procedures.

Safety and Wellbeing

For participants.

There is potential for distress to be caused when interviewing individuals about self-harm, therefore, a thorough consideration of participants' wellbeing above standard protocol was needed. Although there have been concerns about the impact of asking self-harm related questions, no evidence supports the claim that this has a detrimental impact (Lloyd-Richardson et al., 2015). Lloyd-Richardson et al. (2015) suggest that some individuals find participating in self-harm research helpful as it allows for self-reflection. This has support from Biddle et al. (2013) who examined the emotional state of participants before and after interviews regarding suicide and self-harm. They found that 50-70% of participants noted an improvement in their wellbeing and suggested that taking part in the research had been a cathartic process. However, this is best considered as a potential benefit of engaging in research of this kind rather than a guaranteed one.

Prior to participants engaging in the project, I provided them with an information sheet to make them aware of the purpose and nature of what was involved and potential implications of the study. This is aligned with Lockwood, Townsend, Royes, Daley, and Sayal (2018) who discussed that the potential for distress in self-harm research could be mitigated if participants see the project as worthwhile.

Participants were made aware of confidentiality protocols and that they could withdraw from the study at any time. A debriefing sheet with information regarding relevant support services was provided to participants prior to the interview. A safety plan was discussed with participants at the start of the interview to identify support services or strategies they could use if they became distressed. Lloyd-Richardson et al. (2015) recommend that a discussion at the start of the study about the best ways to manage distress should be held between researcher and participant. I also remained vigilant for signs of distress during the interview and a risk escalation procedure was in place. After the interview there was an opportunity for participants

to feedback as to how they found the interview and I checked in with how the participant was feeling.

As participants were asked to opt in by replying to adverts it was assumed that they made a decision that they felt to some extent comfortable taking part; this project was not targeting people in crisis. The approach to participant safety outlined above was developed with the PPI group and third sector partners who work with my main supervisor on a number of projects. This recognises the potential for distress whilst also acknowledging and supporting the rights of the participant to be in control of their own mental health support.

For the researcher.

Lloyd-Richardson et al. (2015) outline the potential for researcher distress when conducting qualitative research on sensitive topics. To offset this, they suggest regular supervision which I engaged with. My main supervisor was available by phone on the days of participant interviews meaning that concerns could be addressed; however, this support was not needed. I organised interviews with sufficient breaks for reflection and to ensure that the emotional impact of the interview was given consideration.

Reflexivity

Reflexivity is important within qualitative research and encourages the researcher to consider how their own experiences, values and beliefs have shaped the research and how, in turn, the research may have affected the researcher (Willig, 2008). It challenges the researcher to see themselves as having an active role in the research rather than seeing themselves as a neutral observer (King et al., 2019).

I am a white British female in my late-twenties, living in West Yorkshire. I was brought up in North Yorkshire, living with my parents and older sister. I completed an undergraduate Psychology degree in London and for the past few years have been completing the Clinical Psychology Doctorate, hoping to take on a Clinical Psychologist role after this.

I have had personal experience of self-harm in the form of friends who have self-harmed and have professional experience of working with those who self-harm on inpatient wards and in the community. It was important to me to research a topic with clear clinical implications as mental health is the area I endeavour to work in. Additionally, from both personal and professional viewpoints, the narratives of self-harm being viewed as only ‘manipulative’ or ‘attention-seeking’ sit uncomfortably with me, so it felt important to allow room for often stigmatised individuals to be heard. Over the years that I have worked in mental health services, I have seen the rise in the role of social media as both a source of support to otherwise isolated people and a

cause of distress. It is these experiences that have fuelled my interest in exploring more about this area. Social media is ever-evolving, therefore I feel it is essential that we stay up to date regarding this. This has become even more imperative in the last year due to the Covid-19 pandemic, with everyone spending more time at home and, consequently, more time online.

During my research interviews I found it difficult to hold being the 'researcher' not the 'Trainee Clinical Psychologist' in mind. Haverkamp (2005) outlines the difficulty of navigating between therapist and interviewer roles. This highlights the need to acknowledge our multiple selves and their interaction with the research, considering not only our 'research self' but our professional and personal selves too (King et al., 2019). For example, in an initial interview, I noted saying *"it can be tough if you come up against professionals… that can give you a difficult view of that sort of support can't it?"* as a display of empathy and validation to the participant. On reflection, I felt this was more appropriate for a therapeutic assessment rather than a research interview and was also a leading question. Haverkamp (2005) discusses the need to remain human and compassionate and foster a beneficial researcher-participant relationship without migrating into therapy. Responding too therapeutically in a research interview can be confusing for the participant and can influence the participant's answers to questions (Knox & Burkard, 2009). I was aware that my role as a therapist in my clinical work could also affect the analysis. For example, when coding one transcript, I reflected in supervision on the code *'moving away from problem solving'* which leans more towards therapeutic language. This highlights how prior experiences impact what we attend to and how we interpret data collected.

I was also aware of my own thoughts surrounding social media use. From comparison with similar peers, I would argue that my social media use is less than average. I have always been hesitant at engaging with social media and have been sceptical about its use, fearing the impact that social media comparison-making has on myself and those around me. From engaging in this research however, the participants have enlightened me to some of the benefits of engaging in social media and how important it can be for those who feel they have nowhere else to turn.

Finally, my ethnicity and gender introduced different dynamics to certain interviews. Two interviews in particular were conducted with one individual identifying as transgender and another identifying as Asian. While this was an element of difference between myself and the interviewee, they were both very open to sharing their experiences of self-harm in relation to their backgrounds. The participant identifying as transgender talked about the rates of self-harm in the LGBTQI+ community and how specific LGBTQI+ social media sites can be hostile platforms. The participant from an Asian - Indian background talked about the stigma of self-harm in their culture and how social media sites relating to supporting self-harm and mental health rarely target campaigns at those from Asian backgrounds, meaning that existing campaigns were felt to be less relatable. Additionally, a female participant also noted how men

are often treated with more hostility online and are less likely to receive support than females. Whilst my lack of knowledge in these areas could have been a barrier to the interview's progress, all participants were open to discussing these issues. This depicts how the research has changed and affected me, as well as how I have affected the research.

Dissemination

All participants were interested to know the conclusions of the project; I will create a summary report and email this to them as agreed. The research will be published on the White Rose eTheses site and there are plans to submit it for formal publication.

CHAPTER FOUR: RESULTS

In this chapter, I will first outline the participant demographic information, followed by the results from the TA.

Participant Demographic Information

Fifteen telephone interviews were conducted. Participants were aged between 18 – 29 years (mean age: 24.1 years). Ten identified as White British, three identified as White – Other, one participant identified as Black/Black British – African, and one identified as Asian/Asian British – Indian. Nine females and six males (one transgender) took part. Regarding relationship status, seven were single, six were cohabiting, one was in a long-term relationship and one participant was married. The highest educational qualification varied; one participant had completed A-levels, four were currently undertaking an undergraduate degree, two had completed an undergraduate degree, two participants had completed Diplomas, five had a Masters, and one participant had a PhD.

Self-harm.

The age of onset of self-harm ranged from 9 – 23 years with a mean age of onset of 14.8 years. Ten participants reported multiple methods of self-harm, including: cutting, scratching, burning, skin-picking, head-banging, overdosing, hair pulling, pinching self, biting self, blood-letting, ligature tying and hitting self.

The frequency of self-harm was variable within and between participants, from daily, weekly and monthly occurrences to a couple of times a year. Three participants had not self-harmed for over a year at the time of filling in the questionnaire. Two participants had not self-harmed for over six months. One participant self-harmed for the last time a few months prior to the questionnaire. Four participants outlined self-harming in the month prior and five participants self-harmed in the week prior to completing the questionnaire.

Social media use.

Eight participants were spending 1-3 hours per day on social media (including general and self-harm related social media use), six participants were spending 4-6 hours per day and one participant was spending less than one hour a day. Figure 1. shows the social media sites participants used in general. Figure 2. shows the social media sites participants used in relation to self-harm.

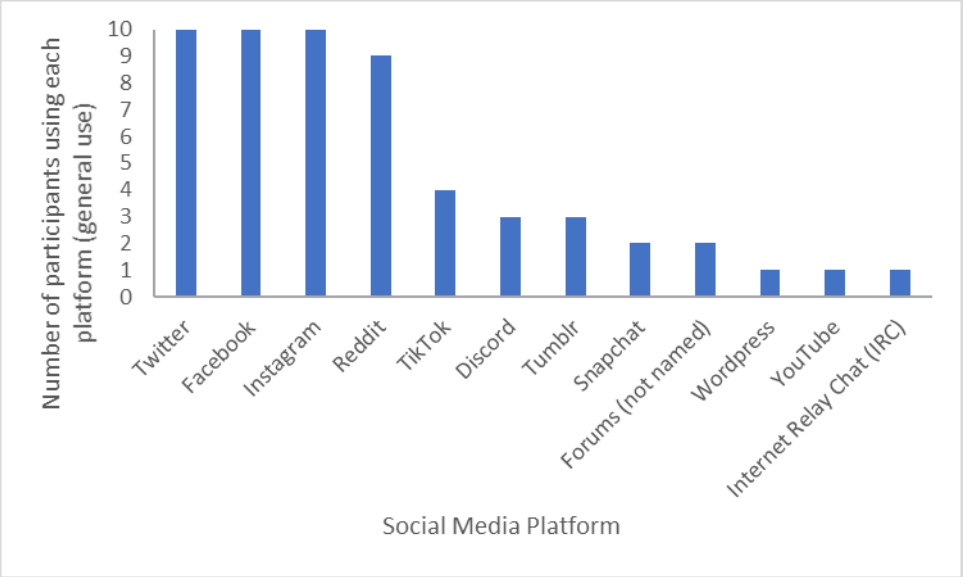

Figure 1. Number of participants accessing different social media platforms for general use.

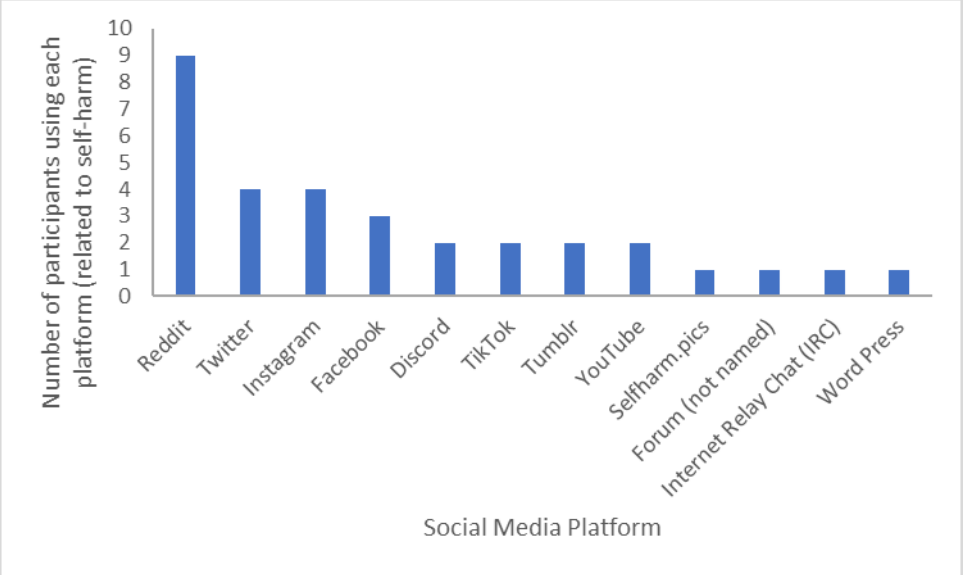

Figure 2. Number of participants accessing different social media platforms to view, share or discuss self-harm related content.

Qualitative Results

Across the interviews, participants discussed how and why they were using different social media sites related to self-harm. There were explanations about how participants began using these sites and how their use changed over time. There was consideration as to how someone's gender, age or self-harm experience interacted with the content and other users. There was discussion about how social media compared to 'offline' support and the limited nature of

professional support. Participants also considered their views on content being banned and whether they would recommend self-harm related social media use to others.

In this chapter, the four themes relating to the research questions will be outlined. The themes are ‘Offline/Online Relationships’, ‘Regulating Feelings’, ‘In Group’, and ‘Control’. These are shown in Figure 3. along with associated sub-themes.

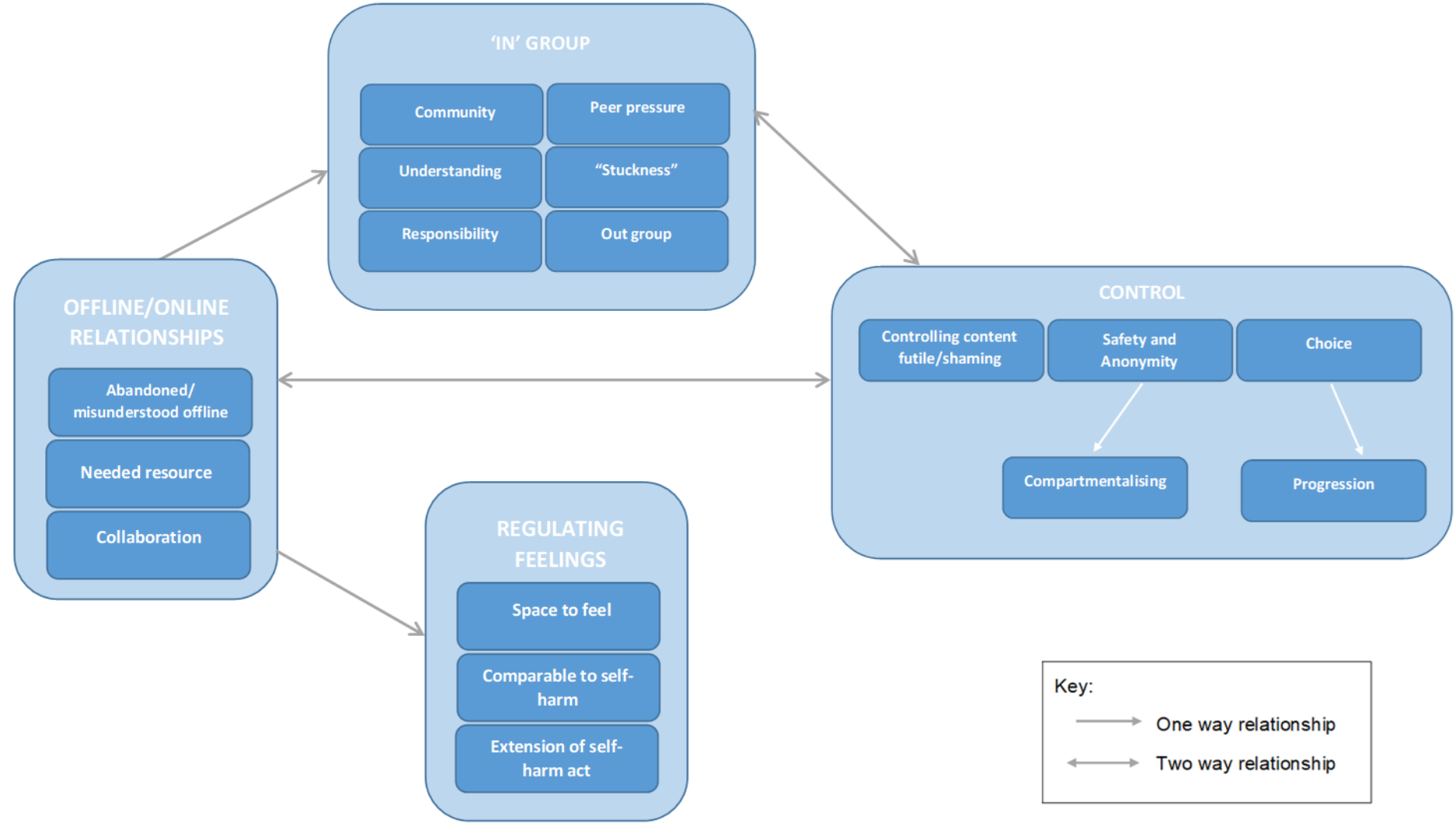

Figure 3. Thematic Map

Summary Description of Thematic Map

Participants were drawn to self-harm related social media use, in part, due to the responses, or lack of responses, they received offline - captured in the 'Offline/Online Relationships' theme. Being online allowed participants space for emotion regulation and expression, linking the 'Offline/Online Relationships' and 'Regulating Feelings' themes. However, in the 'Regulating Feelings' theme, participants discussed how social media formed part of the self-harm process which could perpetuate self-harm.

Social media offered an experience of not feeling alone or judged, influencing the development of the 'In Group' theme. There were different pressures and responsibilities when being part of the 'in' group, including feeling disconnected from this group, which perpetuated feelings of isolation. This linked to the 'Control' theme, where participants considered what safeguards are in place to protect them from these pressures and demands. Participants considered the choices they have about engaging with content or not and the control they held in keeping their offline/online worlds separate. This separation and anonymity enabled the honest and open expression of the community but also enabled online abuse to take place. Additionally, keeping their worlds separate could mean that they remain 'stuck' as distress is only managed online, which could be an unreliable source of support. This all contributed to a link back to the 'In Group' theme.

Also acknowledged were the wider perceptions of how social media has tried to control and censor content. This could be silencing and shaming - leaving participants to again feel misunderstood, showing the interaction between the 'Control' and 'Offline/Online Relationships' themes. This connection is bidirectional as participants discussed the need for offline and online worlds to work together to create a sense of control and understanding regarding content that is safe but not silencing.

I will now discuss each theme and its sub-themes, providing supporting quotes from participants.

Theme 1: Offline/Online Relationships

This theme outlines how difficulties in 'offline' interactions regarding self-harm led participants to rely on social media as an accessible support or outlet for their distress. 'Offline' relationships here related to both personal and professional relationships. Some participants reported that a perceived societal view of distress and self-harm - that distress needs to be 'fixed' and self-harm should be stopped - hindered 'offline' help-seeking also. At times, offline and online support did not exist in complete opposition, with it being accessed simultaneously or participants journeying between the two. This theme has three sub-themes: 'Abandoned/misunderstood offline', 'Needed resource' and 'Collaboration'.

Abandoned/misunderstood offline.

Participants described feeling abandoned and misunderstood offline. There was no room for distress to be discussed as participants feared the stigma of self-harm and being perceived as 'weird' or a 'freak' as others were confused about their self-harm. Participants felt that others, in their 'offline' life, would be unable to cope with the distress they felt.

"There's a lot that happens in our lives that teaches us that our distress is not welcome in the real world, that we won't get a good reaction to it, that there's no space for it… and I don't think the people in my life then were capable of handling, or responding to, or recognising me as a person who was existing with that much distress." (Participant 2)

One participant talked about there being no room for distress in particular for adults who self-harm due to the stereotype of it being a 'young person's problem.' Therefore, the shame of being older and self-harming impacted upon the offline outlets they had for support.

"I think it's a lot harder for adults to talk about stuff, considering it is traditionally viewed as a young person's problem, so I think there is a lot of shame around adult self-harm." (Participant 7)

Participants spoke of the difficulty accessing 'offline' help due to fears of how self-harm would be reacted to – either an over or under-reaction from those in their personal lives or professionals. For example, this could come in the form of professionals ignoring disclosures or wanting to call emergency services which panicked some participants. Participants feared that their loved ones would be upset at their disclosures of self-harm. There was also the difficulty in accessing referrals, poor relationships with professionals or lack of mental health service funding which formed a barrier to accessing support. Negative experiences of trying to access help, such as unhelpful responses from professionals, deterred participants from future help-seeking.

"I don't often talk about it with therapists or doctors because, again, the alarm that comes from that sends me. I get very bad anxiety. So, there have been times where I have been trying to be open and honest with someone about my self-harm and they've gone, right, I'm calling an ambulance..." (Participant 12)

There was concern about waiting times and the distribution of funding and support in that only those in crisis were seen as being able to access help.

"…mental health support, especially in the UK, it's not funded enough, it's just not. This medical framework for supporting people that do self-harm, unless you are literally on the verge of killing yourself, you're not going to get a referral to adult mental health services." (Participant 13)

There were concerns about the lack of mental health experience clinicians had; participants felt this contributed to professionals being unsure of how to helpfully respond to them. One participant remarked that they were actively discouraged from talking to their GP about self-harm due to potential repercussions.

"…other times it's kind of been more like, 'oh you shouldn't talk to me about self-harming because then that will be on your record forever and you don't want that'." (Participant 7)

If support was accessed, there was concern with the limited nature of the support offered. Support could be too basic and concerned only with maintaining the individuals safety rather than feeling therapeutic. Participants outlined issues with support being generic, and not being enough with a finite number of sessions given.

"…there is that common understanding that for a lot of people, just going to a mental health professional and getting the standard treatment, it doesn't really do much and so it's sort of slightly apathetic and robotic in that repetition…" (Participant 3)

"We all make fun of the techniques that you get taught, like a rubber band around the wrist or holding an ice cube or drawing a butterfly on yourself…they're useless things, they don't work at all." (Participant 12)

Needed resource.

The barriers and inadequacy of 'offline' help led to or reinforced help-seeking online as social media fulfilled a need and was seen as a valued resource by those who self-harm.

"…it was pivotal in my staying sane shall we say… I would actually go so far as to say I don't think without that sort of community around constantly, I'd say a lot of people would be in a lot worse of a state." (Participant 3)

Social media support was seen as flexible - something that could be accessed on an ad hoc basis rather than waiting or accessing time-limited treatment. It was also seen as not being constrained by timed opening hours. Social media was seen as open and available – with no threats of being discharged if you have been unable to access support regularly for some time.

"... you can go to a forum and you can be on there every day for a week and then not use it and then go back two months later and they're not going to go, 'oh no, you've had your time.'" (Participant 4)

Collaboration.

There were connections and journeys between social media and 'offline' support. The type of support needed was not considered fixed; participants spoke about how even though professional support was not what they were looking for right now, they may feel that this is what they would want in future. Social media was generally a first port of call for participants,

potentially due to the barriers of accessing professional support. However, professional support was often signposted by those online. Yet, for one participant, this was seen as less helpful if someone went online for support from that online source and did not want to be re-directed.

"…the most repeated phrase on places like that is that 'we are not mental health professionals you need to go and seek professional help' and obviously to a person who's going to post there, that's not helpful at all." (Participant 3)

Participants spoke about content online normalising accessing therapy offline and offering a realistic view of it; that therapy is not about 'fixing' people quickly. This was perhaps contrary to the societal view they had gathered about what therapy is and can achieve.

"…it never made me lose faith that therapy was a good thing or anything like that. I think it was just that it made me feel a bit more okay with the fact that I didn't go to a couple of sessions with the therapist and then magically get better, which I think was the view of some of the adults around me..." (Participant 10)

Over time the divide between social media and professional support was thought to have reduced, with some participants suggesting accessing online and offline support simultaneously.

"I think I would definitely suggest, speak to your GP first and then while you've got a treatment plan in place, look at these things, because they'll help. You know, it's kind of like using mindfulness alongside using an SSRI [an antidepressant medication] *or something. I think it's about using the two in tandem, and then really using one to bolster the other." (Participant 8)*

Participants suggested that more collaboration and communication between professionals and social media to support self-harm is needed. It was suggested that this could be done through trained professionals sharing knowledge online or having conversations with people about their self-harm related social media use.

"What would be helpful is someone with the qualifications going there and looking through some of these and just giving their two cents and helping out some people..." (Participant 3)

"Whereas when my medical professional started going 'why don't you try and get something positive out of it [accessing social media for self-harm purposes]', *that I actually started looking for stuff like that." (Participant 12)*

Some participants unusually wanted more connection between their personal offline world and their online self-harm content. This was in order to feel they had things in common with others in their offline world, to have help from loved ones regarding changing the way they use social media, to raise awareness of their struggles to friends/family and to have more personal responses from people they knew. This seemed somewhat contrary to other views where anonymity was paramount and there was a clear separation between offline/online worlds.

"I didn't mind anybody posting but the ones I wanted to hear from were the really close friends or the family..." (Participant 4)

"...with the support of my partner, we identified… like he used to be quite worried about my internet usage and what I was using the internet for and he has given me a lot of support in making social media a more positive place for myself." (Participant 10)

This theme captured how the different barriers and limitations of offline support such as stigma, fear, lack of funding and poor relationships led young people to access self-harm content online. Participants made recommendations for there to be more communication between offline and online resources to show acceptance to the inevitability of self-harm related social media content. This could also offer a mechanism to enhance the accessibility of professional support and keep conversations about self-harm related social media content open.

Theme 2: Regulating Feelings

The 'Regulating Feelings' theme encapsulates how social media can be used as both a 'healthy' and 'unhealthy' resource to regulate feelings; either allowing participants a space to feel or forming part of the self-harm process. Feelings and self-harm discussions were accepted online and regulated through different mechanisms such as being validated or through the use of humour. This emotional release was comparable to an actual act of self-harm and meant that for some participants, social media could serve as an alternative to self-harm. However, it formed part of the process for other participants' self-harm, either by participants viewing content prior to self-harm to trigger urges or viewing it after to regulate feelings of guilt or extend the high self-harm had produced. This theme had three sub-themes 'Space to feel' 'Comparable to self-harm' and 'Extension of self-harm act'.

Space to feel.

Social media was seen as providing an outlet for cathartic self-expression and participants described the sense of release they received from offloading.

"...it helps to stop it building up in my head until it explodes really, by sort of letting it out, like opening a tap." (Participant 15)

It offered participants room to express their distress and have it witnessed and validated without the immediate pull for someone to try and 'fix' them. It seemed that the solution focused approaches offline had the potential to invalidate the individual's experience. There was a sense of people and self-harm feeling accepted rather than shamed.

"…it was space which sort of affirmed that distress, I could be distressed there and I didn't have to immediately snap out of it or I didn't have to have somebody immediately say, 'oh but it's alright you'll feel like this' or 'why don't we do this and then you'll feel better.'" (Participant 2)

While participants spoke of the importance of making room for distress, social media was also a place they went to reduce difficult feelings.

"…if I was upset and overwhelmed and unable to articulate it…I could step out of the room and look on Tumblr and that could feel a bit comforting…" (Participant 2)

Humour was cited as a mechanism to regulate feelings and participants described seeking this out to relate to their experiences in a more 'light-hearted' way as it enabled the 'heaviness' of someone's experience to be reduced.

"It's like joking about an experience takes away the heavy cloud over your head." (Participant 11)

One participant remarked how important space for humour was. This space is given to other mental health concerns but not as often for self-harm, perhaps due to society's fear of this 'normalising' the behaviour.

"I think a lot of places just skirt round it and don't really want to talk about it and are really awkward about it. It's nice to see other people talking about it normally and treating it like any other kind of… because people joke about depression and anxiety all the time, so it's kind of nice to see it be treated in the same way." (Participant 14)

However, one participant spoke about humour being 'validating in the wrong way' as it makes them feel that self-harm is not serious.

"For me personally, it makes me think that self-harming is not a big deal and that if you do it other people shouldn't think that it's a big deal and when other people get upset about self-harm, if I've been on that subreddit, then I have to snap back to reality and go 'oh actually this is quite serious and this has serious consequences for the people I know.'" (Participant 15)

Comparable to self-harm.

Parallels were drawn by participants between self-harm itself and interacting with or sharing self-harm content on social media. Social media was seen as allowing a vicarious emotional release, similar to the function of self-harm. For some, this acted as an alternative to self-harm and helped individuals slow down their thought process and manage self-harm urges.

"I think it's like a calm reaction. I feel …I wouldn't say relaxed, but it will slow down the thoughts making me want to do it, because it's almost like I can get to the after-effect of seeing the blood and the cuts and stuff without actually having to do it to myself." (Participant 14)

For one participant, whether social media was able to act as an alternative or not depended on the function of self-harm. If the function was linked to the visual aspects of self-harm, social media could be a substitute. Social media could not fulfil this same role if someone wanted to hurt themselves.

"Sometimes it's about wanting to hurt myself and it doesn't really fill that void. But when I just want to look at the blood and things, then it can fill that space." (Participant 10)

Extension of self-harm act.

For some participants going on social media was seen as part of the self-harm process. One participant noted that viewing images related to self-harm would be part of the lead up to self-harming, acting as a trigger. They would 'store' the images to act upon later, although they were not always a necessary pre-requisite for self-harm.

"I wouldn't necessarily then go back because I'd already have the pictures saved in my mind, locked and loaded." (Participant 7)

"If I'm feeling very down and I've got the thoughts, 'oh, should I self-harm or should I not?' at the back of my mind, that is where I go to it... I go to it on purpose because it triggers me..." (Participant 6)

Participants talked about the comforting influence of self-harm images; they were calming as they reminded participants of the reaction they get from self-harming. Participants outlined how images validated and encouraged their decision to self-harm.

"I think looking at images is comforting because it reaffirms that, even though it's probably wrong, reaffirms that 'yes, I've made the decision, it's probably the right thing to do, I can do this and then I'll feel better afterwards…'" (Participant 7)

Another participant outlined how going online and talking about self-harm afterwards extended the 'high' of self-harm.

"…when I was posting on IRC, that was essentially just a part of the process in that I had done it, I was still riding the euphoria of having done it and I was extending that by continuing to think about it and discuss it…" (Participant 3)

For other participants, going online helped them manage feelings of guilt after self-harming. One participant reflected on the emotional feedback from self-harm being positive in the short-term but this is overtaken by feelings of guilt, which social media can mitigate.

"…obviously you do self-harm out of some pretty bad feelings, but obviously by self-harming, although it's a short-term solution, the feeling of control, you do start to feel bad or guilty about it. So, I guess by looking at the content, it just mitigates that guilt that you feel..." (Participant 13)

In summary, the 'Regulating Emotions' theme explores how social media provided room where distress and self-harm could be discussed which highlights the lack of this space in many participants' offline lives. Similar physical and emotional responses were commented upon between self-harm and viewing or sharing self-harm content, which reduced self-harm urges for

some. Online humour was important for many in reducing the 'heaviness' associated with self-harm, but there was also the fear that joking about self-harm could mean it is not taken seriously. Social media could also form an extension of the self-harm act with participants using it pre-self-harming to trigger or validate a decision to self-harm or to reduce guilt or extend the high post self-harming.

Theme 3: 'In' Group

Due, in part, to difficulties in 'offline' support, participants talked about wanting to find similar others and not feel like the 'odd one out.' Being part of an online community gave a sense of belonging and allowed participants to understand themselves and self-harm. There was a sense of participants being able to give and receive support online. However, participants reflected on the responsibilities and cost of being part of the 'in group' as this space could see distress circling between users and give rise to self-harm comparisons, competition, encouragement and online abuse. For some, whilst not overtly harmful, social media did not offer a different perspective, meaning that participants were saturated with similar self-harm content with little opportunity for a 'way out'. Others highlighted the risk of being in the 'out group' and the impact of not being able to relate to others when this is what you had been motivated to use social media for in the first instance.

This theme had six sub-themes 'Community', 'Understanding', 'Responsibility', 'Peer pressure', 'Stuckness', and 'Out Group'.

Community.

Social media provided a sense of community. There was comfort and relief taken for participants in not feeling alone and being able to relate and connect to others and the content. At times, this countered the perceptions participants had from society of people who self-harm being 'weird'.

" ...it's just knowing that there's a group out there with thousands of people on it and probably from different parts of the globe, but just knowing that it exists, just to say, 'okay, I'm just one from, I don't know how many thousands and hundreds of thousands' so it makes me feel less weird." (Participant 6)

The sense of not being alone was especially important for older participants as it countered the shame they had felt at being an 'adult who self-harms.'

"... as an adult people don't expect you to be self-harming because they see it as a teenage activity and so seeing other people on social media doing it too makes me feel better - not about doing it but makes me feel like there are other people who are going through the same thing, that feel the same shame and it just makes me feel less alone." (Participant 15)

Participants spoke about the comfort of knowing that other people share your experiences and how this brought users together. Participants talked about how this motivated them to access social media in the first place. It gave participants a place where they felt cared for and were shown kindness. This was contrasted to the lack of care one participant felt was characteristic of professionals.

"The people online seem to care more. I know that sounds bad, but they do seem to be more invested in actually helping." (Participant 14)

Participants talked of being in the helper role themselves, where they could show care to others. At times, this was to show others that they weren't alone or to discourage them from self-harming.

"…a lot of people in the Reddit adult self-harm group, they say, 'oh my god, I'm 28 and I'm still doing this thing,' and I just feel I have to reply to them to show that they're not the only ones." (Participant 6)

"when I come into contact with someone else who was thinking of starting self-harming or thinking of repeating self-harm, I would always encourage them 'don't do that because we both know it's a bad idea.'"(Participant 3)

Participants talked about how being in the helper role made them feel 'better'. There was acceptance regarding differences in how active in the helping role different users were. Helping others allowed some users to see how they could help themselves

"It felt good, you see from helping others that there are ways to help yourself..." (Participant 3)

A key aspect that set social media apart from professional support was the existence of those with lived experience, this created a level of support that felt impossible to receive 'offline'.

"…the fact that there were people that did understand what I was going through, that had been through it that kind of thing, which is a thing that obviously no one else can do." (Participant 3)

This unparalleled sense of feeling heard and supported meant that participants felt they could speak freely without the fear of repercussions that they get 'offline'. They did not have to fear the responses they would get for having discussions around self-harm offline, such as shocked or upset responses or overreactions.

"…you never feel like you have to be cautious about what you say so nothing bad happens, you can just say anything you want really and that's helpful." (Participant 1)

Hearing others' accounts provided participants with a sense of hope. Some participants used this more 'positive' content to inspire and motivate themselves. Participants would encourage recovery from self-harm in other users and share their own recovery progress.

"...if I've not done it for a certain amount of time and I share that and I get encouragement, I'll want to come back later and say I've continued that." (Participant 9)

"...here were people who I could see going through, or had gone through, the recovery process and managing their mental health in a way that didn't involve self-harming and things. And so…it gave me that awareness that I could get past these things." (Participant 10)

Understanding.

As well as being motivated to find people like them, participants also wanted to gain knowledge. From being part of this 'in' group, participants developed understandings about self-harm and themselves. These understandings were motivated by three interacting aspects; to educate oneself, to educate others and to de-stigmatise self-harm and mental health. Participants reported that this was fuelled at times by curiosity as self-harm is a 'taboo' and private topic offline so had not been able to be discussed. Participants gained insight into how the aesthetic of self-harm was built up online, the images, personas, TV and music associated with this world, and used this to understand their own self-harm identity.

"what was posted on Tumblr tended to be more about like subjective internal experiences of self-harm, people talking about their own experiences of self-harm, people talking about their own sense of themselves and a tendency for that to interact with excerpts from things that other people had written about like madness or distress, fiction or even TV programmes."
(Participant 2)

Participants sought to understand self-harm through educational and research-based content. A number of participants had also engaged in their own self-harm or mental health-based research.

"...there are some YouTube psychologists or people who don't currently self-harm but did in the past and they're just showing their scars, or they talk about the kinds of feelings surrounding it and I guess the educational way of looking at it is also a way of coming to terms with self-harm…." (Participant 13)

Information was sought on social media by participants relating to first aid, harm-reduction, accessing support, alternative coping strategies and how to help with scarring. There was a sense of people online being accepting of self-harm happening and offering other users ways to manage if self-harm has occurred. The online support was therefore seen as helpful because it allowed for these discussions around self-harm to be had. This was a contrast to the experience participants had offline of just being told to stop self-harming which shut these conversations down.

"I use the broad groups for tips that I have found for self-care and to help with the urges." (Participant 12)

"The most helpful I've found has been medical advice…like taking care of your wounds and preventing infections..." (Participant 9)

Viewing others' content, and sharing their own, enabled participants to make sense and bring clarity to their own experiences and there was a desire to understand others too.

"I didn't know anything about self-harm; I didn't realise people did it for particular reasons. I didn't even realise that there was a pattern to my self-harm. So, those things I became aware of online." (Participant 12)

These understandings and interactions with others allowed for a process of self-reflection. This, at times, meant participants questioned their urges to self-harm and the potential consequences of doing so (e.g., the effort of having to manage cuts effectively) which could give someone a 'reality check' and meant self-harm did not occur.

"… if your post is a bit more distressing they'll ask you a question like 'why do you want to do this?' and that will bring me back down and go 'well why?'" (Participant 15)

"it's almost like a reality check. I'll look at the pictures and think, 'I wonder how long that would take to heal up properly and what marks that would leave,' and it makes me reconsider it." (Participant 14)

Participants reflected on engaging with accounts related to mental health activism to try and de-stigmatise mental health and self-harm. Some participants wanted to raise others' awareness - to develop their understanding of self-harm and mental health and to highlight the difficulties of accessing help.

"I wanted people to see that there could be somebody closer to them who's struggling but doesn't know any way to reach out, so that people might be able to see certain signs." (Participant 4)

However, participants also said it was a place where they could gather knowledge on how to self-harm in certain ways, what 'tools' would be needed to do this and how to hide it. This encapsulates the drawbacks of having open discussions where content about how to harm could be found alongside other more supportive information.

"… some of it does act as instructions…I've seen videos of how to hold the blade to do this..." (Participant 14)

As well as giving information for methods of self-harm and concealment, social media was also seen as highlighting self-harm as an 'option' or bringing it into someone's conscious awareness.

"They use a lot of this terminology like they say, 'oh, I've had styro' which is the fat layer, I didn't even know that that was a thing. So, you have these terminologies in your mind and I

guess even if you don't want them to, they're still in your mind, so they still exercise an influence." (Participant 6)

"I would never do it directly because of something I'd seen, it's more subtle and insidious than that, it's more that it persists in your mind that you've seen that people are doing this and that it works for some people and then that being in your mind means that next time you have a crisis, you're thinking 'okay well I don't have any other good options why don't I just try this thing that I saw four days ago.'" (Participant 3)

Participants talked about this pull to copy others' self-harm out of curiosity and desperation as social media content provided the knowledge to participants that self-harm was an effective strategy for others.

"I was thinking 'she's the same sort of mind as me and she's doing it and it sort of vaguely helps her, at least a little bit, might as well give it a go.'" (Participant 3)

There were also concerns that, as a source of information, social media could be unreliable. Participants highlighted how sometimes posts did not receive replies or people received generic or inaccurate responses, which were perceived as unhelpful.

"Sometimes no one will respond to you, you won't get a like, no one will view it. Because you know from the stats that you can see that no one had interacted in any way and it makes you feel even more ignored." (Participant 12)

"...this person was saying they were a doctor and posting about all these fake certificates they had, while at the same time giving absolutely terrible advice to people. Like there was someone saying that they had some cuts that they wanted to cover up before their parents saw them, and they advised painting over them..." (Participant 14)

It appeared that participants accessed social media to gain understandings in the presence of a non-judgemental environment. This raised awareness, enabled participants to self-reflect, allowing them to understand themselves and self-harm better. Yet the openness of the platforms meant that unreliable information and information about how to harm could also be gathered. Searching for understandings can give participants more information than they perhaps wanted or needed and not all information gathered is reliable.

Responsibility.

Being in the 'in' group brings with it a level of responsibility. Participants had concerns about the ethics of sharing content and the impact certain 'graphic' content could have on others – fearing it could trigger self-harm or distress in someone else. Participants had concerns about both the content already on the platforms that others could come across and the impact that their own content, namely images of self-harm, could have. The latter prompted participants to

engage in a process of self-censorship to prevent other users from having a similar negative reaction to certain content that they once had.

"I just don't think it's moral. When I was in the position of going through all those blogs to upset myself or to see the things, I knew how bad that felt and I didn't want to put that position onto other people." (Participant 11)

These concerns were particularly aimed at those who were young or inexperienced, as participants feared they were more impressionable and such content could cause them to start self-harming or could exacerbate their self-harm.

"I worry if someone is having those first urges and hasn't actually self-harmed yet and they would come across that kind of material and it might make them start cutting or make things worse." (Participant 10)

One participant reflected on the impact content could have on people who do not self-harm and that it could fuel misunderstandings of the behaviour.

"We should be mindful when posting pictures of it online, not only that it can trigger other people into self-harming, but also people who don't self-harm and don't really understand it, that is not going to help them understand it…" (Participant 15)

Participants spoke about the fear of being responsible if they recommended social media spaces to someone and this affected them adversely. This helps to explain why participants said they preferred others to take ownership of their own self-harm related social media use. It also demonstrates recognition that not everyone on sites or interacting with content is supportive.

"…you might even get somebody writing something horrible which doesn't really happen very often but I s'pose… kind of worrying recommending it to someone else that…what if someone replies and says something really horrible to them, that wouldn't be very useful." (Participant 1)

There was also the responsibility when helping others in case this did not 'work' and left the user feeling concerned about the others' welfare. This outlines the personal impacts involved in interacting with content from others in a supportive way.

"…it can be draining in that if there's someone you fail to help, for example, that obviously is not gonna bode well for your mental state..." (Participant 3)

Peer Pressure.

Participants talked about the pressure they felt to behave in a certain way regarding their self-harm, potentially to retain their 'in group' membership. In turn, this could increase the likelihood of self-harm occurring or pressure to ensure that self-harm was done 'good enough' to 'count'.

“I want to show other people that ‘I’m just as capable of this as you people are and I feel this way too and I’m part of the same community as you.’" (Participant 14)

On social media participants discussed the existence of self-harm competitions and contests, which could increase the severity and frequency of self-harm.

“…in the sense of the mental illness aspect, there is that race to the bottom but in self harm it's a lot worse and usually it’ll end up with you doing something so dangerous that you end up going to hospital and breaking something permanently, and I can’t underestimate the number of people who I saw did do that.” (Participant 3)

"...people use Twitter to almost compete with each other in terms of self-harm, like who can cut the deepest..." (Participant 13)

Participants noted comparing themselves to other people’s self-harm, distress and general life achievements viewed on social media. This created a sense of pressure due to feeling not ‘enough’ which exacerbated participants own distress. This sense of not being ‘enough’ extended in both directions; both not ‘bad enough’ in terms of distress and self-harming for it to ‘count’ and also feeling as though you haven’t achieved enough in life to be ‘good enough’.

"I felt like I was faking it or if I wasn't cutting down to the fat that I wasn't depressed enough." (Participant 15)

"I think sometimes so many people post just the positives that it ends up making you feel worse because you feel like everyone’s got a better life than you." (Participant 4)

While some participants were concerned that their self-harm and distress wasn’t ‘enough’, others had concerns that they were not on the right road to recovery. One participant explained how when they compared themself to others, they felt ashamed for not wanting to ‘recover’.

"…like they’re happy, ‘oh, it’s been two months since self-harming, it’s been three months’…and I guess…since for me that is currently maybe a distant thing… So, I don’t like those kinds of posts. I guess it makes me feel bad about myself." (Participant 6)

However, one participant noted that comparing themselves to others pressured them to fight to get the support they felt they deserved.

"There’d be times where people would need further help and something would get put in, like inpatient…And it pressured me to be like… to acknowledge that I was having the same issues as them and maybe I should be fighting for more help than was given." (Participant 11)

There were instances disclosed of people actively being pressured to self-harm, this incitement outlines how peer interactions on social media are not always positive. This incitement was used as a form of online abuse. Individuals were told to harm themselves or ganged up against by other users. It appeared that the anonymity online facilitated this abuse.

"…on Tumblr you can be anonymous you don't have to have your face or your name on there and so people can just attack you and I felt like people were unduly nasty because of that." (Participant 15)

"And then the person on the screenshot who is in the wrong would have all of their friends gang up and tell the person who told them to report to, like, self-harm. " (Participant 11)

Two participants identified that online abuse was a prominent concern for men and those from the transgender community.

"Trying to find friendly transgender and LGBT things on Discord is just a nightmare really. Because there are lots of discussions around… like people will say, 'I'm struggling with self-harm,' and sometimes you'll get laughed at." (Participant 14)

"Mainly it's Facebook…the majority, 99 per cent of the members are women, and the members that are men don't post their own originals because they will either be completely ignored or attacked…" (Participant 12)

Another form of pressure on participants was the pressure for them to use the platforms in the expected way. One participant spoke of the pressure they felt to ensure they responded to all comments left to them or they would be threatened e.g., with being reported.

"…it started with people being rude if you didn't respond in time, going 'if you don't respond in the next five minutes I'm calling an ambulance or if you don't respond I'm going to report your comment...'" (Participant 12)

"Stuckness".

This sub-theme represented how being immersed in the online world made participants feel trapped. For one participant there was a sense of 'surviving not thriving' online, being given space to feel and talk without being offered an alternative way of being.

"…it didn't feel like Tumblr necessarily helped me to feel less distressed and it didn't necessarily offer me tools for working out what in my life needed to be different, or what I needed to change to make my life more liveable, but it did feel like within the boundaries of my life as it was, it helped me to just survive..." (Participant 2)

In the 'in' group, self-harm was 'normalised' to an extent and some participants reported that this made them feel as though no help needed to be sought. This highlights the differences in how content is perceived - a shared experience for some was comforting and motivated them to seek the help they felt they deserved whereas for others it normalised self-harm and meant being stuck.

"You know, 'I'm fine, all these people are doing the same as me, and we're all cool, it's all great. I don't need to talk to anyone about this. It's not a problem, it's just something that we

do.' So that definitely contributed directly to the lack of communication and for me, not reaching out and not getting help. " (Participant 8)

Another participant highlighted the difficulty of 'normalising' always having a negative connotation. There appeared to be a difference between 'normalising' being linked to the maintenance of self-harm compared to 'normalising' being de-shaming and allowing someone to feel accepted.

"But you could just talk about your day and stuff, and then I'd see people saying, 'yeah today was alright but I did end up hurting myself later.' And that kind of normalisation of it and just being able to say stuff like that." (Participant 14)

Distress was maintained by a sense of saturation and 'stuckness' when interacting with self-harm content and feeling sucked in by being online. Participants explained how distress circulated and was amplified by content and others on social media which made participants feel worse, there was a sense of distress fostering distress online.

"…the way in which Tumblr particularly - because it has this re-blog function… has an ability to…I wouldn't have described it this way at the time, but in hindsight what I would describe it as is like a circulation of affect, that this intense distress got passed around between different blogs…" (Participant 2)

Multiple participants used the term "rabbit hole" specifically to describe how they became immersed in the content and there was a sense of losing track of time when using the platforms.

"...you start clicking on one and then it takes you to another and another and another and like 10 different hashtags later and you realise you've been doing it for ages and ages..." (Participant 7)

"I went down rabbit holes, first I started with the first one, then I was looking at pictures and stuff, and I know that it was triggering for me." (Participant 6)

One participant talked about how the platform algorithms somewhat enabled this immersion in similar, repeated content.

"...because of what I followed and things that I liked, a lot of my suggestions tended to be quite dark as well so it was all, kind of, around the same thing." (Participant 4)

Being immersed in this content meant individuals could be more likely to witness explicit content such as photos or descriptions of severe self-harm.

"… people there were sharing depths of cuts where you can see bone for example..." (Participant 3)

Participants also talked about bearing witness to judgmental views, such as that self-harm is a form of manipulation or 'weird', which led participants to feel upset and remain trapped by the stigmatising views of self-harm.

"It's highlighted how a lot of people and teenagers see self-harm as this scary, weird thing, I've noticed. It's still got a lot of stigma and fear around it." (Participant 14)

"I find that even though my Twitter feed is quite saturated with that sort of discussion it's not repeatedly upsetting, but on the occasions when something is particularly about judgement or punishment or criticism then that feels more upsetting…" (Participant 2)

This all held the potential to escalate someone's self-harm with participants linking some content with the maintenance and exacerbation of their self-harm.

"So, whilst it's comforting and reassuring as well, it is also kind of like I'm feeding the beast." (Participant 7)

"I fully attribute the content that I was viewing, to the severity and really…I can't find the words, just the way that it developed. The extremities that it reached and the speed at which it kind of snowballed..." (Participant 8)

'Out' Group.

This sub-theme highlighted how not everybody felt in the 'in group'. Some participants noted the risk of feeling left out and disconnected online. They did not feel part of the community for a variety of reasons, such as feeling that they could not relate to others. This enhanced participant's feelings of loneliness.

"I feel it's a bit like a club. So, everyone's in this club, and that makes it less accessible to you. When you see there's lots of self-help places, they all wear the same sort of clothes, and it makes you feel like you're out of the bubble, or there's people with similar personalities, like very chatty and able to talk, but if that doesn't reflect on you, then you don't feel like this help is right for you." (Participant 5)

However, one participant explained that they did not actually want to identify with other users as in general they talked about not identifying as being someone who self-harms.

"I wouldn't necessarily want to talk to other people who self-harm, because I feel like for some reason I wouldn't kind of identify with that…I kind of felt outside of the self-harm community." (Participant 7)

The disconnected feeling was fuelled by some participants not feeling they understood other users' reasons for posting. It seemed that they were sceptical about other users posting to be supportive, rather, they felt they could be posting to gain popularity or approval.

“I don't think they are doing it to help anybody or to make anybody else feel comforted really. I think it's mostly just about, I don't know, probably getting likes..." (Participant 7)

Some participants felt that the lack of diversity represented online could have created, maintained or exacerbated this feeling of being in the ‘out group’. Participants talked about the majority of users being young white females. Participants found it difficult to be from different backgrounds (in terms of gender, age and ethnicity) and felt that their experiences were not as well represented and discussed.

"…most of the posts from people on self-harm on Facebook are on women-only groups, which is a shame because men do self-harm for the same reasons and roughly the same amount." (Participant 12)

One participant considered how their initial experience of social media reinforced the stereotype of self-harm being a teenage concern. This made them disengage from the platform as they felt different to other, younger, users.

"I’ve started self-harming at an older age, so that reinforced the idea that I’m a bit old for this. And I stopped engaging, I think I unfollowed it, so that was my first experience." (Participant 6)

Participants reflected on how this lack of diversity online could make them feel embarrassed and added to the secrecy surrounding self-harm in the Asian community and self-harm in adults.

"…for me, there was hardly anything, in fact there was nothing on British Asians, and I think it’s a very taboo subject." (Participant 5)

"… if I do stop and look at quotes or anything about the kind of people who are posting the pictures, it's embarrassing for me because it makes me feel like self-harming is just something that young teenagers do." (Participant 7)

One participant recommended that diversity is something that needs consideration both offline and online in terms of supporting those who self-harm.

"I think age plays an important role. So, predominantly the media tends to more cover…obviously because it’s very alarming that 11-year-olds, 13-year-olds…those 13-year-olds eventually grow up, and they become 40-year-olds and…because I feel it now and I’m 25, and I’m pretty young, so I guess we should also not discount those kinds of experiences and the importance that when you seek support online, offline, or anything, it is age-appropriate." (Participant 6)

In summary, the ‘In Group’ theme explores how social media offered participants a space to feel understood alongside others with lived experience. They could learn and be curious in a non-judgemental environment. This afforded participants a process of self-reflection, to make sense of their experiences. However, this community membership was not without its costs. There

was the weight of responsibility participants held relating to the impact of content on others or being in a supporting role. There was particular concern for less experienced users and the fear that content could precipitate or perpetuate their self-harm and distress. Along with this responsibility was the pressure to prove oneself, to be 'good enough' at self-harming and stay in the 'in' group. Other, more overt, harm came in the form of online abuse, incitement and explicit content. Participants also talked of less overt harm - the difficulties caused with being stuck and saturated with self-harm content which offered no alternative ways of being. There was the manner in which social media could present self-harm as an option and give ideas for ways in which to self-harm. There was also the risk of being in the 'out group', although not all participants were equally negatively affected by feeling unable to identify with others online. The lack of diversity represented online was acknowledged and led some participants to feel disconnected and embarrassed as they felt they could not relate to others online who fit the more stereotypical view of someone who self-harms.

Theme 4: Control

Being online for self-harm purposes has demands and risks attached, controls have been enforced in an attempt to protect against these. The theme 'Control' explores the control society attempts to put on self-harm content and participants views on this. This theme also encapsulates the control already existing on the platforms via content warnings and moderators. The importance for participants to remain anonymous was discussed. This was seen as allowing platforms to feel safe but also deepened the divide between offline and online worlds. Also acknowledged is the level of control and capacity participants exercised to choose what they view and post online, as well as deciding when to move away from using social media related to self-harm. This theme had five sub-themes 'controlling content futile/shaming', 'safety and anonymity', 'compartmentalising', 'choice' and 'progression'.

Controlling content futile/shaming.

Participants described how controlling self-harm content is not the answer as there is the potential for people to feel shamed and judged and their views are silenced, which causes harm.

" … she had a photo of her body, in which her scars were visible and Instagram took it down and I thought that was horrifying… like that's her body, her body exists as her body, she's not done anything wrong, she's not done anything illegal and she has an absolute right to post a picture that shows her arms and her legs whether they have scars on them or not and I can't think of anything more harmful." (Participant 2)

This relates to the difficulty with understanding the intent of posts, for example pictures of scars may be banned when they are actually a promotion of recovery.

"…she comments frequently on how her Instagram posts, when she's just posing with her boyfriend, and she's got her arms out and her scars are out, you know, they get banned, because there's mention of self-harm. And of course, that's tricky, because she's actively encouraging safe recovery from self-harm. But because it's so nuanced, and because of course, the social media sites have to be so cautious, they get blanket banned with all the rest that mention self-harm." (Participant 8)

One participant highlighted the role of algorithms in failing to recognise the nuances of intent.

"It's a difficult one because I think in a lot of cases it can be about intent and the algorithms behind the censoring often don't pick up on that." (Participant 10)

Controlling content was seen as futile as social media sites and their content constantly evolve and can be recreated. Participants discussed how darker content can migrate to other sites or changing the spellings of certain terms means they can circumvent restrictive guidance.

"… if you delete the communities or make sure that they can't exist on certain platforms, then they will just find even shadier and more graphic and violent platforms to function on." (Participant 13)

One participant explained how they would look for content online through general searches when social media was not available to them. This gave a sense that people would find the content they want regardless of social media.

"I was still looking on Google for pictures and stuff before I had social media." (Participant 7)

There can also be differences between sites, and within/between person changes in how they react to content over time and with increasing age/experience. Therefore, a stable, global solution (e.g., blanket ban on content) is not seen as helpful.

"An important distinction would be on Reddit you see posts of healed self-harm. Whereas, on Twitter you see fresh which, I guess, is quite an important distinction because if you're seeing healed stuff you're seeing positive progress." (Participant 9)

"I think my main kind of thought about it really is that, all things balanced, I think it was positive basically for me, not sure it would be for everyone but think it's definitely something which I've benefitted from." (Participant 1)

Participants suggested that just focusing on controlling social media content will only have a limited effect on self-harm. This is because they considered the relationship between self-harm/distress and social media as unclear - participants described self-harm as a complex process, affected by more than just social media use.

"I think the frequency was probably more related to stuff that was going on in my life, I think there are a lot of different things that contributed to…like at a lot of different points because it

was very variable how often I was self-harming, whether I was self-harming, how I was self-harming, that felt much more like it was to do with what I was reacting to in my life." (Participant 2)

Social media use was commonly noted as occurring after self-harm. This again shows that participants acknowledged other factors outside of social media influencing their self-harm, suggesting why controlling social media may be limited in its effect on self-harm.

"I'd self-harm and then go on Facebook." (Participant 5)

"…obviously it's been a thing before social media so I would say the people who did it before that, they obviously had to have a reason for that besides the social media contagion effect." (Participant 3)

Therefore, participants suggested a wider focus is needed to support people who self-harm, considering other contextual factors that have precipitated self-harm, rather than using social media as the only target for change.

"… I don't necessarily think that somebody becomes hugely depressed and hugely distressed because of Tumblr, I think there are probably other complex difficult things going on in their lives and that those are the places where the intervention is most needed." (Participant 2)

While there are concerns with controlling content such as it being futile and silencing, participants also noted the difficulty of individuals 'coming across' content that they did not want to see, linking again to social media algorithms.

"I feel like I wouldn't outwardly go and look for self-harm material, but I would come across it." (Participant 5)

One participant pointed to the need for these algorithms to be amended to foster 'healthier' ways of navigating platforms rather than just censoring content.

"I think it's less about censorship and more about actually, well 'how do we foster an algorithm that focuses on welfare and positive mental health?'" (Participant 13)

Safety and anonymity.

Participants spoke about the importance of safety and anonymity on social media when using it for self-harm related purposes. Internal controls such as moderators were important in maintaining safety online. The level of anonymity was different between sites and a higher level of anonymity was linked to participants feeling less constrained by feelings such as embarrassment so they could be more honest.

"…being anonymous is freeing and you're not worried that people you know are going to find you and worry about you and yeah it's free from embarrassment." (Participant 15)

Safety online was thought to be upheld by the presence of moderators. Moderators acted as protectors and as a safeguard, removing content that was seen as abusive.

“I think that one of the things that’s benefitted me is that they’re very well moderated, there’s really just not too many bad people on there and if anyone was to post anything particularly negative on anyone’s posts they’d just get banned immediately...” (Participant 1)

One participant talked of the importance of moderators being human and part of the community as they can empathise with the intent and feelings behind the posts.

"it’s really important that there’s not blanket moderation on the entire thing by some AI algorithm, it is actual people that are also part of the community that moderate it, which I think is really important… because obviously they’re not just looking at keywords, they’re looking if someone actually needs help because they can emotionally empathise with the person posting." (Participant 13)

Another participant spoke about wanting to protect other users, which links to the sense of community fostered online.

"I have got involved on there in the past when I’ve seen something that is definitely wrong." (Participant 14)

The presence of content warnings and support flags was also discussed. Certain platforms hid content and asked users whether they wanted to view it or not, providing a safety mechanism for some participants.

"…on Instagram and stuff like that, if you search for certain terms now, they come up with ‘are you sure you want to see this?’" (Participant 8)

However, one participant spoke of how this introduced hurdles to them viewing the content they wanted to.

"I can understand why sites do it and I do think that it is an important thing, but I think just for me, I almost didn’t want the hurdles of the pop-ups saying, ‘this image might be distressing; or we’re not showing these pictures because they could be upsetting.’" (Participant 10)

Compartmentalising.

Safety and anonymity were important to participants and fostering these private worlds allowed them to control the compartmentalising of their distress to their online world. However, one participant considered how limiting it was to only have one place (social media) in which to make room for distress which could be unreliable in terms of consistency of support.

“I think there’s something a little limiting sometimes about putting all your distress only in one place because it means that you never ever develop any abilities for that distress to exist in the real world.” (Participant 2)

There was also fractured online activity within social media itself, with participants starting and curating different accounts for self-harm and non-self-harm related content.

"I actually have two separate Twitter accounts because I don't really want my use of self-harm content to be linked to my original account." (Participant 13)

Participants also discussed having private chats with other users separated from the wider online community.

"I usually do private messages. I don't like to publicly comment on YouTube. But you can send private messages, so I do that with YouTubers that I follow..." (Participant 12)

It was also explained that social media did not discourage this compartmentalising, so participants had different 'selves' presented in the different worlds and distress was only accepted in some parts.

"It wouldn't be a bad thing if there was more communication between the sort of very secret separate space of self-harm and of distress and of my real world self which is very put together and efficient and helpful but… I don't know if that's something that's really resolvable but I don't think that Tumblr necessarily encouraged a communication between those two things." (Participant 2)

One participant also reflected on how the compartmentalisation of distress meant that the help they sought 'offline' was delayed.

"...had I not been using that as a crutch, I probably would have sought help from people in my personal life more quickly." (Participant 8)

Choice.

Participants spoke of the control and choices they had regarding what they shared or did not share of their own experiences, and how they curated their online world, where they set the tone, based on content from other users and different sources.

"It's [Tumblr] *very content driven actually in a way that other sites are not. I hadn't thought of that but I think that is the case and it's much more about this sense of collaging content in which you sort of draw from different blogs and different places to create your own feed or your own sense of what's interesting." (Participant 2)*

Participants discussed both the choices they made to actively seek out some of the self-harm content and the choices they made to detach from self-harm related social media use.

"When I was really struggling, so between the ages of probably about 15 and 17, I was having a really, really hard time. And I was actively searching things to do with self-harm…" (Participant 8)

"…other times I'd just completely ignore that [self-harm] *side of Tumblr and try and avoid it." (Participant 10)*

This all speaks to a sense of agency and the level of capacity that people have when using social media for self-harm purposes.

"I think people will find their own way, I don't necessarily think that the space I found on Tumblr exists anymore, I think people will find their own way to the space that maybe they need, or maybe that they don't need." (Participant 2)

Progression.

Participants described a sense of progression and growth relating to how they started to use social media for self-harm purposes and how they moved away from doing so. Participants would often choose to use platforms they already had for self-harm related purposes.

"I think I've been on Reddit for maybe two or three years and I think I was going through a bit of a mental health crisis and I was just searching for mental health subreddits and just through the rabbit hole found the various self-harm forums..." (Participant 15)

As people matured/aged or had more self-harm experience they started to relate to the content differently. This involved being able to curate their social media more, to look at more varied content or finding they did not need to use social media for the same self-harm related purposes as they once did.

"And it's a far more positive source of information…it's the opposite of what I was doing with the internet, in regards to self-harm when I was younger." (Participant 8)

The transition away from self-harm related social media use was attributed to different reasons. Participants felt that the content was no longer congruent with how they were feeling, and the content felt no longer needed.

"I think it was more helpful when I was having more issues really and now that I'm doing a bit better, I just don't really need it very much at all really… I don't really spend much time on it." (Participant 1)

The choice to move away from the content was linked to participants developing more self-awareness regarding the negative impact the content was having on them.

"There's a sort of, aesthetic to things like depression and self-harm on Tumblr that I know isn't necessarily positive. So I try and limit that." (Participant 10)

Some participants suggested they had 'outgrown' certain content and no longer found it relatable. There was a sense that participants had developed in their ability to curate and moderate their own social media use and to not engage with content that they found distressing.

"I think I just grew up around it and I realised what I was doing, it's not something to romanticise, like I'm going to end up ill type of thing. And the whole mindset around self-harm changed and then so did my activity of what I was viewing." (Participant 11)

"So, you just have to self-moderate, and if you know that you're going to be affected by those pictures, don't click on them." (Participant 14)

Explanations were given regarding this growth, including that people felt that their offline life had changed to allow them chances to speak about self-harm, in comparison to when they were younger and felt less able to do so.

"...because I didn't feel so isolated from people around me, I didn't necessarily need to find other people who felt like me online." (Participant 10)

Other participants wanted to reduce self-harm related social media use as they wanted a more private lifestyle compared to being younger when they wanted more connection online.

"...being more busy I don't post as often and things like that because I don't have the time necessarily to allow myself to get to that. And I guess, as you get older sometimes you want bits of your life to be more private..." (Participant 4)

One participant discussed how they began to understand the impact self-harm was having on those around them which stopped them engaging with content on social media.

"When my family found out about me self-harming and I realised that what I was doing, it was hurting people around us, that kind of made us realise that this isn't something romanticising, I don't like agreeing with any of the platforms anymore." (P11)

The 'Control' theme captured how both internal and external controls are exerted on social media. External forms of control were perceived as shaming and somewhat pointless given the ever-evolving landscape of social media. On the other hand, the form of control exerted 'internally' by the communities themselves was of importance in maintaining the secrecy and anonymity that allowed participants to speak freely and feel safe online. However, this anonymity also facilitated online abuse and meant that distress was only made room for in the 'online' area of someone's life which could be a risky and unreliable way to manage distress. Participants recognised the control and choice they had over their use of social media. However, there is the acknowledgment that people can still come across content, perhaps due to algorithms used by the platforms, that they find harmful and did not wish to see.

Summary

To summarise, participants were drawn to social media due to difficulties in support offline. Social media acted as a source of social support and a mechanism to manage difficult feelings and urges. However, it also played a role in the journey of participants' self-harm and could

cause damage and further distress to young people. This study highlighted the role algorithms have to play in self-harm related social media content; whilst participants may choose to engage with such content there are also concerns with it being encountered accidentally. Participants voiced concerns over the implications of just banning content to ‘solve’ this concern. This speaks to the importance of more coherent collaboration between social media, technology, professionals and, most vitally, people who self-harm to foster better working practices to support young people who access self-harm content online.

CHAPTER FIVE: DISCUSSION

In this chapter I will explore the research findings in relation to my research questions and existing literature. I will consider the study's strengths and limitations and discuss clinical implications. Finally, I will provide suggestions for future research, my personal reflections and conclusions.

Revisiting Research Questions

This study aimed to explore the use and perceptions of social media in relation to self-harm from the perspectives of young people who have self-harmed. I conducted 15 semi-structured telephone interviews and used thematic analysis (Braun & Clarke, 2006) to analyse the transcripts and investigate my research questions:

1. How have young people who self-harm used social media to view, share and discuss self-harm material?
2. What were the motivations for using social media in relation to self-harm?
3. What are their perceptions of social media as a vehicle to discuss self-harm/seek support?

I will first provide summary answers followed by a discussion of key findings in relation to the themes and existing literature. Four main themes resulted from the analysis of the interviews: 'Offline/Online Relationships', 'In Group', 'Regulating Feelings' and 'Control'.

Question 1: Using social media.

Participants discussed how social media was often a first port of call for support and they could access it as and when they needed. They would use sites they were already familiar with to find self-harm material. At times, it was used simultaneously to 'bolster' professional support, so offline and online supports did not always exist in isolation. Participants reflected on the level of choice and control they had relating to what they shared and did not share online and whether they chose to engage with self-harm content or not. However, content could also be encountered accidentally, often due to algorithms used by the platforms. Social media was accessed pre- and post-self-harm to regulate feelings and sometimes served as an alternative to self-harming or could form part of the self-harm process. Participants maintained a separation between offline and online worlds by having anonymous accounts. Many assumed observing rather than active roles online. They also had different accounts for the same site to keep self-harm related content separate from general social media or more inspirational/motivational content and used online

private chats. For some participants, there was an influence on their social media use from the offline world with professionals or partners querying if they could use social media in a different way such as by interacting with more supportive content. There was a sense of progression away from self-harm content as participants grew up and no longer felt they could relate to the content or they developed an understanding of the negative impact the content could have.

Question 2: Motivations for social media use.

Participants explored how difficulties in offline interactions led them to access social media in relation to self-harm. Participants described feeling abandoned and misunderstood offline by both professionals and those in their personal lives. In these contexts, they suggested there was little space to talk about self-harm or distress and support was difficult to access or limited in nature. Consequently, social media was seen as an essential, flexible and accessible support source. The motivations for using social media centred around using it as a place to offload and to not feel alone, offering participants a sense of community. At times it was able to reduce self-harm urges, but some participants used social media to trigger or validate a decision to self-harm or to extend the emotional 'high' self-harm evoked. Social media also allowed participants to make sense of their own experiences and seek knowledge and understandings related to self-harm, this also included seeking information on how to self-harm. Participants wanted to help others understand self-harm and raise mental health awareness. Some used it as a place to motivate recovery or to get encouragement for continued recovery. Anonymity was key in why participants accessed social media as they felt safe to view and post content. Moderators were viewed as important in maintaining this sense of safety. In contrast to the majority, some participants were motivated to discuss self-harm on social media in the hope that their loved ones would better understand their difficulties and would offer more personalised support.

Question 3: Perceptions of social media.

Participants valued social media as a needed resource for support. They described interactions online as being honest, without the same fear of repercussions or stigmatisation self-harm discussions had offline. Anonymity online was key for participants in allowing free interactions but there was a risk of distress being compartmentalised to a participants' online world only, leaving no alternative option if online support was not reliable or sufficient. Anonymity was also thought to facilitate online abuse, a particular concern for men and those from the transgender community. Social media had a sense of reciprocity, there was experience of both being helped and being the helper with practical and emotional support offered. There was a level of responsibility that came with using social media. Participants feared how posts or interactions would be perceived, especially by more inexperienced users. There was also the

emotional toll of being responsible if a participant's offer of help to another did not 'work'. There was pressure to remain in the 'in' group and alongside this were the risks of self-harm encouragement, competition, and comparison making, leaving participants to feel that others had better lives than them or that their self-harm or distress was not 'bad enough to count.' Participants described the all-consuming nature of self-harm content with explicit content or stigmatising views likely to be encountered. Participants discussed how distress circulated and was amplified online. Self-harm could be 'normalised', leaving participants to 'survive not thrive'. Others felt disconnected due to the lack of diversity represented, enhancing the feelings of isolation. There was also the risk of being ignored online or being able to access inaccurate or unhelpful information. The external controls, e.g., content bans, enforced to mitigate these risks were considered futile and shaming. But internal controls such as moderators and other users helped to create the sense of safety that was important on social media. Participants considered how more collaboration is needed between offline and online sources to increase understanding of self-harm related social media use. This could foster a more helpful and safer online environment for young people.

Key Findings

Social media not the only target for change.

Prior research has identified that social media can be linked causally to the observed rises in self-harm in young people. However, participants in this study highlighted the fact that self-harm is a complex behaviour not resulting merely out of contact with social media content. Self-harm was commonly cited as occurring prior to social media use (as in Harris & Roberts, 2013). This is echoed in The Lancet (2019) which suggests that links between social media and self-harm are not well understood and social media is just one aspect of a much bigger picture relating to what influences young people's mental health. Therefore, rather than using social media as the only target for change we need to consider what societal structures are in place that contribute to the precipitation and maintenance of a young person's self-harm (e.g., Lavis & Winter, 2020). Participants in this study suggested that a wider repertoire of how to support those who self-harm needs thought rather than just considering social media.

Participants in this study described how support or information related to self-harm was sought online due to the difficult responses received offline, both personally and professionally. This perceived lack of support, feeling unheard and misunderstood, is a concern raised throughout self-harm research. For instance, using a survey Quinlivan et al. (2021) highlighted how participants felt as though their concerns were not taken seriously when speaking with professionals, that the help offered was generic or laced with stigmatising attitudes such as self-

harm being the individuals' fault' and they were wasting services' time. Other investigations raised concerns that young people felt professionals were not genuine (Rodham et al., 2013) or participants were concerned about accessing help as they feared hurting those around them or being labelled as 'crazy' (Cislaghi, 2020). Interactions in participants personal offline lives were also problematic with there being no room for self-harm discussions (e.g., Hilton, 2017).

Unusually, a few participants in this study wanted a connection between their personal offline world and their online world. They posted in the hope of reaching their loved ones and receiving personal responses. This could show how, for these participants, social media was acting as a facilitator for difficult conversations related to self-harm and mental health that participants were trying to have with friends and family. In support, having sensitive conversations online has been suggested to increase confidence and comfort in having these conversations offline (e.g., Desjarlais & Joseph, 2017).

Age was highlighted as a key factor in my study; participants in their mid to late twenties highlighted the shame attached to adult self-harm which further compounded these help-seeking difficulties. Boyce (2021) also discussed how adults in their investigation were hesitant to tell others about their self-harm due to the stigma and embarrassment attached to adult self-harm; with participants receiving messages from the wider population that they should have more control or other ways to cope than self-harm now they are older. There is the 'double stigma' of adult self-harm, firstly with self-harm being seen as an 'unacceptable' behaviour by society and secondly with an older age not fitting the assumed age of someone who self-harms – intensifying feelings of shame (Boyce, 2021). This highlights a clear need for a change in attitudes towards self-harm, ensuring this shift encompasses those who self-harm at an older age too, to reduce stigma and challenge the assumption that self-harm only occurs in adolescents.

The lack of room participants had to talk about self-harm could be linked to the stigmatising narrative of self-harm being attention-seeking (Morrissey, Doyle, & Higgins, 2018). If this narrative is portrayed as fact, then 'offline' networks may fail to support the individual regarding self-harm for fear that they will 'reinforce' the behaviour by showing care (e.g., Brown & Sidlauskas, 2016). For professionals in particular, the lack of responses offline could be linked to a gap in training (McHale & Felton, 2010) – as outlined by one participant also, or a lack of consultation time to adequately discuss self-harm or refer to the appropriate service. Overreactions to discussions around self-harm could come from a place of fear for the individual's welfare yet they can be stigmatising and shaming and breach confidentiality which displaces the trust in the relationship and shuts down future conversations about self-harm (Gholamrezaei, Heath & Panaghi, 2017). Repeatedly has research, including this study, demonstrated this lack of space for helpful, supportive conversations about self-harm, which raises the question of why these practices remain unchanged.

Participants discussed the limited nature of support if they were able to access help. Some of the alternative strategies recommended by professionals (e.g., holding ice cubes), were laughed at by social media users, as described by participants, due to being 'useless'. Research suggests that professionals can be pulled to recommend behavioural interventions due to fear related to lack of understanding of self-harm (Long, 2018). In support, using online questionnaires and semi-structured interviews, Wadman et al. (2020) found that young people viewed these harm-minimisation strategies (e.g., flicking rubber bands against the skin) as ineffective or only effective in the short-term. They suggest that being repeatedly advised to try these strategies can impact future help-seeking as the young person loses confidence in services. It also means that the underlying reasons for self-harm are being ignored, locating the blame in the young person, and leaving them to feel silenced and shamed once more. Essentially, there needs to be a societal shift in how self-harm is perceived and responded to (Lavis & Winter, 2020). And rather than generic interventions for self-harm, a more individualised approach needs to be taken; reflecting the uniqueness of the individual who self-harms and their experiences (e.g., Morrissey et al., 2018).

These patterns of judgment by society, or self-harm being ignored offline, contributed to the use of social media in relation to self-harm, a finding consistent with previous research (Harris & Roberts, 2013; Rodham et al., 2013). Social media offered a space for participant's distress and allowed this to be regulated. This open expression was contrary to the societal view that distress should just be 'fixed' and self-harm is taboo (Rodham et al., 2013) and is comparable to Lavis and Winter's (2020) finding where participants virtually 'sat' with each other's distress. The fact that participants were motivated to go on social media to express themselves shows how little opportunity they were given for this kind of space offline and perhaps how much more comfortable they were having these discussions online. Social media was considered accessible and participants could engage with it as and when they wanted without being victim to waiting lists and the constraints of NHS services (e.g., Naslund et al., 2016). Participant preference to access help online (rather than phone or face-to-face support) is aligned with the view of social media feeling more accessible due to its non-threatening nature, with connections being facilitated from the safety of the individual's own home (Naslund, Grande, Aschbrenner & Elwyn, 2014). Spinzy, Nitzan, Becker, Bloch and Fennig (2012) noted that being able to control entry and exit to social media gave individuals control and could reduce the anxiety associated with in-person interactions.

There was consideration to how social media could be a first port of call for self-harm support, enabling some participants to go on to access professional or offline support. In relation to Rickwood et al.'s (2005) help-seeking model, social media could be this first point of contact as it enables the individuals concerns to be expressed and feel understood by the community, it is an accessible form of support, and the individual may be more willing to disclose due to the

anonymity social media affords. This finding is also aligned with the notion of social media acting as a steppingstone to offline support for self-harm (e.g., Daine et al., 2013; Dyson et al., 2016) and with Frost and Casey's (2016) pathways to care model which sees online help-seeking as a potential introductory step to offline help-seeking. Social media support could be empowering to young people seeking offline support as they gain an understanding and familiarity about what these offline help-seeking interactions may be like (e.g., Naslund et al., 2016).

This investigation highlighted the importance of opening up conversations about normalising accessing therapy and the process of therapy itself. Participants discussed how social media helped to counter the societal view participants had previously faced - that therapy is about 'fixing' people. It could be argued that this societal view could be setting therapy up to fail and contributes to the view of professional support being inadequate. Therefore, society has an important role in helping to present a more realistic view of what therapy is and can achieve. The signposting to professional support was not welcomed by all participants. This seems a rational reaction given the challenging nature of accessing professional support which may have been what led the participant to go online. Therefore, they are being signposted back to the very resource that failed to support them initially.

Additionally, therapy engagement and outcomes are improved if client's and professional's expectations of therapy are aligned (McClintock, Anderson, & Petrarca, 2015; Snippe et al., 2015). Research suggests that professionals are focused on stopping someone self-harming which does not always align with an individual's aims (Owens et al., 2020). Owens et al. (2020) interviewed those with experience of self-harm and found that indicators of improvement were related to positive achievements - engagement with services, social participation and general daily functioning - as opposed to just stopping self-harming. These areas not only acted as a potential measure of improvement but were means by which improvement could be facilitated. This all points to a need for us to understand the desired outcome for that person, rather than making assumptions on what this outcome should be.

Participants discussed the need for there to be further interconnected working between professionals and social media. Prior research (e.g., Lewis et al., 2012; Moreno et al., 2016; Pritchard et al., 2021) has suggested professionals explore self-harm-related social media use with young people or use social media as a way to connect with young people (Carey et al., 2018). Lavis and Winter (2020) outline the need for these conversations to be centred on the impact of social media content and what led the young person to go online for support. This could help to highlight where gaps in current support provisions are. The fact that this recommendation (of exploring someone's social media use with them) repeatedly comes up in research reflects that it is not being translated into services. This could be a product of there

being other tasks completed at referral point and assessment into services, so social media is a topic that gets overlooked. However, overlooking this means we are missing an opportunity to understand a major part of someone's life.

In addition to opening up conversations, participants recommended that professionals should increase their presence on social media. In support, Stones and Smith (2018) suggested that interactions between patients and professionals on social media could enhance the understanding of the patient experience, allow for instantaneous feedback and breakdown barriers and power imbalances in the professional-patient relationship. They suggested that this could be because online interactions are less intimidating so the patient can feel empowered. Due to the increases in remote working in the pandemic, health services have become more familiar with communicating with patients virtually (e.g., Johnson et al., 2021) . This presents an opportunity that could be capitalised on, making services more accessible and flexible to meet the needs of those who self-harm and may prefer online communication due to its less intimidating nature. However, these interactions are not without concerns such as difficulty in managing crisis situations online and the potential for professional boundaries to be blurred. These concerns highlight the careful consideration and proper management required if social media is to be effectively, and safely, integrated into healthcare.

In sum, this investigation has highlighted the dire need for a systemic shift in how we support those who self-harm, changing attitudes and responses to self-harm, considering adequacy of support and interventions, and becoming more flexible and attuned to the way in which someone wants to discuss self-harm, which may involve social media.

Importance of context.

Key in this investigation was how participants themselves shared useful insights into how the perceptions of content vary depending on the context. This demonstrates how paramount it is for their voices to be heard throughout discussions regarding online content safety. There is a need to stop focusing entirely on finding definitive labels for how content is perceived and instead understand the complexity of the social media experience on an individual basis, developing an appreciation for how fluid perceptions of self-harm content are within different contexts.

For example, participant's accounts highlighted the context dependent nuances of 'healthy' and 'unhealthy' mechanisms of regulation via social media. The regulation could be achieved through the use of humour, validation or offloading. Research has outlined that acceptance (through validation and empathy) and reappraisal (providing an alternative perspective on a situation) are two ways of regulating emotions (Doré, Morris, Burr, Picard, & Ochsner, 2017). Hilton (2017) also found that participants discussed self-harm in the context of humour. Most

participants in this study considered humour to be a helpful way to reduce distress by relating to self-harm in a more 'light-hearted' way. It was also seen as useful in creating a level playing field between how other mental health concerns are talked about and self-harm. Various mechanisms have been suggested through which humour can assist the regulation of emotions. For instance, humour could provide a change of perspective which allows some reappraisal or distancing from one's distress (Samson & Gross, 2012). However, one participant noted that humour could be minimising to self-harm and make it more likely to occur (as was found by Hilton, 2017), highlighting the individual differences in the perception of content.

Social media served as an alternative to self-harm for some participants as the emotional release it allowed was similar to the release received from self-harming. This reflects existing research (e.g., Rodham et al., 2013) which suggests online images were thought to reduce self-harm urges. At other times and with other participants, social media held the potential to form part of the self-harm process. Participants spoke about how they accessed self-harm related social media content both before and after self-harming. This could be to trigger oneself prior to self-harming, as was also found by Jacob et al. (2017) who likened viewing images to part of the "ritualistic practice of self-harm" (p.145). It served as a reminder of the relief self-harming could bring. However, the viewing of images was not considered a 'vital' prerequisite for self-harm by participants in this study contrary to Jacob et al. (2017). This difference could be attributed to the fact that Jacob et al.'s (2017) investigation aimed to explore how young people understood and used self-harm images online, compared to the perceptions of general social media self-harm content this investigation was concerned with. Therefore, when advertising and recruiting for their study they may have attracted participants for whom images played a larger role in their self-harm. Online content also formed part of the self-harm process through justifying a pre-existing decision to self-harm by viewing images. This is aligned to the findings of Brett-Taylor (2015), who discussed how the justification of self-harm (via looking at online content) can serve to mitigate some of the societal and self-imposed shame related to self-harm.

Post-self-harm social media use could be to relieve the guilt and shame felt after self-harming (e.g., Laye-Gindhu & Schonert-Reichl, 2005). Notably, in this study, social media was also used by one participant to extend the euphoria self-harming created. This relates to the experiential avoidance model of self-harm (Chapman et al., 2006) where self-harm facilitates the move away from negative emotions and towards positive ones. This shows how self-harm can be reinforced but also, in relation to this study, how social media can form part of this reinforcement.

Therefore, this study's findings reinforced the complexities highlighted in prior research where participant reactions from viewing self-harm content can be seen as triggering and part of the process, versus content acting as a substitute to self-harm via the production of a comparable physical or emotional reaction (Baker & Lewis, 2013; Seko, Kidd, Wiljer, & McKenzie, 2015).

This study also showed the nuances of the use of humour, which at times can be a helpful way to release difficult emotions, but at others can be seen as minimising self-harm. This reinforces how self-harm and social media use is complex and cannot be reduced merely to content being classified as bad or good. This study also extends our understanding of the complexity of self-harm related social media use not just being concerned with the individual differences between users but also within users over time and different contexts, one of which being the function of the self-harm. For instance, social media could serve as an alternative to self-harming for one participant if they just wanted the reaction from seeing blood but if they wanted to feel pain social media could not serve as this alternative. This also parallels with the alternatives to self-harm professionals advise which are not always effective if misaligned with the function of self-harm for the individual (e.g., Wadman et al., 2020). Additionally, one participant discussed how self-harm content could help her manage her self-harm urges if they were related to depression. On the other hand, if she associated the self-harm to the emotion of anger and it was a more impulsive act, she would use social media afterwards to make sense of and discuss the self-harm that had occurred. Another participant discussed how self-harm content would be viewed differently dependent on how recently they had self-harmed, with content being perceived as less triggering if they had self-harmed in the last week.

Individual differences were also noted in content related to recovery from self-harm. One participant reflected on how they felt ashamed for not wanting to recover when compared to those on social media sharing how many weeks or months they had been without self-harming. However, for another, making these comparisons with content gave them the motivation to fight for the help they felt they deserved, suggesting that not all comparison-making was linked to a feeling of shame. This highlights the differences in the perceptions of self-harm content e.g., with some finding self-harm recovery content inspirational versus it making others feel ashamed. This, in turn, is perhaps related to where the person is positioned in relationship to their own self-harm.

Perceptions of content were shown to shift over time within participants as they developed awareness as to the impact the content could have on them. This meant that some chose to transition away from using certain sites, to self-moderate or to relate to social media in a different way. Existing research also points to this sense of resilience that social media users can have to choose to disengage from sites when they recognise the negative impact the content is having on their wellbeing (Tucker & Lavis, 2019). Lewis and Michal (2016) also refer to users transitioning away from self-harm related social media use when it no longer feels relevant to them. Contextual factors like lifestyle changes such as distress being made room for offline, understanding the impact of self-harm on others and wanting a more private life were some reasons behind the progression away from self-harm related social media use. This has parallels with some of the reasons young people have for stopping self-harming; the resolution of self-

harm behaviours can be a result of moving out of the turbulence of teenage lives and development and having a greater sense of control (Moran et al., 2012). Furthermore, this study suggests that age could have a key role to play in how users interact with self-harm content on social media. Multiple participants discussed how the changes mentioned above were linked with their own growth and development. However, this is not to suggest that there is a certain age at which individuals become adept at self-moderating or changing their relationship with self-harm content as again this is likely to depend upon someone's developmental trajectory – one individual at 29 years old could present as developmentally quite different to another of the same age.

It is imperative that we appreciate how dynamic and fluid perceptions of self-harm content are both between and within individuals. Just as much as how existing research has shown us that it is too simplistic to classify any one site as a benefit or a risk, this investigation has shown how the perception of self-harm related social media content does not remain constant within one individual either and the context in which someone is looking at the content needs appreciation as this will interfere with how it is perceived by them. The same individual may find the same content helpful one day and triggering the next. This links to difficulties in the 'Draft Online Safety Bill' (Department for Digital, Culture, Media and Sport, 2021) which references policing material that is 'legal but harmful' but fails to explain how to define 'legal but harmful' material (Fenwick, 2021). And as demonstrated here, the term 'harmful' is not a static, universal entity. We need to work with the complexity as opposed to expending our energy fighting against it and trying to simplify the relationship between social media and self-harm so much so that we silence young people once more.

The dilemmas of peer support

This study helped to disentangle some of the nuances of peer support on social media. In the absence of support offline, participants gained a sense of community online. Wanting to not feel alone was a key motivating and maintaining factor for self-harm related social media use. This finding also supports Naslund et al.'s (2016) conceptual model for social media help-seeking where social media is accessed to reduce isolation, gather information and challenge stigma safely. Challenging stigma was key for young adult participants in this study who felt motivated to not feel alone and to also ensure other adults who self-harm knew that they were not alone either.

As part of the community, the peer-to-peer support - being helped and helping others - gave participants a sense of purpose (e.g., Dyson et al., 2016; Adler & Adler, 2013). Research suggests that those who help others have a greater sense of self-worth (e.g., Krause, 2016), which could be due to the fact that helping others can foster a sense of competency and enhance social connectedness (Zuffianò et al., 2014), making the individual feel 'better' as one

participant noted. It also allowed participants to see how to help themselves from helping others. Doré et al. (2017) suggest that by helping others to regulate their emotions we can enhance our own regulatory skills, as helping others allows these skills to be practiced and refined. This reciprocal nature of online support was also highlighted by Lewis and Michal (2016) and Lavis and Winter (2020) with participants providing suggestions to manage urges as well as showing others they were not alone. This reciprocity links to social exchange theory (Homans, 1974) where participants were potentially providing help to others to repay support they themselves had once received online. Mutual support is suggested to be an expectation of online communities and users also protect one another online by ensuring boundaries related to what is acceptable to post and not post are maintained (Smithson et al., 2011), as was discussed by participants.

However, online peer support can also be rejecting with unhelpful responses or no responses given at all. This lack of response mirrors the rejection and isolation participants felt in their offline worlds (Harris & Roberts, 2013). Naslund et al. (2016) reiterate the concern relating to advice and support offered by untrained peers and the detrimental impact this could have. There is a tension here between the value of having personal experience so that the helper can really understand and the desire to give 'professional level' advice. However, research also suggests that individuals using social media for advice are adept at evaluating the advice suggested (e.g., Armstrong & Powell, 2009; Schrank, Sibitz, Unger & Amering, 2010). This does however invite the question, perhaps for younger users more so, whether it is their responsibility to be vetting the advice given on social media and also whether they have capacity to do so. Capacity to vet content could also fluctuate depending on how distressed an individual is. Therefore, it is important to engage young people in discussions about self-harm in a safe, non-judgmental and effective way. This could provide young people with another avenue where they can explore answers to their questions or make sense of their own experiences and reduce the risk of them experiencing harmful or unreliable advice online.

Furthermore, with this sense of reciprocity and belonging comes responsibility and pressure. There are the expectations placed on individuals to help others when they may not be in a place where they are able to do so. This links to 'caregiver distress' in peer support where those providing the support can feel overwhelmed and frustrated as they are experiencing an interpersonal conflict in managing their own mental health concerns and others' (Shah, Wadoo, & Latoo, 2010; Naslund et al., 2014). Being in a helping role online brings with it a certain toll if the 'helper' ends up being concerned about another's welfare (Lavis & Winter, 2020), showing the personal impact a supporting role can have. Additionally, the emotional toll on the supporter can result from vicarious trauma. This relates to the helper experiencing trauma or stress symptoms from knowing about the traumatising event experienced by another without them experiencing harm or the threat of harm directly (Evces, 2015).

There was a sense of responsibility to manage what the 'in' group is and how it may be perceived. Participants felt responsible for the impact that online content and communities could have on others and were especially concerned about the impact this could have on inexperienced users. This depicts how participants recognised that not all users of self-harm related social media were supportive and indicates a level of care and insight which young people have over how content could be perceived (Lewis & Michal, 2016). This is also aligned with research relating to self-censorship. For instance, Sleeper et al. (2013) suggested that individuals on social media are more likely to self-censor when they are uncertain of their audience. In relation to this study, the anonymity on social media means that participants could not be sure of what content was being seen by whom and explains their concerns regarding responsibility and being mindful of the impact of content on others. This could have been a particular concern for young adult participants in this study who had their own experiences of the impact of self-harm content and felt more protective over younger users.

There are other issues which come from receiving peer support online, including a level of pressure felt to stay in the 'in' group. Participants spoke of the pressures they were faced with in relation to their self-harm. This related to self-harm competitions, comparison making, online abuse and encouragement. The comparisons with other users had the propensity to make participants feel worse if they felt inferior (Chou & Edge, 2012). Comparison making is a feature of social media in general where individuals often compare themselves against idealised representations. This study highlighted how this sense of inferiority could come from three different angles; not having achieved enough in life, not self-harming or distressed enough, or not wanting to recover enough. One participant outlined how general life comparisons were more damaging to them than self-harm content as it made them feel 'worthless'. This stronger effect was perhaps related to general comparisons being more common and pervasive across multiple life areas e.g., living arrangements and job success, than specific self-harm content/comparisons. Participants talked about how comparing their self-harm could lead them to be 'less safe' if they felt their self-harm was not 'good enough' (e.g., Baker & Lewis, 2013; Jacob et al., 2017). This parallels the messages of being undeserving that services and service funding can inadvertently give to individuals – that only those in crisis receive support. This points to a need for services to consider the detrimental impact these messages can have and to start to act in a more supportive and, in some instances, preventative way as opposed to waiting for individuals to reach a crisis point before help can be accessed.

Another important aspect of being in the 'in' group was having shared experiences and understandings, this meant that participants could speak freely online without fear of over or under reactions. The interactions with people with lived experience facilitated these free and honest expressions. This lived experience was key in setting online and offline support apart. Other research noted that professionals and family members were considered unable to

understand unless they had self-harm experience themselves (e.g., Rodham et al., 2013; Lewis & Michal, 2016). Additionally, Bassett, Faulkner, Repper and Stamou (2010) outline the importance of individuals sharing experiences with each other to foster genuine empathy, reassurance, understanding and hope. These shared experiences relate to the importance of group identity (Williams, Nielsen & Coulson, 2020); the perceived shared identity existing on self-harm related social media platforms means that users are more influenced by each other's suggestions. This could explain why online support is more readily accepted by participants when compared to offline support.

While participants discussed the need for the 'in' group to solidify this sense of shared understanding, this can feed into what some have termed 'normalising'. The reinforcement of 'shared' experience can mean there is an echo chamber effect, which algorithms help to maintain. For example, the co-occurrence of certain hashtags together on Instagram means that following the '#depression' can also link to '#cutting' (Scherr, Arendt, Frissen, & Oramas, 2020). This sense of an 'in' group means the community has decided what is 'in' or acceptable and what is 'out' or unacceptable and this limits an individual's ability to see other avenues. Participants described feeling sucked in by and saturated with the online content. In turn, this led participants down 'rabbit holes', which offered no alternative perspectives and normalised self-harm, a demonstration of cultivation theory in action (Gerbner et al., 2002). There was also a sense of circularity of distress, with participants being made to feel worse by what they viewed or interacted with on social media.

This notion of social media 'normalising' self-harm relates to self-harm being presented as 'not serious' and that no support needed to be sought for it, echoed by the findings of both Lewis et al. (2012) and Lewis and Knoll (2015). It could be perceived as the accepted coping strategy 'script' (Abelson, 1976) which reduced motivation to locate alternative strategies (Dyson et al., 2016). This links to script theory (Abelson, 1976) which outlines that individuals develop responses to their environments which are held as scripts that guide future behaviour. Young people who self-harm can adopt self-harm scripts where self-harm is viewed as a response to internal distress and environmental stressors. Scripts can be reinforced through observation or storylines, therefore bearing witness to social media self-harm narratives can serve to strengthen these scripts and can reinforce self-harm.

The idea that self-harm being normalised acts as a barrier to help-seeking was also found by Daine et al. (2013). This normalisation is also considered to exacerbate and perpetuate self-harm (Jacob et al., 2017; Hilton, 2017). On the other hand, what this study highlighted was that self-harm being 'normalised' was not always considered a negative. The normalisation of mental health has become more widespread and outlines the view that mental health concerns can touch us all, a concept which can be helpful in tackling stigma (e.g., Barlott, Shevellar, Turpin, &

Setchell, 2020). Participants considered how self-harm could be normalised like other mental health concerns to enable it to be talked about and supported rather than considered taboo. This however suggests that there is a fine line between sharing experiences to de-shame self-harm and sharing experiences that serve to perpetuate and encourage self-harm. It seems there is a need to normalise self-harm enough to reduce stigma, isolation and encourage support seeking, but not normalise it so much that it is seen as the only coping strategy for someone and that discussions and support around it are not needed.

As well as being considered a support source, being part of this 'in' group also acted as a source of information with participants developing understandings about self-harm and themselves by learning from others and their content. Participants were motivated to: educate themselves and make sense of self-harm (Lavis & Winter, 2020), educate others and share understandings (akin to Lewis & Michal, 2016), and raise awareness and destigmatise self-harm. Participants sought information regarding alternatives to self-harm, accessing support and first aid tips. There seemed to be a more accepting narrative of self-harm, rather than only offering cessation as the solution, which also facilitated and opened up conversations. At times, this increase in understanding gave insight and allowed for self-reflection which meant participants questioned their own reasons for self-harming which could prevent self-harm occurring. Research suggests that developing an understanding of one's self-harm can improve someone's self-image and mastery of self-harm urges (Tofthagen, Talseth, & Fagerstrøm, 2017).

However, these open discussions meant that the information gathered could be harmful. For instance, there were opportunities to search or find knowledge relating to methods of self-harm and how to hide it (Cavazos-Rehg et al., (2017). Jacob et al. (2017) also outlined how participants would search for advice for managing distress but self-harm images and instructions would come up. Participants highlighted how this information could give them 'ideas' relating to self-harm. The nature of self-harm content was described as having an 'insidious' effect, distinguishing between the overt encouragement and competition online and a more subtle form of self-harm 'inspiration' and information to be stored and acted on later (as in Jacob et al., 2017). Participants were pulled to self-harm at times out of desperation and they understood it as a strategy that helped others online, and so could help them. This can be explained by social learning theory (Bandura, 1971) and specifically Nock's (2009) social-learning hypothesis of self-harm. Participants witnessed self-harm being presented in a favourable light so it was positively reinforced and meant they were more likely to enact a similar behaviour.

Therefore, this investigation has further disentangled the nuances of peer support for those who self-harm. With social media offering space for reciprocal support, the sharing of experiences

and information whilst also risking the creation of an echo chamber of similar content, unhelpful or inaccurate information which could serve to perpetuate self-harm.

Moderation: a fine line between safety and silencing.

Internal and external controls were discussed by participants to mitigate some of the risks of using social media. Research has suggested the need for advancements in technology to accurately identify self-harm on social media (Arendt et al., 2019). For example, Scherr et al. (2020) piloted the use of a content-driven algorithm instead of a hashtag-driven algorithm on Instagram. It was suggested that this would censor content more accurately as it can identify the images' content, as opposed to just the hashtags which can be changed to circumvent content bans e.g., using '#cat' to post self-harm cuts. However, this kind of external control exerted on the platforms was seen as shaming and silencing to participants. Part of this was attributed to failings to consider the intent behind banned posts (e.g., Lavis & Winter, 2020). For instance, prior research suggests that posts of self-harm scars can be linked to a promotion of recovery (Seko & Lewis, 2018) rather than linked to self-harm encouragement as is often assumed. Participants, in part, associated the failure to consider the intent of posts to algorithms. Other participants noted the importance of human moderators to control content as they can understand and empathise with the intent behind posts. Technology would have to advance considerably to create a comparable way to moderate content safely but without shame, silencing and judgement. This is of particular relevance with the 'Draft Online Safety Bill' (Department for Digital, Culture, Media and Sport, 2021) which sparked concerns that individuals would be wrongly censored if social media companies used artificial intelligence algorithms to regulate content in line with the bill (BBC, 2021). Participants also recommended the need to consider the algorithms involved in how self-harm content is encountered to foster healthier ways of navigating platforms.

Controlling content was also seen as futile due to content constantly changing (e.g., Lloyd, 2014) and participants noted how different terms can still be used to overcome restrictions on content (as in Vega et al., 2018; Record et al., 2019). There were also different reactions within and between participants, so an all-encompassing solution to controlling content was seen as impossible. While such a solution could alleviate the risk of some seeing content that they find harmful, it could also restrict access to the same content which others find comforting or useful. This is aligned with fears that the 'Draft Online Safety Bill' lays out plans that will stifle free speech. All of which points to how essential it is for professionals, social media companies, technology and especially young people who self-harm to collaborate regarding online content safety.

The anonymity of some sites was a motivating factor for self-harm related social media use and fostered a sense of safety. In support, Carey et al. (2018) and Rodham et al. (2013) argue that

anonymity is key in facilitating the honest expression seen online. Deindividuation theory suggests that being immersed in a group or setting can result in a loss of self-identity, and anonymity is suggested to facilitate deindividuation (Zimbardo, 1969). Concerns around self-evaluation are reduced with anonymity which helps to explain why participants felt more at ease to speak their mind. However, this loss of identity also means that individuals can deviate from socially accepted behaviours (Zimbardo, 1969), potentially resulting in the online abuse that participants witnessed on social media. In support, Lowry, Zhang, Wang and Siponen (2016) suggest that anonymity can facilitate cyberbullying.

Safety was maintained by moderators and users themselves. It was important to participants that these controls came 'internally' from within the communities. Smithson et al. (2011) outlined the importance of moderators to remind users of the boundaries online. This kept the online world predictable, consistent, and therefore safer. Smithson et al. (2011) also reflected on how self-harm forum users took the expert role in setting and maintaining the online boundaries. They would challenge each other if posts were contrary to these. There appears a need for balance in the moderation of sites, too much moderation can feel strict and silencing but not enough can feel unsafe.

To maintain a level of anonymity and control participants also self-moderated. There was a sense of agency and choice participants had over what content to share and whether to engage with social media related to self-harm or not. Social media offers young people a choice over how active or passive they are in their engagement with it (Naslund et al., 2016). It is also a place where young people can discard and create different identities for themselves (Daine et al., 2013). This can be done through combining media (e.g., music, television quotes and screenshots etc.) and content from other peers online (Moreno et al., 2016), placing the young person in the position of 'curator'. Participants also kept their offline and online worlds separate and had separation within their online world by keeping different accounts for the same platforms. Research supports this as Moreno et al. (2016) discuss how maintaining two Instagram accounts enables the young person to keep their self-harm identity separate and anonymous from their 'real-world' self. This divide was seen as only allowing distress to exist in the online world which could be risky and could mean that offline help-seeking was delayed, also suggested by Pritchard et al. (2021). It could also allow the avoidance of the offline world to be perpetuated, hindering the development of supportive relationships or other coping strategies (Lavis & Winter, 2020; Lewis et al., 2012). It is important to acknowledge that young people who self-harm and use social media are inhabitants of both online and offline worlds meaning that they are in the difficult position of having to navigate between these (Rodham et al., 2013). This is no doubt made more challenging for them with online and offline worlds currently not working in collaboration, encouraging compartmentalisation.

In sum, moderation of content by the user themselves, 'internal' site moderators or external content controls has the potential to facilitate a safer environment online but also runs the risk of silencing the voices of some people who self-harm. In the case of self-moderation, there is also the concern that other avenues for support could be silenced if self-harm discussions are only taking place in one online area of someone's life. Therefore, not only do other avenues for support need to be made more accessible, the safety of the online world needs thoughtful exploration – always including the voices of those who self-harm and use these sites.

Strengths and Limitations

Strengths.

This study updates existing research in this field and explores perceptions across different social media sites, giving a wider understanding of self-harm related social media use. A key strength is the direct engagement with people who use social media in relation to self-harm, allowing their voices to be heard through in-depth interview exploration (e.g., Branthwaite & Patterson, 2011). This allowed the views of different types of users to be included, such as those who take on more observing roles and do not actively post. This study incorporated a wider age range of participants than previous investigations (e.g., Jacob et al., 2017), which allowed an exploration of how self-harm related social media use changes over time and with developing maturity. It also attempted to allow for the voices of a more diverse sample to be heard. The use of telephone interviews meant that more inclusive, national recruitment could take place, and this allowed participants to maintain a level of anonymity (Irvine, 2010).

Quality checks, such as supervision and a clear audit trail, as well as consideration of reflexivity, were conducted to ensure rigor (e.g., Nowell et al., 2017). The research journal allowed for self-reflection throughout the process and helped me consider how my Trainee Psychologist role influenced this process and how my research skills developed. Arguably the most important quality check was the member checking of preliminary themes which allowed another opportunity for the participant's voices to be heard and incorporated into the results.

Limitations.

The participants were from a self-selected sample and were recruited via social media platforms. This does not account for people who self-harm but no longer use social media in relation to self-harm. This could have meant that more positive perceptions related to social media were gathered from the people still using the platforms. However, using social media did prove to be an efficient form of recruitment. Recruitment took place across five platforms, which meant that potential participants who used sites not recruited from were excluded; limiting the number of

recruitment sites did allow for easier management of recruitment, however. When recruiting I did not exclude participants who had not self-harmed for over a year. This could have introduced further differences into the results, as those not actively self-harming but using social media related to self-harm could be doing so in a markedly different way than those using social media and still self-harming. However, including these participants was important as it allowed the exploration of how their relationship with social media changed when they stopped self-harming. To exclude these participants, I would have had to implement a seemingly arbitrary criterion based on recency of self-harm. Employing the NICE (2013) definition of self-harm could have affected recruitment as participants not relating to this definition would have been excluded. I could have used the client's definition of self-harm instead, however the NICE definition is broad so hopefully encompassed many interpretations of self-harm. Whilst the study attempted to remain inclusive of factors such as gender and ethnicity, it must be acknowledged that the majority of participants identified as White British females. Participants were also well-educated, all having attained at least A-levels, which may limit the transferability to less educated populations. Failing to include a diverse representation can limit our understanding regarding self-harm and social media use in other populations and can mean policies related to this fail to meet the needs of these populations (e.g., Erves et al., 2017).

The study allowed for an examination across different social media sites; however, a cost of this meant that a detailed examination of individual sites was not possible. There could be differences between perceptions of self-harm dedicated subreddits versus self-harm posting on general sites such as Instagram, for example. Additionally, the data collection took place during the Covid-19 pandemic, limiting the transferability of findings. Whilst participants reflected on social media use prior to the pandemic also, the pandemic is likely to have affected their social media habits (e.g., Valdez, Ten Thij, Bathina, Rutter & Bollen, 2020).

Clinical Implications

This research has explored and reflected on young people's perceptions of using social media related to self-harm and gives rise to clinical implications in this field.

A key motivating factor for participants using social media was the absence of accessible and effective support offline. Whilst this research focused on social media, participants raised the recommendation for a wider perspective on supporting young people who self-harm to be considered, as opposed to just targeting social media as the only area for change. A more systemic approach is needed, for social media to be included in this but not merely used as a scapegoat – the reductionist view taken by some, of shutting down sites or banning content, means that we are yet again failing to consider the systemic failures in place that mean self-harm in young people is increasing and that support offered is inadequate or unavailable. This

points to a need both societally, and with professionals more specifically, to develop opportunities for self-harm to be discussed in a non-judgemental and non-shaming manner. This could be actioned through better training and awareness of self-harm for professionals. Participants here have highlighted the need for a balance between sitting with someone's distress and taking action e.g., to keep someone safe. There is a pull for professionals to, understandably, focus solely on someone's risk which can result in the individual being passed on to other services. Whilst maintaining the safety of the person is paramount, we must also acknowledge the impact that this 'passing on' has to the individual – sending the message that their distress cannot be managed and perhaps leading them to feel rejected. Therefore, a professional's management of their own anxiety surrounding risk needs consideration so that this does not lead to the shame and isolation of people who self-harm being perpetuated. Equally, professionals need to appreciate individual differences in how helpful someone finds sitting with distress versus a more active form of therapeutic 'intervention' being undertaken. This invites the question, one which needs asking on an individual basis, when does just giving room for distress stop being enough?

Recent campaigns e.g., ITVs 'Britain Get Talking' initiative (ITV, 2021) focus on enhancing mental wellbeing, but discussions related to self-harm are still shied away from. This keeps young people who self-harm isolated and misunderstood. Platforms and campaigns such as this could play a role in opening up self-harm discussions in wider communities, not just health professional settings, to challenge the stigma associated with self-harm.

There needs to be relevant support available for those from different backgrounds. Participants commented on the lack of helpful online and offline representation of people who self-harm from BAME backgrounds, those who self-harm at an older age, men and those identifying as transgender. Media campaigns, online and offline, offer a possibility for a more diverse representation of different communities which could be more relatable and reach wider audiences.

Regarding self-harm related social media use, discussions need to open up or the topic will continue to be misunderstood. There is need for individual differences in self-harm related social media use to be recognised, as participants have shown how the same content affects individuals differently. This could take the form of clinicians asking individuals about their social media use, enabling them to reflect on why they use social media in this way and the impact this has on them, offering an opportunity for young people to consider how they could relate to social media in a more beneficial way. Whilst this has been recommended previously (e.g., Lewis et al., 2012; Moreno et al., 2016; Pritchard et al., 2021) asking individuals about social media and its impact has not yet become a standard part of assessment procedures. Without this, we are missing a whole aspect of someone's life – failing to consider that they

exist in both online and offline worlds, and consequently failing to acknowledge the interaction between these two worlds. Participants here commented on how when self-harm or mental health related social media use was discussed with them, either by those in their personal lives or professionals, this altered the way they used sites, allowing them to do so in a 'healthier' way. It is clearly important for us to take a more personalised approach to an individual's social media use; exploring the idiographic benefits and harms on a case-by-case basis (e.g., Timpano & Beard, 2020) which will help us consider the fluid and dynamic nature of an individual's perceptions surrounding self-harm content on social media.

My findings suggest that social media use can change with age, but this does not mean that there is no need to discuss self-harm related social media use with younger people. Having these discussions early means that we have an opportunity, and arguably a duty of care, to share what we know and educate young people regarding the benefits and risks of self-harm related social media use. This can help young people appreciate both the impact of content on themselves and others.

There is a need to explore with young people whether they are seeking out self-harm content online or whether they are accidentally coming across content. For the former, it needs to be questioned why and how this content is sought out and for the latter, there should be consideration of what could be done to amend algorithms. Social media algorithms need consideration as participants discussed the difficulty in coming across content that they had not searched for and did not wish to see. These algorithms also fail to accurately assess the intent of a post which mean posts related to self-harm recovery or support can be silenced. To action this, there needs to be more collaborative working between professionals, social media, technology platforms and young people who self-harm to consider ways to make platforms safe and useful to those who need them most. Professionals could also work alongside technology companies and young people who self-harm to produce guidelines that keep in mind the wellbeing of all users. It was clear that participants had a better sense of the nuances of social media and how perceptions vary within and between people when compared to policy makers. It is imperative that we consider that hearing the voices of people who self-harm is not limited only to a clinical/therapeutic setting and that we involve young people in research and at policy-making levels. This is key in order for us not to keep ignoring the complexity of self-harm related social media content.

Additional consideration should be taken regarding how much responsibility is fair to place on young people to 'self-moderate' and to accept that they can actively choose what they engage with online, versus the impact coming across unwanted content can have and how this can be controlled in a safe, but non-shaming manner. There is question over whether, when young

people are at their most vulnerable with high levels of distress, they will be able to engage in a process of self-moderation or attend to content warnings (Baker & Lewis, 2013).

The offline world needs to keep up with the ever-changing online world. With care and consideration, social media could be a useful resource for professionals and family or friends to connect and support young people who self-harm.

Future Research

Social media research will inevitably need regularly updating as sites become dated or fall out of use and get replaced by new platforms. Future research could consider self-harm related social media use in less researched groups such as those from BAME backgrounds, men and those identifying as transgender.

While there was some sense from participants that they were seeking self-harm content out, they would also come across content that could encourage self-harm or make them feel worse. Therefore, greater understanding is needed relating to the impact of intentional versus unintentional engagement with self-harm content on social media (Lewis & Michal, 2016). Linked to this, it would be beneficial to gain further understanding regarding how 'healthier' algorithms could be fostered to ensure that individuals are not becoming immersed in 'rabbit holes' of content that they did not set out to engage with.

The terminology used in self-harm/social media research could be explored with those with lived experience. For instance, the term 'normalising' was shown to have both negative and positive connotations for participants. This would add to our understanding and challenge the assumptions often made in this area of what is helpful and harmful for those who self-harm.

Finally, to support more collaborative working between professionals, social media, and those who self-harm, the perceptions of professionals regarding self-harm related social media use could be explored. This could allow for barriers in engaging with this collaboration on the part of professionals to be examined.

Personal Reflections

As a novice researcher, I started this project feeling overwhelmed at the tasks ahead, a feeling that was exacerbated by the uncertainties brought about by the pandemic. Despite these delays and issues, I was able to recruit and interview 15 individuals and I will always be grateful to the time and effort they committed into sharing such useful and interesting perspectives with me.

I was shocked to hear the number of revelations relating to poor 'offline' support and unhelpful responses by professionals. It was disheartening to see such practices still occurring. One

participant outlined how they had heard of professionals not administering anaesthetic when suturing a self-harm wound, saying to the individual “you did it yourself, surely this doesn’t hurt either”. As a practicing clinician, this had me questioning what kind of people and systems are in place to allow these reported failures to occur so repeatedly. It has motivated me to want to get involved in staff training and education to help them question their assumptions and judgments related to those who self-harm, in order to assist them in providing the care that individuals who self-harm truly deserve. On the other hand, hearing about the care and protection young people offer each other online was heartening. From conducting this research there seems to be a sense of a ‘blame game,’ with society considering that it is easier to blame social media for young people’s self-harm rather than considering the wider context of why young people are so distressed and turning to self-harm and then social media as a way to manage. Overall, I have found this experience challenging but more rewarding that I ever thought it would be.

Conclusion

The participants in this study showed that social media plays a key role for those who self-harm. Social media is an inevitable entity, what is important now is for us to focus our efforts on ensuring collaboration and communication between those who self-harm and use social media, professionals and social media platforms. This is with the hope that doing so will provide space and opportunity for the development of discussion around self-harm, and for the creation of accessible, safe and helpful working practices to be fostered to support young people who access self-harm content online.

REFERENCES

Abelson, R. P. (1976). Script processing in attitude formation and decision making. In J. S. Carroll & J. W. Payne (Eds.), *Cognition and Social Behavior*. Hillsdale, NJ: Lawrence Erlbaum.

Adler, P. A., & Adler, P. (2013). Self-Injury and the Internet. Reconfiguring the Therapeutic Community. *RESET. Recherches en sciences sociales sur Internet*, (2).

Aichner, T., & Jacob, F. (2015). Measuring the degree of corporate social media use. *International Journal of Market Research*, *57*(2), 257-276.

Ando, H., Cousins, R., & Young, C. (2014). Achieving saturation in thematic analysis: Development and refinement of a codebook. *Comprehensive Psychology*, *3*, 4.

Arendt, F. (2019). Suicide on Instagram - Content Analysis of a German Suicide-Related Hashtag. *Crisis-the Journal of Crisis Intervention and Suicide Prevention*, *40*(1), 36-41.

Arendt, F., Scherr, S., & Romer, D. (2019). Effects of exposure to self-harm on social media: Evidence from a two-wave panel study among young adults. *New Media & Society*, *21*(11-12), 2422-2442.

Armstrong, N., & Powell, J. (2009). Patient perspectives on health advice posted on Internet discussion boards: a qualitative study. *Health Expectations*, *12*(3), 313-320.

Baker, D., & Fortune, S. (2008). Understanding self-harm and suicide websites: a qualitative interview study of young adult website users. *Crisis*, *29*(3), 118-122.

Baker, T. G., & Lewis, S. P. (2013). Responses to Online Photographs of Non-Suicidal Self-Injury: A Thematic Analysis. *Archives of Suicide Research*, *17*(3), 223-235.

Bandura, A. (1971). Vicarious and self-reinforcement processes. In R. Glaser (Ed.), *The nature of reinforcement.* New York: Academic Press.

Barlott, T., Shevellar, L., Turpin, M., & Setchell, J. (2020). Destabilising social inclusion and recovery, and pursuing'lines of flight'in the mental health sector. *Sociology of Health & Illness*, *42*(6), 1328-1343.

Barr, S. (2020, October 7). Six ways social media negatively affects your mental health. *The Independent.* Retrieved from https://www.independent.co.uk/life-style/health-and-families/social-media-mental-health-negative-effects-depression-anxiety-addiction-memory-a8307196.html

Basset, T., Faulkner, A., Repper, J., & Stamou, E. (2010). Lived experience leading the way: Peer support in mental health. *London: Together UK*.

BBC. (2021). Online Safety Bill 'catastrophic for free speech'. Retrieved from https://www.bbc.co.uk/news/technology-57569336

Beaunoyer, E., Arsenault, M., Lomanowska, A. M., & Guitton, M. J. (2017). Understanding online health information: evaluation, tools, and strategies. *Patient education and counseling*, *100*(2), 183-189.

Berryman, C., Ferguson, C. J., & Negy, C. (2018). Social Media Use and Mental Health among Young Adults. *Psychiatric Quarterly*, *89*(2), 307-314.

Best, P., Manktelow, R., & Taylor, B. (2014). Online communication, social media and adolescent wellbeing: A systematic narrative review. *Children and Youth Services Review*, *41*, 27-36.

Biddle, L., Cooper, J., Owen-Smith, A., Klineberg, E., Bennewith, O., Hawton, K., ... & Gunnell, D. (2013). Qualitative interviewing with vulnerable populations: individuals' experiences of participating in suicide and self-harm based research. *Journal of affective disorders*, *145*(3), 356-362.

Bokhorst, C. L., Sumter, S. R., & Westenberg, P. M. (2010). Social support from parents, friends, classmates, and teachers in children and adolescents aged 9 to 18 years: Who is perceived as most supportive?. *Social development*, *19*(2), 417-426.

Borschmann, R., & Kinner, S. A. (2019). Responding to the rising prevalence of self-harm. *The Lancet Psychiatry*, *6*(7), 548-549.

Bottino, S. M. B., Bottino, C., Regina, C. G., Correia, A. V. L., & Ribeiro, W. S. (2015). Cyberbullying and adolescent mental health: systematic review. *Cadernos de saude publica*, *31*, 463-475.

Boyce, M. (2021). "It doesn't stop when you get to 18": experiences of self-harm in adults. *Mental Health Review Journal*. Retrieved from https://arro.anglia.ac.uk/id/eprint/706645/6/Boyce_2021.pdf

Bramwell, K. (2019, May 30). Instagram: 'I don't want people to be ashamed of their scars.' *BBC News*. Retrieved from: https://www.bbc.co.uk/news/health-48431858

Branley, D. B., & Covey, J. (2017). Is exposure to online content depicting risky behavior related to viewers' own risky behavior offline? *Computers in Human Behavior*, *75*, 283-287.

Branthwaite, A., & Patterson, S. (2011). The power of qualitative research in the era of social media. *Qualitative Market Research: An International Journal 14(4), 430-440*.

Braun, V. & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds), *APA handbook of research methods in psychology, Vol. 2: Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 57-71). Washington, DC: American Psychological Association.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Brett-Taylor, L. (2015). *The lived experiences of females in mid-adolescence who use social media in relation to self-harm.* (Unpublished doctoral dissertation). University of East London, London.

Brown, T. B., & Kimball, T. (2013). Cutting to live: A phenomenology of self-harm. *Journal of Marital and Family Therapy, 39*(2), 195-208.

Brown, T. B., & Sidlauskas, R. (2016). Application: Self-Harm. In R.W. Summers (Ed.), *Social Psychology: How Other People Influence Our Thoughts and Actions* (pp.143-161). Santa Barbara, California: Greenwood.

Brunborg, G. S., & Andreas, J. B. (2019). Increase in time spent on social media is associated with modest increase in depression, conduct problems, and episodic heavy drinking. *Journal of Adolescence, 74*, 201-209.

Bryant, L. D., O'Shea, R., Farley, K., Brennan, C., Crosby, H. F., Guthrie, E., & House, A. (2021). Understanding the functions of repeated self-harm: AQ methodology approach. *Social Science & Medicine, 268*, 113527.

Butler, C., Joiner, R., Bradley, R., Bowles, M., Bowes, A., Russell, C., & Roberts, V. (2019). Self-harm prevalence and ideation in a community sample of cis, trans and other youth. *International journal of transgenderism, 20*(4), 447-458.

Callahan, A., & Inckle, K. (2012). Cybertherapy or psychobabble? A mixed methods study of online emotional support. *British Journal of Guidance & Counselling*, *40*(3), 261-278.

Carey, J. L., Carreiro, S., Chapman, B., Nader, N., Chai, P. R., Pagoto, S., & Jake-Schoffman, D. E. (2018). SoMe and Self Harm: The use of social media in depressed and suicidal youth. *Proceedings of the Annual Hawaii International Conference on System Sciences, 2018*, 3314-3319.

Carr, M. J., Ashcroft, D. M., Kontopantelis, E., Awenat, Y., Cooper, J., Chew-Graham, C., ... Webb, R. T. (2016). The epidemiology of self-harm in a UK-wide primary care patient cohort, 2001–2013. *BMC psychiatry, 16*(1), 53.

Carr, N.G. (2010). *The shallows: what the internet is doing to our brains.* New York: W. W. Norton.

Carroll, R., Metcalfe, C., & Gunnell, D. (2014). Hospital presenting self-harm and risk of fatal and non-fatal repetition: systematic review and meta-analysis. *PLoS One*, *9*(2), e89944.

Carter, S. M., & Little, M. (2007). Justifying knowledge, justifying method, taking action: Epistemologies, methodologies, and methods in qualitative research. *Qualitative Health Research, 17*(10), 1316-1328.

Castleberry, A., & Nolen, A. (2018). Thematic analysis of qualitative research data: Is it as easy as it sounds?. *Currents in Pharmacy Teaching and Learning, 10*(6), 807-815.

Cavazos-Rehg, P. A., Krauss, M. J., Sowles, S. J., Connolly, S., Rosas, C., Bharadwaj, M., . . . Bierut, L. J. (2017). An Analysis of Depression, Self-Harm, and Suicidal Ideation Content on Tumblr. *Crisis, 38*(1), 44-52.

Chapman, A. L., & Gratz, K. L. (2009). *Freedom from self-harm: Overcoming self-injury with skills from DBT and other treatments*. Oakland, CA: New Harbinger Publications.

Chapman, A. L., Gratz, K. L., & Brown, M. Z. (2006). Solving the puzzle of deliberate self-harm: The experiential avoidance model. *Behaviour Research and Therapy, 44*(3), 371-394.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* London: Sage Publications.

Charmaz, K. (2014). *Constructing grounded theory*. London: Sage.

Chou, H.-T. G., & Edge, N. (2012). "They are happier and having better lives than I am": The impact of using Facebook on perceptions of others' lives. *Cyberpsychology, Behavior, and Social Networking, 15*(2), 117-121.

Choy, L. T. (2014). The strengths and weaknesses of research methodology: Comparison and complimentary between qualitative and quantitative approaches. *IOSR Journal of Humanities and Social Science, 19*(4), 99-104.

Cislaghi, B. (2020). *Attitudes Towards Self-Harm.* (Unpublished master's thesis). Murray State University, Murray, Kentucky.

Cooper, J., Murphy, E., Jordan, R., & Mackway-Jones, K. (2008). Communication between secondary and primary care following self-harm: are National Institute of Clinical Excellence (NICE) guidelines being met?. *Annals of general psychiatry, 7*(1), 21.

Corbin, J., & Strauss, A. (2008). *Basics of qualitative research.* Thousand Oaks, CA: Sage.

Coyne, S. M., Rogers, A. A., Zurcher, J. D., Stockdale, L., & Booth, M. (2020). Does time spent using social media impact mental health?: An eight year longitudinal study. *Computers in Human Behavior, 104*, 106160.

Daine, K., Hawton, K., Singaravelu, V., Stewart, A., Simkin, S., & Montgomery, P. (2013). The Power of the Web: A Systematic Review of Studies of the Influence of the Internet on Self-Harm and Suicide in Young People. *PLoS ONE, 8*(10).

Davis, K. (2012). Friendship 2.0: Adolescents' experiences of belonging and self-disclosure online. *Journal of adolescence, 35*(6), 1527-1536.

De Choudhury, M., & Kiciman, E. (2017). The Language of Social Support in Social Media and Its Effect on Suicidal Ideation Risk. *Proceedings of the International AAAI Conference on Web and Social Media, 11*(1). Retrieved from https://ojs.aaai.org/index.php/ICWSM/article/view/14891

Department for Digital, Culture, Media and Sport. (2021). *Draft Online Safety Bill*. Retrieved from

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/985033/Draft_Online_Safety_Bill_Bookmarked.pdf

Desjarlais, M., & Joseph, J. J. (2017). Socially interactive and passive technologies enhance friendship quality: An investigation of the mediating roles of online and offline self-disclosure. *Cyberpsychology, Behavior, and Social Networking, 20*(5), 286-291.

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical education, 40*(4), 314-321.

Doré, B. P., Morris, R. R., Burr, D. A., Picard, R. W., & Ochsner, K. N. (2017). Helping others regulate emotion predicts increased regulation of one's own emotions and decreased symptoms of depression. *Personality and Social Psychology Bulletin, 43*(5), 729-739.

Dosani, S., Harding, C., & Wilson, S. (2014). Online groups and patient forums. *Current psychiatry reports, 16*(11), 1-6.

Duggan, J. M., Heath, N. L., Lewis, S. P., & Baxter, A. L. (2012). An examination of the scope and nature of non-suicidal self-injury online activities: Implications for school mental health professionals. *School Mental Health, 4*(1), 56-67.

Dworkin, S. L. (2012). Sample size policy for qualitative studies using in-depth interviews. *Archives of Sexual Behavior, 41*(6), 1319-1320.

Dyson, M. P., Hartling, L., Shulhan, J., Chisholm, A., Milne, A., Sundar, P., . . . Newton, A. S. (2016). A systematic review of social media use to discuss and view deliberate self-harm acts. *PLoS ONE, 11*(5).

Edmondson, A. J., Brennan, C. A., & House, A. O. (2016). Non-suicidal reasons for self-harm: A systematic review of self-reported accounts. *Journal of Affective Disorders, 191*, 109-117.

Erves, J. C., Mayo-Gamble, T. L., Malin-Fair, A., Boyer, A., Joosten, Y., Vaughn, Y. C., ... & Wilkins, C. H. (2017). Needs, priorities, and recommendations for engaging underrepresented populations in clinical research: a community perspective. *Journal of community health, 42*(3), 472-480.

Evces, M. R. (2015). What is vicarious trauma? In G. Quitangon & M.R. Evces (Eds.), *Psychosocial stress series. Vicarious trauma and disaster mental health: Understanding risks and promoting resilience*, (pp. 9-23). New York: Routledge.

Fenwick, J. (2021, October 23). Twitter says Online Safety Bill needs more clarity. *BBC News.* Retrieved from https://www.bbc.co.uk/news/uk-politics-59010723

Festinger, L. (1954). A theory of social comparison processes. *Human relations, 7*(2), 117-140.

Fortune, S., Sinclair, J., & Hawton, K. (2008). Help-seeking before and after episodes of self-harm: a descriptive study in school pupils in England. *BMC public health, 8*(1), 1-13.

Frost, M., & Casey, L. (2016). Who Seeks Help Online for Self-Injury? *Archives of Suicide Research, 20*(1), 69-79.

Frost, M., Casey, L., & Rando, N. (2016). Self-Injury, Help-Seeking, and the Internet Informing Online Service Provision for Young People. *Crisis-the Journal of Crisis Intervention and Suicide Prevention, 37*(1), 68-76.

Fylan, F. (2005). Semi-structured interviewing. *A handbook of research methods for clinical and health psychology, 5*(2), 65-78.

Gabriel, F. (2014). Sexting, selfies and self-harm: Young people, social media and the performance of self-development. *Media International Australia, 151*(1), 104-112.

George, M. (2019). The Importance of Social Media Content for Teens' Risks for Self-harm. *Journal of Adolescent Health, 65*(1), 9-10.

Gerbner, G., Gross, L., Morgan, M., Signorielli, N., & Shanahan, J. (2002). Growing up with television: Cultivation processes. In J. Bryant, D. Zillmann, J. Bryant & M. B. Oliver (Eds.), *Media effects* (pp. 53-78). New York: Routledge.

Geulayov, G., Casey, D., McDonald, K. C., Foster, P., Pritchard, K., Wells, C., . . . Waters, K. (2018). Incidence of suicide, hospital-presenting non-fatal self-harm, and community-occurring non-fatal self-harm in adolescents in England (the iceberg model of self-harm): a retrospective study. *The Lancet Psychiatry, 5*(2), 167-174.

Gholamrezaei, M., Heath, N., & Panaghi, L. (2017). Non-suicidal self-injury in a sample of university students in Tehran, Iran: prevalence, characteristics and risk factors. *International journal of culture and mental health, 10*(2), 136-149.

Gooseens, C., Cleator, A., Dziurawiec, S., & Chen, W. (2016). The roles played by social media in deliberate self-harm among children and adolescents. *Australian & New Zealand Journal of Psychiatry, 50*, 63.

Gorrese, A., & Ruggieri, R. (2012). Peer attachment: A meta-analytic review of gender and age differences and associations with parent attachment. *Journal of youth and adolescence, 41*(5), 650-672.

Griffin, E., McMahon, E., McNicholas, F., Corcoran, P., Perry, I. J., & Arensman, E. (2018). Increasing rates of self-harm among children, adolescents and young adults: a 10-year national registry study 2007–2016. *Social Psychiatry and Psychiatric Epidemiology, 53*(7), 663-671.

Guerra, C., Ferreira, P., Moura, M., & Silva, A. (2013). 1064 – Does internet promote self-harm behavior? *European Psychiatry, 28*, 1.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field methods, 18*(1), 59-82.

Guest, G., MacQueen, K. M., & Namey, E. E. (2012). Introduction to applied thematic analysis. *Applied thematic analysis, 3*, 20.

Gunnell, D., Kidger, J., & Elvidge, H. (2018). Adolescent mental health in crisis. *British Medical Journal, 361*.

Hamilton, R. J., & Bowers, B. J. (2006). Internet recruitment and e-mail interviews in qualitative studies. *Qualitative Health Research, 16*(6), 821-835.

Harris, I. M., & Roberts, L. M. (2013). Exploring the Use and Effects of Deliberate Self-Harm Websites: An Internet-Based Study. *Journal of Medical Internet Research, 15*(12).

Haverkamp, B. E. (2005). Ethical perspectives on qualitative research in applied psychology. *Journal of counseling psychology, 52*(2), 146.

Hawkins, J. E. (2018). The practical utility and suitability of email interviews in qualitative research. *The Qualitative Report, 23*(2).

Hawton, K., Bergen, H., Cooper, J., Turnbull, P., Waters, K., Ness, J., & Kapur, N. (2015). Suicide following self-harm: findings from the Multicentre Study of self-harm in England, 2000–2012. *Journal of Affective Disorders, 175*, 147-151.

Hawton, K., Rodham, K., Evans, E., & Harriss, L. (2009). Adolescents who self harm: a comparison of those who go to hospital and those who do not. *Child and Adolescent Mental Health, 14*(1), 24-30.

Hawton, K., Saunders, K. E., & O'Connor, R. C. (2012). Self-harm and suicide in adolescents. *Lancet, 379*(9834), 2373-2382.

Hawton, K., Witt, K. G., Salisbury, T. L. T., Arensman, E., Gunnell, D., Hazell, P., ... van Heeringen, K. (2016). Psychosocial interventions following self-harm in adults: a systematic review and meta-analysis. *The Lancet Psychiatry*, *3*(8), 740-750.

Heffer, T., Good, M., Daly, O., MacDonell, E., & Willoughby, T. (2019). The longitudinal association between social-media use and depressive symptoms among adolescents and young adults: An empirical reply to Twenge et al.(2018). *Clinical Psychological Science*, *7*(3), 462-470.

Henderson, M., Johnson, N. F., & Auld, G. (2013). Silences of ethical practice: dilemmas for researchers using social media. *Educational research and evaluation, 19*(6), 546-560.

Hern, A. (2019, February 8). Instagram heads off regulations with ban on self-harm images. *The Guardian.* Retrieved from: https://www.theguardian.com/technology/2019/feb/08/instagram-heads-off-regulations-with-ban-on-self-harm-images

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of counseling psychology, 52*(2), 196.

Hilton, E. (2017). Unveiling self-harm behaviour: what can social media site Twitter tell us about self-harm? A qualitative exploration. *Journal of Clinical Nursing, 26*(11-12), 1690-1704.

HM Government. (2019). *Online Harms White Paper.* Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/793360/Online_Harms_White_Paper.pdf

Hodkinson, P. (2008). Grounded theory and inductive research. In N. Gilbert (Ed.), *Researching Social Life*, 3rd edition. London: Sage Publications..

Hökby, S., Hadlaczky, G., Westerlund, J., Wasserman, D., Balazs, J., Germanavicius, A., ... & Carli, V. (2016). Are mental health effects of internet use attributable to the web-based content or perceived consequences of usage? A longitudinal study of European adolescents. *JMIR mental health*, *3*(3), e5925.

Holloway, I., & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research, 3*, 345–357.

Holt, A. (2010). Using the telephone for narrative interviewing: a research note. *Qualitative Research, 10*(1), 113-121.

Homans, G. C. (1974). *Social behavior: its elementary forms.* New York: Harcourt, Brace, & World.

House, A. (2020a). Measuring outcomes in self-harm trials: what is important and what is achievable?. *BJPsych open*, *6*(2).

House, A. (2020b). Social media, self-harm and suicide. *BJPsych bulletin*, *44*(4), 131-133.

Howitt, D. (2019). *Introduction to qualitative research methods in psychology: Putting theory into practice.* Essex: Pearson Education Limited.

Howitt, D., & Cramer, D. (2007). *Introduction to research methods in psychology*. Harlow, Essex: Pearson Education Limited.

Irvine, A. (2010). *Using Phone Interviews.* Retrieved from ESRC National Centre for Research Methods: http://eprints.ncrm.ac.uk/1576/1/14-toolkit-phone-interviews.pdf

Irvine, A., Drew, P., & Sainsbury, R. (2013). 'Am I not answering your questions properly?' Clarification, adequacy and responsiveness in semi-structured telephone and face-to-face interviews. *Qualitative Research, 13*(1), 87-106.

ITV. (2021). Britain Get Talking. Retrieved from https://www.itv.com/britaingettalking/

Jacob, N., Evans, R., & Scourfield, J. (2017). The influence of online images on self-harm: A qualitative study of young people aged 16–24. *Journal of adolescence, 60*, 140-147.

Jager, J., Putnick, D. L., & Bornstein, M. H. (2017). II. More than just convenient: The scientific merits of homogeneous convenience samples. *Monographs of the Society for Research in Child Development*, *82*(2), 13-30.

Joffe, H. (2012). Thematic analysis. In D. Harper & A. R. Thompson (Eds), *Qualitative methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 209-223). Chichester: Wiley.

Johnson, S., Dalton-Locke, C., San Juan, N. V., Foye, U., Oram, S., Papamichail, A., ... & Simpson, A. (2021). Impact on mental health care and on mental health service users of the COVID-19 pandemic: a mixed methods survey of UK mental health care staff. *Social psychiatry and psychiatric epidemiology*, *56*(1), 25-37.

Kaplan, A. M., & Haenlein, M. (2010). Users of the world, unite! The challenges and opportunities of Social Media. *Business horizons*, *53*(1), 59-68.

Kaukiainen, A., & Martin, G. (2017). Who engages with self-injury related Internet sites, and what do they gain? *Suicidology Online*, *8*.

Keipi, T., Oksanen, A., Hawdon, J., Näsi, M., & Räsänen, P. (2017). Harm-advocating online content and subjective well-being: A cross-national study of new risks faced by youth. *Journal of Risk Research*, *20*(5), 634-649.

Kelly, Y., Zilanawala, A., Booker, C., & Sacker, A. (2018). Social media use and adolescent mental health: Findings from the UK Millennium Cohort Study. *EClinicalMedicine*, *6*, 59-68.

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of general psychiatry*, *62*(6), 617-627.

Kim, S., Colwell, S. R., Kata, A., Boyle, M. H., & Georgiades, K. (2018). Cyberbullying victimization and adolescent mental health: Evidence of differential effects by sex and mental health problem type. *Journal of youth and adolescence*, *47*(3), 661-672.

King, N. (2004). Using templates in the thematic analysis of text. In C. Cassell & G. Symon (Eds.), *Essential guide to qualitative methods in organizational research* (pp. 257–270). London, UK: Sage.

King, N., Horrocks, C., & Brooks, J. (2019). *Interviews in qualitative research*. London, UK: Sage.

Klonsky, E. D. (2009). The functions of self-injury in young adults who cut themselves: Clarifying the evidence for affect-regulation. *Psychiatry research*, *166*(2-3), 260-268.

Klonsky, E. D., & Glenn, C. R. (2009). Assessing the functions of non-suicidal self-injury: Psychometric properties of the Inventory of Statements About Self-injury (ISAS). *Journal of psychopathology and behavioral assessment*, *31*(3), 215-219.

Knox, S., & Burkard, A. W. (2009). Qualitative research interviews. *Psychotherapy research*, *19*(4-5), 566-575.

Koro-Ljungberg, M. (2008). Validity and validation in the making in the context of qualitative research. *Qualitative Health Research*, *18*(7), 983-989.

Koutek, J., Kocourkova, J., & Dudova, I. (2016). Suicidal behavior and self-harm in girls with eating disorders. *Neuropsychiatric disease and treatment*, *12*, 787.

Krause, N. (2016). Providing emotional support to others, self-esteem, and self-rated health. *Archives of gerontology and geriatrics, 65*, 183-191.

Lang, T. J., Blackwell, S. E., Harmer, C. J., Davison, P., & Holmes, E. A. (2012). Cognitive bias modification using mental imagery for depression: Developing a novel computerized intervention to change negative thinking styles. *European Journal of Personality, 26*(2), 145-157.

Lavis, A., & Winter, R. (2020). #Online harms or benefits? An ethnographic analysis of the positives and negatives of peer-support around self-harm on social media. *Journal of child psychology and psychiatry, and allied disciplines, 61*(8), 842-854.

Laye-Gindhu, A., & Schonert-Reichl, K. A. (2005). Nonsuicidal self-harm among community adolescents: Understanding the "Whats" and "Whys" of self-harm. *Journal of Youth and Adolescence, 34*(5), 447-457.

Lewis, S. P., & Baker, T. G. (2011). The possible risks of self-injury web sites: a content analysis. *Archives of suicide research, 15*(4), 390-396.

Lewis, S. P., & Knoll, A. K. (2015). Do it yourself: Examination of self-injury first aid tips on YouTube. *Cyberpsychology, Behavior, and Social Networking, 18*(5), 301-304.

Lewis, S. P., & Michal, N. J. (2016). Start, stop, and continue: Preliminary insight into the appeal of self-injury e-communities. *Journal of Health Psychology, 21*(2), 250-260.

Lewis, S. P., & Seko, Y. (2016). A Double-Edged Sword: A Review of Benefits and Risks of Online Nonsuicidal Self-Injury Activities. *Journal of Clinical Psychology, 72*(3), 249-262.

Lewis, S. P., Heath, N. L., Michal, N. J., & Duggan, J. M. (2012). Non-suicidal self-injury, youth, and the Internet: What mental health professionals need to know. *Child and Adolescent Psychiatry and Mental Health, 6*.

Lewis, S. P., Heath, N. L., Sornberger, M. J., & Arbuthnott, A. E. (2012). Helpful or Harmful? An Examination of Viewers' Responses to Nonsuicidal Self-Injury Videos on YouTube. *Journal of Adolescent Health, 51*(4), 380-385.

Lewis, S. P., Heath, N. L., St Denis, J. M., & Noble, R. (2011). The Scope of Nonsuicidal Self-Injury on YouTube. *Pediatrics, 127*(3).

Lewis, S. P., Seko, Y., & Joshi, P. (2018). The impact of YouTube peer feedback on attitudes toward recovery from non-suicidal self-injury: An experimental pilot study. *Digital Health, 4*, 1-7.

Lin, L. Y., Sidani, J. E., Shensa, A., Radovic, A., Miller, E., Colditz, J. B., . . . Primack, B. A. (2016). Association between social media use and depression among US young adults. *Depression and Anxiety, 33*(4), 323-331.

Lincoln, Y., & Guba, E. G. (1985). *Naturalistic inquiry.* Newbury Park, CA: Sage.

Lloyd, A. (2014). Social media, help or hindrance: What role does social media play in young people's mental health? *Psychiatria Danubina, 26*, 340-346.

Lloyd, B., Blazely, A., & Phillips, L. (2018). Stigma towards individuals who self harm: impact of gender and disclosure. *Journal of Public Mental Health, 17*(4), 184-194.

Lloyd-Richardson, E. E., Lewis, S. P., Whitlock, J. L., Rodham, K., & Schatten, H. T. (2015). Research with adolescents who engage in non-suicidal self-injury: ethical considerations and challenges. *Child and Adolescent Psychiatry and Mental Health, 9*.

Lockwood, J., Townsend, E., Royes, L., Daley, D., & Sayal, K. (2018). What do young adolescents think about taking part in longitudinal self-harm research? Findings from a school-based study. *Child and Adolescent Psychiatry and Mental Health, 12*(1), 23.

Long, M. (2018). 'We're not monsters … we're just really sad sometimes:' hidden self-injury, stigma and help-seeking. *Health Sociology Review, 27*(1), 89-103.

Lowry, P. B., Zhang, J., Wang, C., & Siponen, M. (2016). Why do adults engage in cyberbullying on social media? An integration of online disinhibition and deindividuation effects with the social structure and social learning model. *Information Systems Research, 27*(4), 962-986.

Lundh, L. g., WÅngby-Lundh, M., & Bjärehed, J. (2011). Deliberate self-harm and psychological problems in young adolescents: Evidence of a bidirectional relationship in girls. *Scandinavian journal of psychology, 52*(5), 476-483.

Lundh, L. G., Wångby-Lundh, M., Paaske, M., Ingesson, S., & Bjärehed, J. (2011). Depressive symptoms and deliberate self-harm in a community sample of adolescents: a prospective study. *Depression research and treatment, 2011*.

Mack, N., Woodsong, C., MacQueen, K. M., Guest, G., & Namey, E. (2005). *Qualitative research methods: A data collector's field guide.* North Carolina: Family Health International.

Madge, N., Hewitt, A., Hawton, K., Wilde, E. J. D., Corcoran, P., Fekete, S., ... Ystgaard, M. (2008). Deliberate self-harm within an international community sample of young people: comparative findings from the Child & Adolescent Self-harm in Europe (CASE) Study. *Journal of child Psychology and Psychiatry, 49*(6), 667-677.

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: guided by information power. *Qualitative health research, 26*(13), 1753-1760.

Mandolesi, L., Polverino, A., Montuori, S., Foti, F., Ferraioli, G., Sorrentino, P., & Sorrentino, G. (2018). Effects of physical exercise on cognitive functioning and wellbeing: biological and psychological benefits. *Frontiers in psychology, 9*, 509.

Marchant, A., Hawton, K., Stewart, A., Montgomery, P., Singaravelu, V., Lloyd, K., . . . John, A. (2017). A systematic review of the relationship between internet use, self-harm and

suicidal behaviour in young people: The good, the bad and the unknown. *PLoS ONE, 12*(8).

Mars, B., Heron, J., Biddle, L., Donovan, J. L., Holley, R., Piper, M., . . . Gunnell, D. (2015). Exposure to, and searching for, information about suicide and self-harm on the Internet: Prevalence and predictors in a population based cohort of young adults. *Journal of Affective Disorders, 185*, 239-245.

Maslow, A. H. (1943). A theory of human motivation. *Psychological review, 50*(4), 370.

McClintock, A. S., Anderson, T., & Petrarca, A. (2015). Treatment expectations, alliance, session positivity, and outcome: An investigation of a three-Path mediation model. *Journal of Clinical Psychology, 71*(1), 41–49.

McHale, J., & Felton, A. (2010). Self-harm: what's the problem? A literature review of the factors affecting attitudes towards self-harm. *Journal of psychiatric and mental health nursing*, *17*(8), 732-740.

McManus, S., Gunnell, D., Cooper, C., Bebbington, P. E., Howard, L. M., Brugha, T., ... Appleby, L. (2019). Prevalence of non-suicidal self-harm and service contact in England, 2000–14: repeated cross-sectional surveys of the general population. *The Lancet Psychiatry 6*(7), 573-581.

Milojevich, H. M., & Lukowski, A. F. (2016). Sleep and mental health in undergraduate students with generally healthy sleep habits. *PloS one*, *11*(6), e0156372.

Mitchell, C., McMillan, B., & Hagan, T. (2017). Mental health help-seeking behaviours in young adults. *British journal of general practice*, *67*(654), 8-9.

Moran, P., Coffey, C., Romaniuk, H., Olsson, C., Borschmann, R., Carlin, J. B., & Patton, G. C. (2012). The natural history of self-harm from adolescence to young adulthood: a population-based cohort study. *The Lancet*, *379*(9812), 236-243.

Moreno, M. A., Ton, A., Selkie, E., & Evans, Y. (2016). Secret Society 123: Understanding the Language of Self-Harm on Instagram. *Journal of Adolescent Health, 58*(1), 78-84.

Morey, Y., Mellon, D., Dailami, N., Verne, J., & Tapp, A. (2017). Adolescent self-harm in the community: an update on prevalence using a self-report survey of adolescents aged 13–18 in England. *Journal of Public Health*, *39*(1), 58-64.

Morrissey, J., Doyle, L., & Higgins, A. (2018). Self-harm: from risk management to relational and recovery-oriented care. *The Journal of Mental Health Training, Education and Practice 13*(1), 34-43.

Muehlenkamp, J. J., Claes, L., Havertape, L., & Plener, P. L. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and adolescent psychiatry and mental health*, *6*(1), 10.

Naslund, J. A., Aschbrenner, K. A., Marsch, L. A., & Bartels, S. J. (2016). The future of mental health care: peer-to-peer support and social media. *Epidemiology and psychiatric sciences*, *25*(2), 113-122.

Naslund, J. A., Grande, S. W., Aschbrenner, K. A., & Elwyn, G. (2014). Naturally occurring peer support through social media: the experiences of individuals with severe mental illness using YouTube. *PLoS ONE, 9*(10), e110171.

National Institute for Health and Care Excellence. (2004). *Self-harm in over 8s: short-term management and prevention of recurrence* (NICE Clinical Guideline 16). Retrieved from: https://www.nice.org.uk/guidance/cg16

National Institute for Health and Care Excellence. (2013). *Self-harm* (NICE Quality Standard 34). Retrieved from: https://www.nice.org.uk/guidance/qs34/resources/selfharm-pdf-2098606243525

Nesi, J., & Prinstein, M. J. (2015). Using social media for social comparison and feedback-seeking: Gender and popularity moderate associations with depressive symptoms. *Journal of abnormal child psychology*, *43*(8), 1427-1438.

Niwa, K. D., & Mandrusiak, M. N. (2012). Self-injury groups on Facebook. *Canadian Journal of Counselling and Psychotherapy, 46*(1).

Nixon, M. K., Cloutier, P. F., & Aggarwal, S. (2002). Affect regulation and addictive aspects of repetitive self-injury in hospitalized adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *41*(11), 1333-1341.

Nock, M. K. (2009). Why do people hurt themselves? New insights into the nature and functions of self-injury. *Current directions in psychological science, 18*(2), 78-83.

Norman, H., Oskis, A., Marzano, L., & Coulson, M. (2020). The relationship between self-harm and alexithymia: A systematic review and meta-analysis. *Scandinavian Journal of Psychology*, *61*(6), 855-876.

Novick, G. (2008). Is there a bias against telephone interviews in qualitative research? *Research in nursing & health*, *31*(4), 391-398.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1).

O'Connor, R. C., Rasmussen, S., & Hawton, K. (2014). Adolescent self-harm: a school-based study in Northern Ireland. *Journal of affective disorders*, *159*, 46-52.

O'Connor, R. C., Wetherall, K., Cleare, S., Eschle, S., Drummond, J., Ferguson, E., . . . O'Carroll, R. E. (2018). Suicide attempts and non-suicidal self-harm: national prevalence study of young adults. *Bjpsych Open*, *4*(3), 142-148.

O'Reilly, M., Dogra, N., Whiteman, N., Hughes, J., Eruyar, S., & Reilly, P. (2018). Is social media bad for mental health and wellbeing? Exploring the perspectives of adolescents. *Clinical child psychology and psychiatry*, *23*(4), 601-613.

Office for National Statistics, (2019). Milestones: journeying into adulthood. Retrieved from: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/milestonesjourneyingintoadulthood/2019-02-18

Office for National Statistics, (2020). Internet access - households and individuals, Great Britain: 2020. Retrieved from: https://www.ons.gov.uk/peoplepopulationandcommunity/householdcharacteristics/homeinternetandsocialmediausage/datasets/internetaccesshouseholdsandindividualsreferencetables

Oksanen, A., Nasi, M., Minkkinen, J., Keipi, T., Kaakinen, M., & Rasanen, P. (2016). Young people who access harm-advocating online content: A four country survey. *Cyberpsychology-Journal of Psychosocial Research on Cyberspace, 10*(2). doi:10.5817/cp2016-2-6

Opdenakker, R. (2006). Advantages and disadvantages of four interview techniques in qualitative research. F*orum: Qualitative Social Research 7*(4).

Orth, U., Robins, R. W., & Roberts, B. W. (2008). Low self-esteem prospectively predicts depression in adolescence and young adulthood. *Journal of personality and social psychology*, *95*(3), 695.

Owens, C., Fox, F., Redwood, S., Davies, R., Foote, L., Salisbury, N., ... & Thomas, K. (2020). Measuring outcomes in trials of interventions for people who self-harm: qualitative study of service users' views. *BJPsych open*, *6*(2).

Papamichail, M., & Sharma, N. (2019). *Left to their own devices Young people, social media and mental health* Barnardo's Report. Retrieved from: https://www.barnardos.org.uk/sites/default/files/uploads/B51140%2020886_Social%20media_Report_Final_Lo%20Res.pdf

Park, Y. S., Konge, L., & Artino, A. R. (2020). The positivism paradigm of research. *Academic Medicine*, *95*(5), 690-694.

Patton, M. Q. (1990). *Qualitative evaluation and research methods*. Newbury Park, CA: Sage.

Pew Research Centre. (2019). Social Media Fact Sheet. Retrieved from https://www.pewresearch.org/internet/fact-sheet/social-media/

Picardo, J., McKenzie, S. K., Collings, S., & Jenkin, G. (2020). Suicide and self-harm content on Instagram: A systematic scoping review. *PloS one*, *15*(9), e0238603.

Pritchard, T. R., Lewis, S. P., & Marcincinova, I. (2021). Needs of Youth Posting About Nonsuicidal Self-Injury: A Time-Trend Analysis. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine, 68*(3), 532-539.

Quinlivan, L. M., Gorman, L., Littlewood, D. L., Monaghan, E., Barlow, S. J., Campbell, S. M., ... & Kapur, N. (2021). 'Relieved to be seen'—patient and carer experiences of psychosocial assessment in the emergency department following self-harm: qualitative analysis of 102 free-text survey responses. *BMJ open*, *11*(5), e044434.

Radovic, A., Gmelin, T., Stein, B. D., & Miller, E. (2017). Depressed adolescents' positive and negative use of social media. *Journal of adolescence*, *55*, 5-15.

Record, R. A., Straub, K., & Stump, N. (2019). #Selfharm on #Instagram: examining user awareness and use of Instagram's self-harm reporting tool. *Health communication*, *35*(7), 894-901.

Redlich-Amirav, D., & Higginbottom, G. (2014). New emerging technologies in qualitative research. *The Qualitative Report*, *19*(26), 1-14.

Revive Digital. (2020). Most popular social media networks (updated for 2020) – digital marketing's most powerful tool. Retrieved from https://revive.digital/blog/most-popular-social-media/

Rickwood, D., & Thomas, K. (2012). Conceptual measurement framework for help-seeking for mental health problems. *Psychology research and behavior management*, *5*, 173-183.

Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian e-journal for the Advancement of Mental health*, *4*(3), 218-251.

Robinson, O. C. (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative research in psychology*, *11*(1), 25-41.

Rodham, K., Gavin, J., Lewis, S. P., St Denis, J. M., & Bandalli, P. (2013). An Investigation of the Motivations Driving the Online Representation of Self-Injury: A Thematic Analysis. *Archives of Suicide Research*, *17*(2), 173-183.

Rosenrot, S. A., & Lewis, S. P. (2020). Barriers and responses to the disclosure of non-suicidal self-injury: A thematic analysis. *Counselling Psychology Quarterly*, *33*(2), 121-141.

Rowe, S. L., French, R. S., Henderson, C., Ougrin, D., Slade, M., & Moran, P. (2014). Help-seeking behaviour and adolescent self-harm: a systematic review. *Australian & New Zealand Journal of Psychiatry*, *48*(12), 1083-1095.

Saldaña, J. (2021). *The coding manual for qualitative researchers*. London: SAGE Publications Limited.

Samaritans. (2019). Samaritans pioneer new partnership dedicated to suicide prevention in the online environment. Retrieved from https://www.samaritans.org/news/samaritans-pioneer-new-partnership-dedicated-suicide-prevention-online-environment/

Samson, A. C., & Gross, J. J. (2012). Humour as emotion regulation: The differential consequences of negative versus positive humour. *Cognition & emotion*, *26*(2), 375-384.

Scherr, S., Arendt, F., Frissen, T., & Oramas M, J. (2020). Detecting intentional self-harm on Instagram: development, testing, and validation of an automatic image-recognition algorithm to discover cutting-related posts. *Social Science Computer Review*, *38*(6), 673-685.

Schonfeld, I. S., & Mazzola, J. J. (2013). Strengths and limitations of qualitative approaches to research in occupational health psychology. In R.R. Sinclair, M. Wang, & L.E. Tetrick (Eds.), *Research Methods in Occupational Health Psychology: Measurement, Design and Data Analysis* (pp. 268 – 289). New York: Routledge.

Schrank, B., Sibitz, I., Unger, A., & Amering, M. (2010). How patients with schizophrenia use the internet: qualitative study. *Journal of Medical Internet Research*, *12*(5), e70.

Schulenberg, J. E., & Zarrett, N. R. (2006). Mental Health During Emerging Adulthood: Continuity and Discontinuity in Courses, Causes, and Functions. In J. J. Arnett & J. L. Tanner (Eds.), *Emerging adults in America: Coming of age in the 21st century* (p. 135–172). Washington, DC: American Psychological Association.

Seko, Y., & Lewis, S. P. (2018). The self—harmed, visualized, and reblogged: Remaking of self-injury narratives on Tumblr. *New Media and Society*, *20*(1), 180-198.

Seko, Y., Kidd, S. A., Wiljer, D., & McKenzie, K. J. (2015). On the Creative Edge: Exploring Motivations for Creating Non-Suicidal Self-Injury Content Online. *Qualitative Health Research*, *25*(10), 1334-1346.

Shafi, R. M. A., Romanowicz, M., & Croarkin, P. E. (2018). #SwitchedOn: a call for assessing social media use of adolescents. *The Lancet Psychiatry*, *5*(11), e27.

Shah, A. J., Wadoo, O., & Latoo, J. (2010). Psychological distress in carers of people with mental disorders. *British Journal of Medical Practitioners*, *3*(3).

Sharkey, S., Jones, R., Smithson, J., Hewis, E., Emmens, T., Ford, T., & Owens, C. (2011). Ethical practice in internet research involving vulnerable people: lessons from a self-harm discussion forum study (SharpTalk). *Journal of medical ethics*, *37*(12), 752-758.

Silverman, M. M. (2011). Challenges to classifying suicidal ideations, communications, and behaviours. *International handbook of suicide prevention: Research, policy and practice*, 9-25.

Sleeper, M., Balebako, R., Das, S., McConahy, A. L., Wiese, J., & Cranor, L. F. (2013). The post that wasn't: exploring self-censorship on facebook. *In Proc. CSCW, ACM Press*, 793–802.

Smith, J. A. (Ed.). (2015). *Qualitative psychology: A practical guide to research methods*. London: Sage.

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: theory, method, research.* London: Sage.

Smithson, J., Sharkey, S., Hewis, E., Jones, R., Emmens, T., Ford, T., & Owens, C. (2011). Problem presentation and responses on an online forum for young people who self-harm. *Discourse Studies*, *13*(4), 487-501.

Snippe, E., Schroevers, M. J., Tovote, K. A., Sanderman, R., Emmelkamp, P. M., & Fleer, J. (2015). Patients' outcome expectations matter in psychological interventions for patients with diabetes and comorbid depressive symptoms. *Cognitive Therapy and Research, 39*(3), 307–317.

Spinzy, Y., Nitzan, U., Becker, G., Bloch, Y., & Fennig, S. (2012). Does the Internet offer social opportunities for individuals with schizophrenia? A cross-sectional pilot study. *Psychiatry Research*, *198*(2), 319-320.

Sternudd, H. T. (2012). Photographs of self-injury: Production and reception in a group of self-injurers. *Journal of Youth Studies*, *15*(4), 421-436.

Stones, S. R., & Smith, J. (2018). Social media supremacy: a force of change paving the way for the next generation of healthcare and research. *Evidence-Based Nursing*, *21*, 2-3.

Straiton, M., Roen, K., Dieserud, G., & Hjelmeland, H. (2013). Pushing the Boundaries: Understanding Self-Harm in a Non-Clinical Population. *Archives of Psychiatric Nursing*, *27*(2), 78-83.

Sturges, J. E., & Hanrahan, K. J. (2004). Comparing Telephone and Face-to-Face Qualitative Interviewing: a Research Note. *Qualitative Research*, *4*(1), 107-118.

Subrahmanyam, K., & Šmahel, D. (2010). *Digital youth: The role of media in development.* New York: Springer Science & Business Media.

Swannell, S. V., Martin, G. E., Page, A., Hasking, P., & St John, N. J. (2014). Prevalence of nonsuicidal self-injury in nonclinical samples: Systematic review, meta-analysis and meta-regression. *Suicide and Life-Threatening Behavior*, *44*(3), 273-303.

Takizawa, R., Maughan, B., & Arseneault, L. (2014). Adult health outcomes of childhood bullying victimization: evidence from a five-decade longitudinal British birth cohort. *American journal of psychiatry*, *171*(7), 777-784.

Taylor, B. (2003). Exploring the perspectives of men who self-harm. *Learning in health and social care*, *2*(2), 83-91.

Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic analysis. *The Sage handbook of qualitative research in psychology*, 17-37.

Tham, S.-G., Ibrahim, S., Hunt, I. M., Kapur, N., & Gooding, P. (2020). Examining the mechanisms by which adverse life events affect having a history of self-harm, and the protective effect of social support. *Journal of Affective Disorders*, *263*, 621-628.

The Lancet. (2019). Social media, screen time, and young people's mental health. *The Lancet*, *393*(10172), 611.

Till, B., & Niederkrotenthaler, T. (2014). Surfing for suicide methods and help: Content analysis of websites retrieved with search engines in Austria and the United States. *The Journal of clinical psychiatry*, *75*(8), 886–892.

Timpano, K. R., & Beard, C. (2020). Social networking and mental health: looking beyond frequency of use and towards mechanisms of action. *Neuropsychopharmacology*, *45*(6), 905-906.

Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing, 48*, 388–396.

Tofthagen, R., Talseth, A. G., & Fagerstrøm, L. M. (2017). Former patients' experiences of recovery from self-harm as an individual, prolonged learning process: a phenomenological hermeneutical study. *Journal of Advanced Nursing, 73*(10), 2306-2317.

Tucker, I. M., & Lavis, A. (2019). Temporalities of mental distress: digital immediacy and the meaning of 'crisis' in online support. *Sociology of Health & Illness, 41*, 132-146.

Tuckett, A. G. (2005). Applying thematic analysis theory to practice: A researcher's experience. *Contemporary Nurse, 19*(1-2), 75-87.

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & health sciences*, *15*(3), 398-405.

Valdez, D., Ten Thij, M., Bathina, K., Rutter, L. A., & Bollen, J. (2020). Social media insights into US mental health during the COVID-19 pandemic: longitudinal analysis of twitter data. *Journal of medical Internet research*, *22*(12), e21418.

Valkenburg, P. M., & Peter, J. (2009). Social consequences of the Internet for adolescents: A decade of research. *Current directions in psychological science*, *18*(1), 1-5

Vaterlaus, J. M., Patten, E. V., Roche, C., & Young, J. A. (2015). #Gettinghealthy: The perceived influence of social media on young adult health behaviors. *Computers in Human Behavior*, *45*, 151-157.

Vega, D., Sintes, A., Fernandez, M., Punti, J., Soler, J., Santamarina, P., . . . Pascual, J. C. (2018). Review and update on non-suicidal self-injury: who, how and why? *Actas Esp Psiquiatr, 46*(4), 146-155.

Vogel, E. A., Rose, J. P., Roberts, L. R., & Eckles, K. (2014). Social comparison, social media, and self-esteem. *Psychology of Popular Media Culture, 3*(4), 206.

Wadman, R., Clarke, D., Sayal, K., Vostanis, P., Armstrong, M., Harroe, C., . . . Townsend, E. (2017). An interpretative phenomenological analysis of the experience of self-harm repetition and recovery in young adults. *Journal of Health Psychology, 22*(13), 1631-1641.

Wadman, R., Nielsen, E., O'Raw, L., Brown, K., Williams, A. J., Sayal, K., & Townsend, E. (2020). "These things don't work." young people's views on harm minimization strategies as a proxy for self-harm: A mixed methods approach. *Archives of suicide research, 24*(3), 384-401.

Whitlock, J. L., Powers, J. L., & Eckenrode, J. (2006). The virtual cutting edge: The Internet and adolescent self-injury. *Developmental Psychology, 42*(3), 407-417.

Whitlock, J., Eells, G., Cummings, N., & Purington, A. (2009). Nonsuicidal self-injury in college populations: Mental health provider assessment of prevalence and need. *Journal of College Student Psychotherapy, 23*(3), 172-183.

Wilkinson, P. (2013). Non-suicidal self-injury. *European child & adolescent psychiatry, 22*(1), 75-79.

Williams, A. J., Nielsen, E., & Coulson, N. S. (2020). "They aren't all like that": Perceptions of clinical services, as told by self-harm online communities. *Journal of health psychology, 25*(13-14), 2164-2177.

Willig, C. (2008). *Introducing Qualitative Research in Psychology.* Berkshire, England: Open University Press.

Wray, N., Markovic, M., & Manderson, L. (2007). "Researcher saturation": the impact of data triangulation and intensive-research practices on the researcher and qualitative research process. *Qualitative Health Research, 17*(10), 1392-1402.

Zimbardo, P. G. (1969). The human choice: Individuation, reason, and order versus deindividuation, impulse, and chaos. In W. D. Arnold & D. Levine (Eds.), *Nebraska Symposium on Motivation,* (pp. 237-307). Lincoln: University of Nebraska Press.

Zuffianò, A., Alessandri, G., Kanacri, B. P. L., Pastorelli, C., Milioni, M., Ceravolo, R., . . . Caprara, G. V. (2014). The relation between prosociality and self-esteem from middle-adolescence to young adulthood. *Personality and Individual Differences, 63*, 24-29.

APPENDICES

Appendix A
Interview Topic Guide

School of Medicine (SoMREC), Ethics reference: MREC 19-078
Version 2.1
Date: 7/6/2020

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An Exploration of the Use and Perceptions of Social Media of Young People who have Self-harmed

TOPIC GUIDE

Introduce self, purpose of the interview ("this investigation is looking at the perceptions of social media from the perspectives of young people who have experienced self-harm"), and verbally check consent. Check they have completed self-report questionnaire.

Check that they have received the debrief sheet with support service details on. Discussion around remit of risk management and construction of a safety plan.

Area of interest: Social media use in relation to self-harm

- Tell me about how you use social media to share, view or discuss self-harm material *(prompts – which sites, what activity, when, why, is this different for specific sites? Has your use of social media in relation to self-harm changed over time?)*

- What do you get out of it? *(prompts – how does it make you feel, is it useful for advice/information? Have reasons for use changed over time?)*

- Have you had any unhelpful experiences? Can you tell me about these?

- Do you think it has led to any changes in your self-harm? *(if yes how, if not why not, how does it compare to other sources of help/support?)*

Additional prompts if needed:

- *What is your experience of using social media as a source of support for self-harm?*
- *What do you consider the differences between professional and social media support in relation to self-harm?*
- *Does accessing self-harm support from social media change your view on accessing professional support? Can you explain why?*
- *Would you recommend social media as an outlet of support for those who self-harm, and why?*

Is there anything you think I have missed that would be helpful to mention about your experience of social media and self-harm?

Debrief –
Do you have any questions about what we've been talking about?
How are you feeling?
Ask participant if they would be willing to be contacted to discuss the results/themes from the interviews.

Appendix B

Recruitment Advert

School of Medicine (SoMREC), Ethics reference: MREC 19-078
Version 1.0
Date: 7/6/2020

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An Exploration of the Use and Perceptions of Social Media of Young People who have Self-harmed

Hi, my name is Georgie and I am a doctoral student at the University of Leeds,

- I am conducting a study to explore how people who have experienced self-harm use social media.
- This will allow us to learn more about what is helpful and unhelpful about using social media to share, view or discuss self-harm content.
- If you are UK based, aged between 16-29, have self-harmed and use social media in relation to self-harm I would be interested in hearing about your experiences.
- Participants taking part will be entered into a prize draw for a £20 Love2shop gift voucher.
- If you would be interested in taking part or would like to know more, please contact me on the details below.
- Email: umgkb@leeds.ac.uk

Thank you for your help!

Georgie Burnett

Please note recruitment may be stopped when the maximum number of participants has been reached.

Appendix C
Participant Information Sheet

School of Medicine (SoMREC) Ethics reference: MREC 19-078
Version 1.3
Date: 7/6/2020

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An Exploration of the Use and Perceptions of Social Media of Young People who have Self-harmed

PARTICIPANT INFORMATION SHEET

You are invited to take part in a research project. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear, or if you would like more information. Take time to decide whether or not you wish to take part. You will be asked to sign an electronic consent form if you choose to take part.

What is the purpose of the project?

This study will explore the use and experiences of using social media in relation to self-harm, from the perspectives of young people who have self-harmed.

Why have I been chosen?

You have been chosen as you responded to the recruitment advert and identified that you have self-harmed and use social media to view, discuss, or share self-harm related content. Self-harm in this study includes any act of self-harm (including self-poisoning) regardless of motivation. It excludes harm from over or under eating, alcohol or drug use, accidental harm or body piercing or tattooing.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and will be asked to sign a consent form electronically. During the interview, you do not have to answer any questions that you do not want to. You can stop at any time once the interview has started and you do not have to give a reason. You can withdraw your interview from the study up to 10 working days after your interview, this can be done by contacting the main researcher. After this time, you cannot withdraw your interview as analysis will have started. Up until the end of March 2021 you can request that no quotes from your interview are used in the report, after this time the final report will be nearing completion.

What do I have to do?

You will be asked to complete a short self-report questionnaire to give us some detail about you (including information about self-harm history and social media use), this will be emailed to you. You will also be asked to take part in one interview held over the phone. The interview will take approximately 45 minutes. The interview will ask about your experiences of using social media in relation to self-harm.

We will bring together all the interviews in an analysis and report on themes that come from the interviews.

What are the possible disadvantages and risks of taking part?

Self-harm can be a sensitive topic to discuss and some people may find it distressing to talk about their experiences. If you do find it upsetting, then you can stop or pause the interview at any time. A safety plan will be discussed with you at the start of the interview, so you know where to find support if you need it. A sheet with information regarding relevant support services will be provided to you via email.

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What are the possible benefits of taking part?

Some people find it beneficial to talk about their experiences, and your responses will help us understand more about the use of social media. As a thank you for your time, Participants taking part in the project will be entered into a prize draw to win a £20 Love2shop gift voucher.

What will happen to my personal information?

All the identifiable information (such as your address or phone number) that you share during the course of the research will be kept strictly confidential. It will be stored separately from the research data. We will take steps to anonymise the research data so that you will not be identified in any reports or publications.
All data will be stored on password protected computers and will only be accessible to members of the research team.
After 3 years, all respective research related documentation will be destroyed, and electronic files will be deleted from the secure server at the University of Leeds.

For further information, please see the University of Leeds Research Participant Privacy Notice which has been sent with this information sheet and can also be accessed at - https://dataprotection.leeds.ac.uk/wp-content/uploads/sites/48/2019/02/Research-Privacy-Notice.pdf

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

The audio recording of your interview made during this research will be used only for analysis, and possibly quotes from this used as illustration of results in the written report. No other use will be made of them without your written permission.

The recordings will be made on a Dictaphone, they will be transferred to a secure University drive immediately after the interview. The recording will be deleted once it has been transcribed.

What will happen to the results of the research project?

The project will be written up into a Doctoral Thesis which will be published online as an eThesis in the University of Leeds repository. There are also plans to publish this project in a peer reviewed journal.

What type of information will be sought from me and why is the collection of this information relevant for achieving the research project's objectives?

Information regarding your experience, and opinions of using social media for self-harm related purposes will be collected. Demographic information will also be collected to provide context to the results, such as your social media use and history of self-harm.

Who is organising the research?

The research has been organised by myself (Georgie Burnett) a Trainee Clinical Psychologist at the University of Leeds and is supervised by Dr Cathy Brennan (Leeds Institute of Health Sciences) and Dr Helen Crosby (Leeds Trinity University).

The research has received ethical approval from the University of Leeds School of

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Medicine Research Ethics Committee (Approval date: 20/07/2020 Reference number: MREC 19-078).

Contact for further information

Georgie Burnett - Trainee Clinical Psychologist
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If you are unhappy about any aspect of the way you have been approached or treated during the course of this study, and you do not want to discuss this with the researchers, you can contact the School of Medicine Research Ethics Committee:
FMHUniEthics@leeds.ac.uk

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

Appendix D

Background Questionnaire

School of Medicine (SoMREC), Ethics reference: MREC 19-078
Version 2.0
Date: 7/6/2020

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An Exploration of the Use and Perceptions of Social Media of Young People who have Self-harmed

DEMOGRAPHIC/BACKGROUND INFORMATION

1. Age in years (please type in the box below):

2. How would you describe your gender? Please tick one box:

- ☐ Female
- ☐ Male
- ☐ Non-binary
- ☐ Trans
- ☐ Prefer to self-describe
- ☐ Prefer not to say
- ☐ Other – please state:

3. How would you describe your ethnicity? Please tick one box:

- ☐ White British
- ☐ White – Irish
- ☐ White – Gypsy or Irish Traveller
- ☐ White – East European
- ☐ White - Other
- ☐ Mixed – White & Black African
- ☐ Mixed – White & Black Caribbean
- ☐ Mixed – White & Asian
- ☐ Mixed – Other
- ☐ Asian/Asian British - Bangladeshi
- ☐ Asian/Asian British – Chinese
- ☐ Asian/Asian British – Indian
- ☐ Asian/Asian British – Kashmiri
- ☐ Asian/Asian British – Pakistani
- ☐ Asian/Asian British - Other
- ☐ Other Ethnic Groups – Arab
- ☐ Other Ethnic Groups – Roma
- ☐ Other Ethnic Groups – Other
- ☐ Prefer not to say
- ☐ Black/Black British - African
- ☐ Black/Black British – Caribbean
- ☐ Black/Black British – Other

4. How would you describe your relationship status? Please tick one box:

- ☐ Married
- ☐ Co-habiting
- ☐ Civil partnership
- ☐ Divorced
- ☐ Single
- ☐ Prefer not to say
- ☐ Widowed
- ☐ Other – please state:

5. What is your highest educational qualification? Please type below:

6. How did you hear about the study?

- ☐ Advert on social media platform
- ☐ Advert on self-harm support website
- ☐ Other – please state:

7. General social media use:

(a) Which social media sites do you use in general? Please type below:

(b) On a typical day, how much time do you spend on social media?

- ☐ Less than 1 hour
- ☐ 10 hours or more
- ☐ 1-3 hours
- ☐ 4-6 hours
- ☐ 7-9 hours

(c) On which social media sites do you share, discuss or view self-harm material? Please type below:

8. Self-harm history

(a) What age were you the first time you self-harmed? Please type below:

(b) When was the last time you self-harmed? Please type below:

(c) How frequently do you self-harm? Please type below:

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(d) What do you do (i.e. the method) when you self-harm? Please type below:

Thank you for completing this questionnaire.

Appendix E

Participant Consent Form

School of Medicine (SoMREC), Ethics reference: MREC 19-078
Version 1.1
Date: 7/6/2020

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An Exploration of the Use and Perceptions of Social Media of Young People who have Self-harmed CONSENT FORM	Click box if you agree
I confirm that I have read and understand the information sheet (version 1.3, dated 7/6/2020) explaining the above research project and I have had the opportunity to ask questions about the project.	☐
I confirm that I am 16 or over 16 years of age.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time once the interview has started. I understand that I can withdraw 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 understand that I can withdraw the entirety of my data up to 10 working days after my interview, and that this can be done by contacting the main researcher (Georgie Burnett, umgkb@leeds.ac.uk). After this time, I understand I cannot withdraw my responses as the interview will have been transcribed and analysis will have started. Up until the end of March 2021 I understand I can request that no quotes from my interview are used in the report, as after this time the final report will be nearing completion.	☐
I give permission for the interview to be audio recorded.	☐
I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.	☐
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 (typed or electronic)	
Date	
Georgie Burnett (Main Researcher)	
Signature	
Date	

Appendix F

Safety Plan

School of Medicine (SoMREC), Ethics reference: MREC 19-078
Version 1.0
Date: 7/6/2020

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An Exploration of the Use and Perceptions of Social Media of Young People who have Self-harmed

SAFETY PLAN

The following questions are to be discussed with participants at the start of the interview. This will form the safety plan for the participant and will be referred to in the event of the participant feeling distressed during or after the interview. A copy of the safety plan will be emailed to participants.

- What can you do to help you manage your distress?

- What have you done in the past when you've felt like this?

- What has helped you cope/helps to calm or soothe you?

- What can others do to help?

- Who is there for support? (Remember there are support service details on the debrief sheet)

- If you don't feel able to keep yourself safe, what can you do?

Appendix G

Risk Escalation Procedure

School of Medicine (SoMREC), Ethics reference: MREC 19-078
Version 1.1
Date: 7/6/2020

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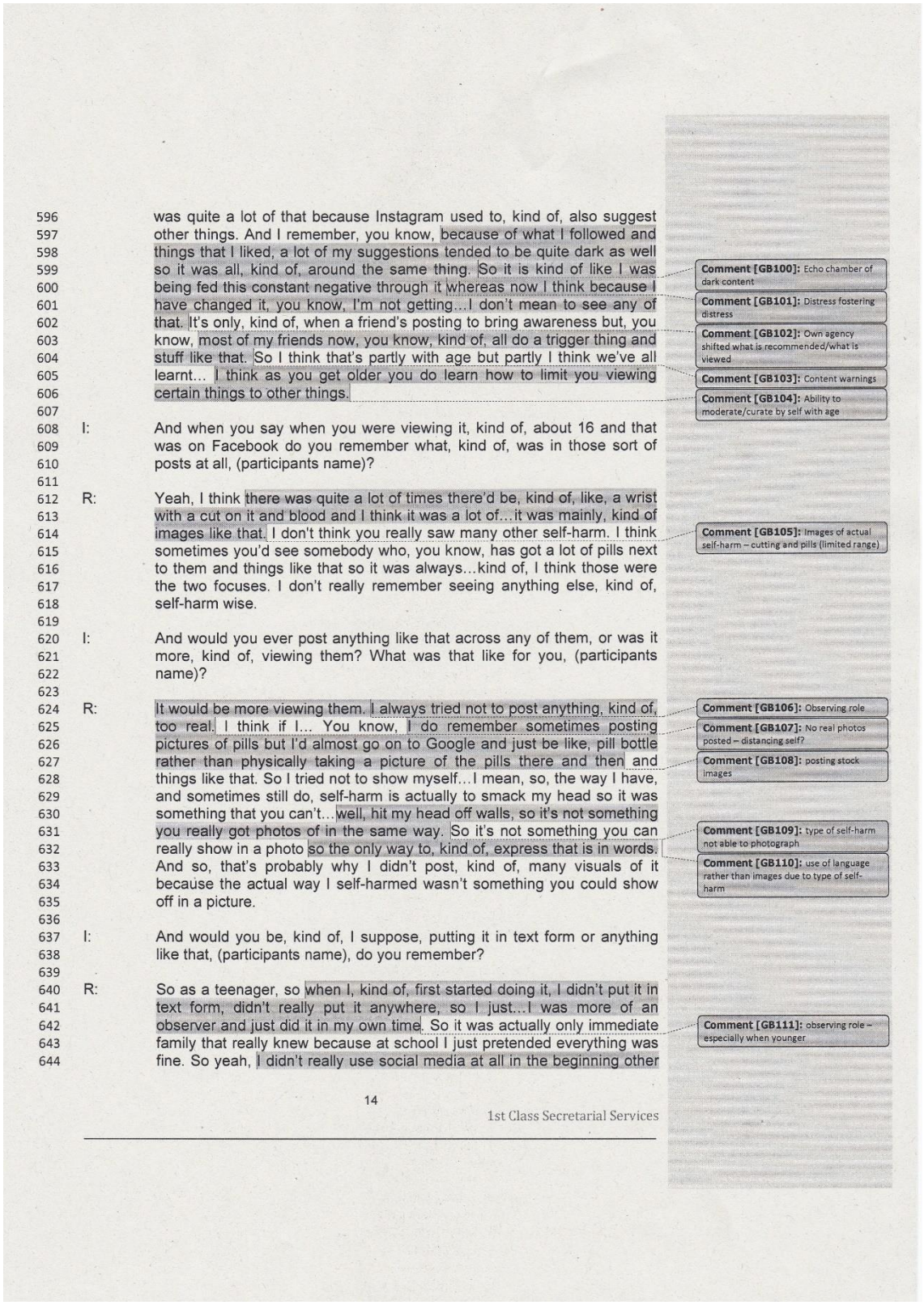
An Exploration of the Use and Perceptions of Social Media of Young People who have Self-harmed

RISK ESCALATION PROCEDURE

1. At the start of the interview, a safety plan would be discussed with the participant, including checking they have received the support service details (on the debrief sheet sent by email prior to the interview) and discussing what steps they can take if they feel distressed or at risk of harm.
2. In the event of a participant becoming distressed, the interview would be paused.
3. Participant will be reminded of the safety plan we constructed at the start of the interview.
4. If appropriate and the participant wishes to continue with the interview, the interview can re-commence. If inappropriate (i.e. client is too distressed) or client does not wish to continue, the interview will be stopped.
5. If there are further concerns regarding risk after discussion with the participant and reference to the safety plan, seek supervision from research supervisors or Clinical Psychology Course tutors.

Appendix H

Example of Transcript Coding



was quite a lot of that because Instagram used to, kind of, also suggest other things. And I remember, you know, because of what I followed and things that I liked, a lot of my suggestions tended to be quite dark as well so it was all, kind of, around the same thing. So it is kind of like I was being fed this constant negative through it whereas now I think because I have changed it, you know, I'm not getting...I don't mean to see any of that. It's only, kind of, when a friend's posting to bring awareness but, you know, most of my friends now, you know, kind of, all do a trigger thing and stuff like that. So I think that's partly with age but partly I think we've all learnt... I think as you get older you do learn how to limit you viewing certain things to other things.

I: And when you say when you were viewing it, kind of, about 16 and that was on Facebook do you remember what, kind of, was in those sort of posts at all, (participants name)?

R: Yeah, I think there was quite a lot of times there'd be, kind of, like, a wrist with a cut on it and blood and I think it was a lot of...it was mainly, kind of images like that. I don't think you really saw many other self-harm. I think sometimes you'd see somebody who, you know, has got a lot of pills next to them and things like that so it was always...kind of, I think those were the two focuses. I don't really remember seeing anything else, kind of, self-harm wise.

I: And would you ever post anything like that across any of them, or was it more, kind of, viewing them? What was that like for you, (participants name)?

R: It would be more viewing them. I always tried not to post anything, kind of, too real. I think if I... You know, I do remember sometimes posting pictures of pills but I'd almost go on to Google and just be like, pill bottle rather than physically taking a picture of the pills there and then and things like that. So I tried not to show myself...I mean, so, the way I have, and sometimes still do, self-harm is actually to smack my head so it was something that you can't...well, hit my head off walls, so it's not something you really got photos of in the same way. So it's not something you can really show in a photo so the only way to, kind of, express that is in words. And so, that's probably why I didn't post, kind of, many visuals of it because the actual way I self-harmed wasn't something you could show off in a picture.

I: And would you be, kind of, I suppose, putting it in text form or anything like that, (participants name), do you remember?

R: So as a teenager, so when I, kind of, first started doing it, I didn't put it in text form, didn't really put it anywhere, so I just...I was more of an observer and just did it in my own time. So it was actually only immediate family that really knew because at school I just pretended everything was fine. So yeah, I didn't really use social media at all in the beginning other

Comment [GB100]: Echo chamber of dark content

Comment [GB101]: Distress fostering distress

Comment [GB102]: Own agency shifted what is recommended/what is viewed

Comment [GB103]: Content warnings

Comment [GB104]: Ability to moderate/curate by self with age

Comment [GB105]: Images of actual self-harm – cutting and pills (limited range)

Comment [GB106]: Observing role

Comment [GB107]: No real photos posted – distancing self?

Comment [GB108]: posting stock images

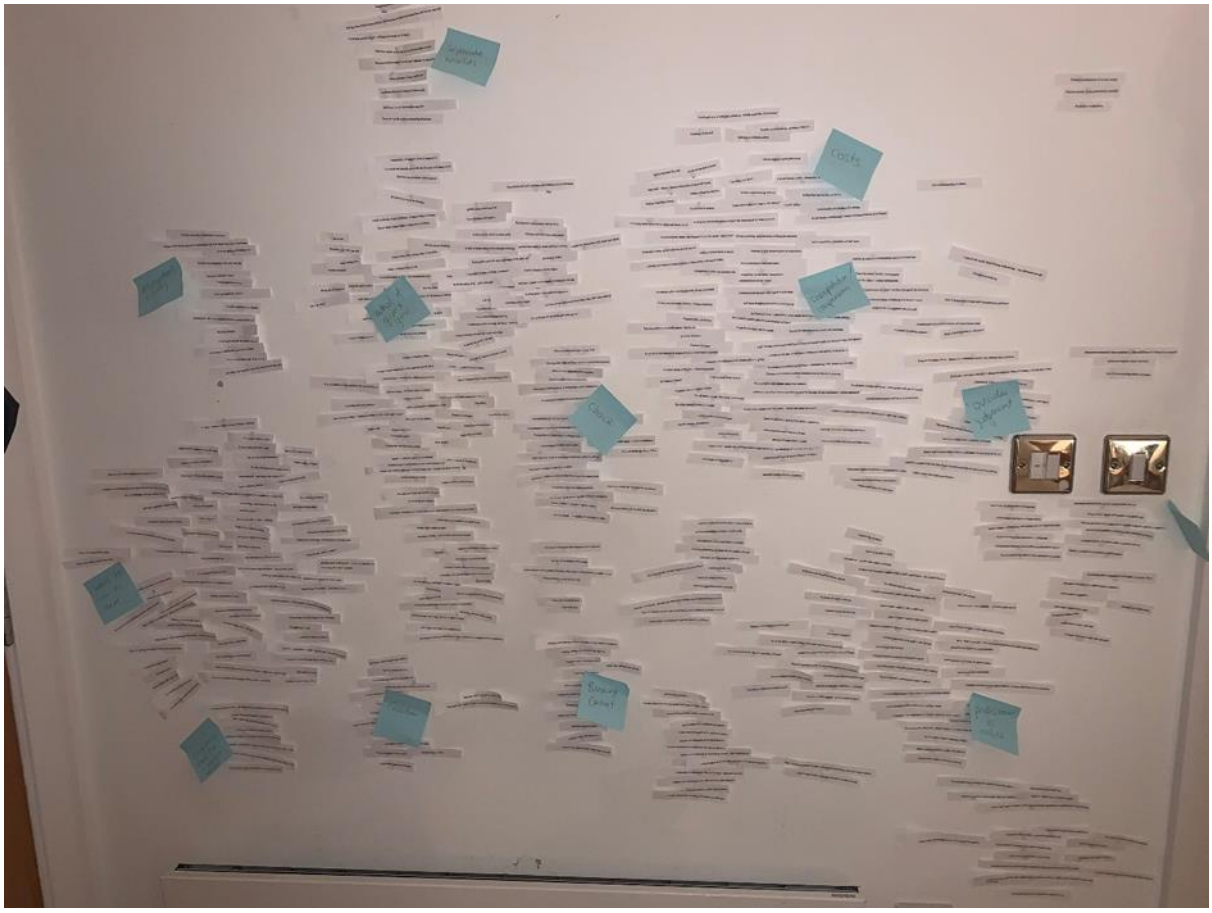
Comment [GB109]: type of self-harm not able to photograph

Comment [GB110]: use of language rather than images due to type of self-harm

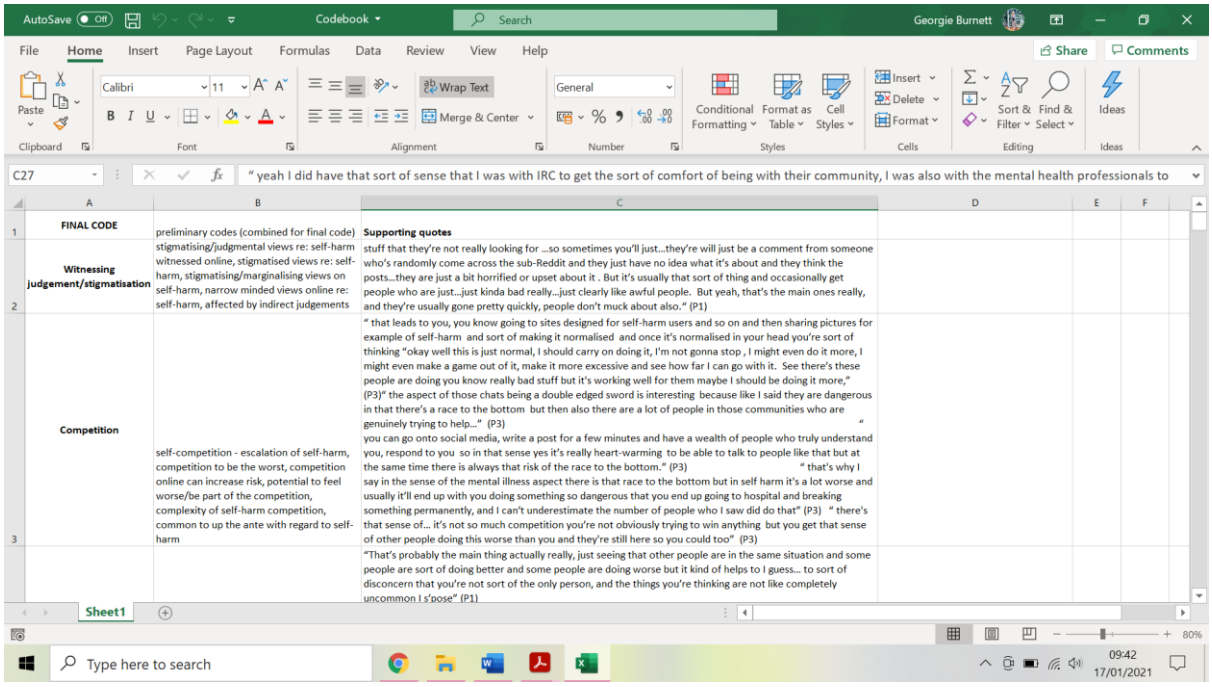
Comment [GB111]: observing role – especially when younger

Appendix I

Photo of code sorting process



Appendix J

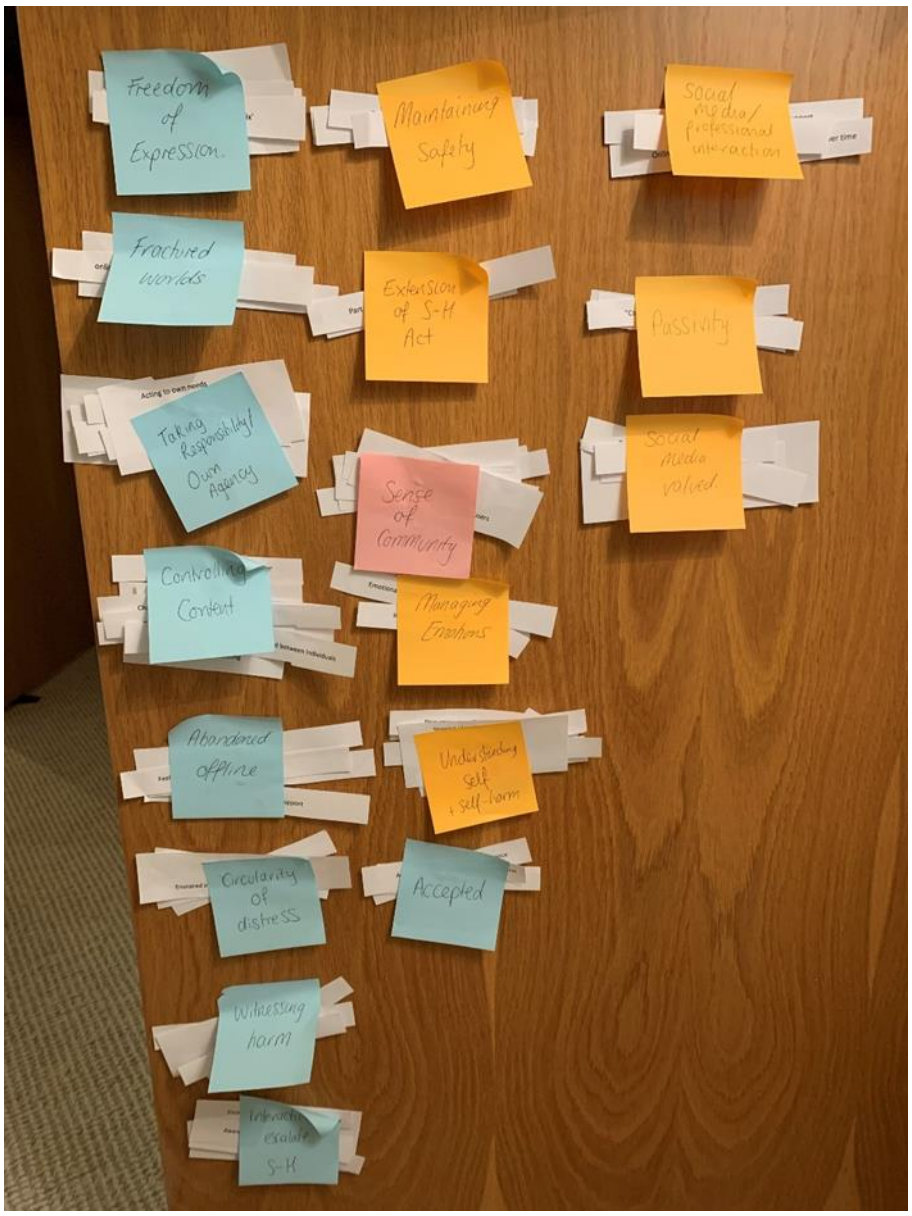


	A	B	C	D	E	F
1	**FINAL CODE**	preliminary codes (combined for final code)	**Supporting quotes**			
2	**Witnessing judgement/stigmatisation**	stigmatising/judgmental views re: self-harm witnessed online, stigmatised views re: self-harm, stigmatising/marginalising views on self-harm, narrow minded views online re: self-harm, affected by indirect judgements	stuff that they're not really looking for ...so sometimes you'll just...they're will just be a comment from someone who's randomly come across the sub-Reddit and they just have no idea what it's about and they think the posts...they are just a bit horrified or upset about it . But it's usually that sort of thing and occasionally get people who are just...just kinda bad really...just clearly like awful people. But yeah, that's the main ones really, and they're usually gone pretty quickly, people don't muck about also." (P1)			
3	**Competition**	self-competition - escalation of self-harm, competition to be the worst, competition online can increase risk, potential to feel worse/be part of the competition, complexity of self-harm competition, common to up the ante with regard to self-harm	" that leads to you, you know going to sites designed for self-harm users and so on and then sharing pictures for example of self-harm and sort of making it normalised and once it's normalised in your head you're sort of thinking "okay well this is just normal, I should carry on doing it, I'm not gonna stop , I might even do it more, I might even make a game out of it, make it more excessive and see how far I can go with it. See there's these people are doing you know really bad stuff but it's working well for them maybe I should be doing it more," (P3)" the aspect of those chats being a double edged sword is interesting because like I said they are dangerous in that there's a race to the bottom but then also there are a lot of people in those communities who are genuinely trying to help..." (P3) " you can go onto social media, write a post for a few minutes and have a wealth of people who truly understand you, respond to you so in that sense yes it's really heart-warming to be able to talk to people like that but at the same time there is always that risk of the race to the bottom." (P3) " that's why I say in the sense of the mental illness aspect there is that race to the bottom but in self harm it's a lot worse and usually it'll end up with you doing something so dangerous that you end up going to hospital and breaking something permanently, and I can't underestimate the number of people who I saw did do that" (P3) " there's that sense of... it's not so much competition you're not obviously trying to win anything but you get that sense of other people doing this worse than you and they're still here so you could too" (P3)			
			"That's probably the main thing actually really, just seeing that other people are in the same situation and some people are sort of doing better and some people are doing worse but it kind of helps to I guess... to sort of disconcern that you're not sort of the only person, and the things you're thinking are not like completely uncommon I s'pose" (P1)			

Screenshot of the Codebook

Appendix K

Photo of organising codes into preliminary themes



Appendix L
Ethical Approval

Rachel De So uza [Medicin e] on behalf of Medicine and Health Univ E thics Review
Mon 20/07/2020 15:25
To: Georgina Burnett
Cc: Medicine and Health Univ I

Dear Georgie

MREC 19-078 - An Exploration of the Use and Perceptions of Social Media of Young People who have Self-harmed

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

With apologies from the committee for the delay, I am pleased to inform you that the above research ethics application has been reviewed by the School of Medicine Research Ethics Committee (SoMREC) and on behalf of the Chair, I can confirm a favourable ethical opinion based on the documentation received at date of this email.

Please retain this email as evidence of 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 seehttps://leeds365.sharepoint.com/sites/ResearchandInnovationService/SitePages/Amendments.aspx or the Research Ethics Administrator for further information (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.

I hope the study goes well.

Best wishes
Rachel
On behalf of Dr Naomi Quinton, 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
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