Self-harm and Resilience Factors in Adult Mental Health Patients

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Thesis Abstract

Self-harm is a complex problem that affects millions of people around the world. It occupies a strategic position in suicide prevention of many countries and those who repeat self-harm may eventually die by suicide, a global health concern.

Despite much research conducted about self-harm in children and young people, very little research has been conducted with adults who self-harm, and their perspectives remain under-researched. This qualitative research focused on the views of adult mental health patients with the lived experience of self-harm to explore and understand their perspectives on self-harm and resilience.

This research has two sections: a systematic literature review and qualitative research. Systematic search of main electronic databases (PsychINFO, CINAHL, MEDLINE and PsychARTICLES) identified twelve articles for meta-synthesis. Four concepts emerged: social connection and belongingness, socio-economic factors, psycho-social factors and religion and cultural belongingness. All have been found to be associated with self-harm in adult mental health patients.

For the qualitative research, adult mental health patients [N=6; Mean age=40] were recruited from non-NHS and NHS sites. Data was obtained using semi-structured one-to-one telephone interviews that covered participants' strategies to prevent or minimise self-harm: what helps them stop or reduce how often they self-harm or the severity of their self-harm, and which one they perceive as the most effective. The recorded interviews were transcribed verbatim and analysed using Interpretative Phenomenological Analysis (IPA).

Seven key themes were identified from the analysis. These were: (1) thinking of the consequences, (2) responding to stressful life events, (3) relationship with family and others, (4) connecting with others with the lived experience of self-harm, (5) understanding my illness and resilience journey, (6) seeking professional support and (7) using coping strategies and skills.

The findings revealed that resilience to self-harm is a non-linear process that involves the interplay of many factors, which may be contextual, the clinical implication of which warrants a holistic assessment and a person-centred approach in planning interventions. Therefore, collaborative working of multi-agency professionals with the adult with the lived experience of self-harm is crucial to support self-harm prevention and management. Strengths and limitations of the study and areas of future research are discussed, then the researcher’s reflective journey, detailing personal experiences and challenges. Following this, is the conclusion to the thesis.

Declaration

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I am indeed grateful to the participants of this study who agreed to share their lived experiences of self-harm. It was a privilege to hear their stories. I would like to thank my supervisors Professor Sarah Lonbay, Dr. Paul Davis and Professor John Fulton for their guidance and support. I would also like to appreciate the support of Dr. Diane Simpson, Professor John Unsworth and other academic and non-academic staff of the University of Sunderland whose names are not mentioned here. Finally, I would like to thank my family and friends for their encouragements and help through this journey. Above all, my gratitude to the invincible God the father of mercy from whom all blessings, wisdom and knowledge flows.

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Chapter 1: Introduction

1.1 Introduction

Self-harm is a complex phenomenon reported among millions of people around the world. It has a wide scope and has attracted much research as the most important singular risk factor to suicide, a public health concern (Knipe et al., 2022; Liu et al., 2022). Despite attracting a plethora of research, those who self-harm, especially adult mental health patients, report being stigmatised by healthcare professionals, due to the latter's poor knowledge and understanding of self-harm (Knipe et al., 2022; Quinlivan et al., 2021; McGough et al., 2021).

Understanding the variety of protective and contributing factors associated with self-harm from the perspectives of the adults with the lived experience is crucial, especially for healthcare professionals. This is because they play vital roles in providing care and interventions to those who present with self-harm. Adults with the lived experience of self-ham are faced with multiple needs which are associated with their emotional distress, and it is essential for the healthcare professionals to utilise their knowledge and skills to address the needs to prevent or minimise self-harm (Morrissey, Doyle, & Higgins, 2018). The healthcare professionals are required to show positive attitudes towards those who present with self-harm, as this can help them understand from their perspectives the function and purpose of their self-harm and improve the quality of care they provide (McGough et al., 2021). It would therefore be beneficial to explore this understanding from the perspectives of the adult mental health patients with the lived experience of self-harm.

Though there are mental health models to guide the understanding of healthcare professionals (Huda, 2021) on underlying mental health issues in self-harm behaviours, it is necessary to check this understanding with the mental health patients with the lived experience of self-harm. For example, the biological model considers mental health problems primarily through biological factors like brain chemistry, genetics or neurological abnormalities requiring interventions using medications. This singular medical model understanding has

been challenged for not meeting the needs of those with self-harm behaviour who may have psychological or psycho-social needs. Singular biomedical understanding has also been critiqued for ignoring patient perspectives (Brandon, 2025;
Rebair, Harrison and Brandon, 2025)

As already mentioned, those who self-harm may have underlying mental health issues and multiple needs (Witt et al., 2019), so a single mental health model may not be ideal in understanding their needs and planning interventions. A holistic combination of models may be advantageous in planning their care. However, it remains expedient to have an idiographic approach that explores the detailed views of the individuals with the lived experience. The experience of individuals varies; therefore, a personalised approach to the complex phenomenon of self-harm is required. Again, the interplay of the multiple underlying protective and contributing factors associated with self-harm is complex. The understanding of this complex interplay from the perspectives of adults with the lived experience of self-harm remains understudied.

Self-harm is often viewed as a sign or symptom of a mental health problem (Lindgren et al., 2022; Angelotta, 2015), and about 90% of those who self-harm have a mental health diagnosis (Hawton et al., 2013), with depression and anxiety being the most reported mental health disorders (Kalin, 2020; WHO, 2017). Although it is argued that self-harm is a behaviour and not a psychiatric diagnosis (Moran et al., 2019), it is a diagnostic criterion for borderline personality disorder (BPD)/emotional unstable personality disorder (EUPD) (American Psychiatrist Association (APA), 2022)and can be seen in patients with psychosis and schizophrenia (Singhal et al, 2014; Hawton et al., 2013; Lorentzen, Mors, and Kjær,
2022). However, self-harm occurs in both clinical and nonclinical populations (Nock, 2010; Horvarth et al., 2020), with about 5.9% of adults in the community reported to have self-harmed at least once (Klonsky, 2011). The clinical population of self-harm is more, ranging from 12% to more than 80% (Washburn et al., 2012). The clinical importance of self-harm as a priority factor

for suicide prevention and patient safety globally (Turecki, et al., 2019; Rheinberger et al., 2022) means that it adds a significant amount of pressure to hospitals' emergency departments. Yet there remains a paucity of research to explore resilience to self-harm from the perspectives of adults with the lived experience.

1.2 **Concept and terms of self-harm**

Self-harm attracts a lot of debate in contemporary society (Wilson and Ougrin, 2021; Long et al., 2013), especially whether the definition should include self-harm with suicidal intent or not. Due to the complexity of the concept of self-harm, there is no global consensus on the definition of self-harm by professionals (Allen, 2007; Jakobsen et al., 2023). Self-harm has been referred to using various terms such as self-inflicted injury, deliberate self-harm (DSH), self-injury (SI), self-injurious behaviour, self-mutilation, suicidal behaviour, parasuicide and non-suicidal self-injury (NSSI).

In the United Kingdom, the National Institute for Health and Care Excellence (NICE, 2022) defined self-harm as self-poisoning or self-injury, irrespective of the apparent purpose for the act. This definition does not consider the intention or reason for the self-injury. Self-poisoning is the intentional self-administration of more than the prescribed or recommended dose of any drug, or of any substance not meant for human consumption irrespective of the reason for the act (NICE, 2022; Martin and Brown, 2020).

Self-harm behaviour is often assumed to be intentional or deliberate (Singtakaew and Chaimongkol, 2021; Jain, Kumar, and Gupta, 2020). In Europe and the United Kingdom, the term deliberate self-harm (DSH) is commonly used. This includes self-poisoning, self-injury or suicidal attempt without regards to the intention or motivation for the act (NICE, 2022; Hawton et al., 2012). In the United Kingdom (UK) the term self-harm is used (Jakobsen et al., 2023; Caine, 2012), whereas in United States of America the term non-suicidal self-injury (NSSI) is used (Kapur et al., 2013).

Non-suicidal self-injury was introduced to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). This new category focused only on damage done to the body tissue, excluding most forms of self-poisoning (Brunner et al., 2021), which typically emerges more often at the emergency departments, unlike self-cutting, which is seen more in other community-based settings. The term “Non-Suicidal Self Injury” (NSSI) is used to describe the deliberate destruction of body tissues without suicidal intent.

There is a difference between suicidal and non-suicidal behaviour (Andover and Gibb, 2010), as in the latter there is no intent to die. Though self-harm is done without the intention to die, suicidal, and non-suicidal behaviours could both occur in an individual (Wilkinson et al., 2011; Andover and Gibb, 2010; Kapur et al., 2013). However, it remains a challenge to ascertain if intention to die is behind the reason for the self-harm behaviour. This is because the reason for self-harm is often obscure, subjective, and dependent on the individual involved communicating his or her reason in clear terms (Silverman, 2016, -p.9).

1.2.1 Diagnostic classification of self-harm

In the International Classification of Diseases 11th edition (Word Health Organisation, 2019) and the Diagnostic and Statistical Manual of Mental Disorders 5th edition (American Psychiatric Association, 2022), self-harm behaviours have been listed as a diagnostic criterion for borderline personality disorder, as already mentioned. People who self-harm are heterogeneous diagnostically and may have other psychological diagnoses (Hawton et al., 2013; Klonsky and Muehlenkamp, 2007). Apart from borderline personality disorder, there are other reported conditions commonly accompanying self-harm. For example, alcohol and substance misuse (Gupta et al., 2019; Harned et al, 2006); eating disorders (Conway-Jones et al., 2024; Truglia et al, 2006); dissociative somatoform, or body dysmorphic disorders (Rautio et al, 2024); depression and anxiety disorders (Klonsky et al, 2003; Andover et al, 2005); post-traumatic stress disorder (Colledge et al., 2020); and psychotic conditions such as schizophrenia (Hawton et al., 2013; Klonsky, 2007).

Due to the heterogeneity of people who self-harm and the multiplicity of self-harm behaviours, clarity is required on the adopted self-harm definition. For this research, the adopted self-harm definition will be NSSI. This is because it appears to be the most inclusive of all the definitions of self-harm. It is found to address the “what”, and “how” of self-harm as well as what it is not. It makes clear the distinction between self-harm and suicidal intent. NSSI is defined as the deliberate self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned (American Psychiatric Association, 2013). This conception of self-harm will be used in the application of participant inclusion and exclusion criteria in this study. However, despite different terms used in referring to self-harm, this research uses the term “self-harm” except when referring to previous research that preferred to use other terms.

1.3 **Concept and critique of resilience**

As this research involves exploring resilience to self-harm, it is expedient to explore and critique the concept of resilience and adopt an operational definition of resilience. This is because of the complex construct and divergent meaning of the word, “resilience” which has attracted various debate in literature.

Resilience is fast drawing attention in mental health as it is bringing more understanding to the varied perspectives of mental illness, especially the link to improved mental health (Stainton et al., 2019). Therefore, understanding resilience to self-harm from the adult mental health patients with the lived experience will be significant for a better outcome in the plan of their self-harm intervention.

Resilience can be defined in context of individuals, families, organisations, societies, and cultures (Southwick et al, 2014). It is commonly referred to as the ability to bend or stretch but not break, and to return to original form, shape or status, and even grow in the face of adverse life situations (Southwick et al., 2014). Though this definition acknowledges resilience as applicable to multiple domains, there may be no coherence in the meaning across the domains. For example individuals’ (adult mental health patients’) resilience to self-harm is not

the same with organisational, society or cultural resilience which may involve collective identity and adaptation. Therefore, it will be difficult to compare resilience across different domains due to lack of critical distinction in the definition between the domains. In addition, Southwick et al.'s (2014) definition of resilience lacks the current debate on whether resilience is a trait, a process or an outcome. It failed to clarify if resilience should be viewed as an individual's inherent personality trait, a dynamic process that is revealed through the interactions of individuals with selves and environment or a desired outcome such as when an individual has stopped self-harm.

The American Psychological Association (2014) defined resilience as the mental, emotional, and behavioural disposure and ability to adapt or adjust to both internal and external demands and pressure. This definition appears not to adequately address the complex nature of resilience. It has not clearly contextualised resilience as the changing capacity that evolves with experience, available support, and environment.

Response to adverse conditions and trauma is the effect of interactions with other human beings, available resources, cultures/religion and societies (Sherrieb et al., 2010). This definition acknowledges multiple domains of resilience and aligns resilience with involvement of support networks and access to resources which in the context of self-harm, can be protective factors or triggers. However, it is also suggestive of static and linear effect and minimises the dynamic concept of resilience.

According to Panter-Brick and Leckman (2013), resilience is accessing available resources to maintain well-being. It is accessing or drawing from both internal and external resources to maintain wellbeing in the face of life adverse situations. This definition appears holistic and addresses the complex nature of resilience. This is because the internal and external resources include genetic, neurobiological, psychological, socio-economic, cultural and religious/spiritual. The ability to draw on the complex interplay of these factors to maintain wellbeing in the face of adversity is resilience. This definition can be applied across context to

families, individuals, and communities. This is because the resources can be broad including for example psychological, social and cultural. The definition is also practicable and can be argued as outcome-orientated. This is because it links resilience to maintaining well-being (e.g. stability from self-harm), a reflection of successful adaptation which can be operationalised in research.

1.4 **Research aims and research questions**

The aim of this research is to explore adult mental health patients' perspectives of self-harm and resilience to determine the effective common and most reported resilience factors to self-harm and how these work to prevent or minimise self-harm and promote mental well-being. It is anticipated that this research will help to inform and contribute to effective management of self-harm in adult mental health patients.

The following questions will be addressed:

- What are adult mental health patients' commonly reported resilience factors to self-harm?

- What does the adult mental health patients consider as the most effective resilience factor in self-harm?
- How do the reported resilience factors work to prevent or reduce self-harm and promote mental well-being?

1.5 **Rationale for the research**

The rationale for this research is the clinical importance and the socio-economic value. Self-harm thoughts and behaviours are documented as precursors of completed suicide, a global public health problem for practitioners, politicians, policy makers, and the public (World Health Organization, 2021; Kokkeci et al., 2012; Karen et al 2012; Kapur et al 2013; Mughal et al 2020). Self-harm which is increasingly constituting a major public health concern (Borschmann

et al., 2018; Pilling et al., 2018; Ayre et al., 2019) has a strategic position in the national suicide prevention in many countries (Tsiachristas et al., 2020). According to Vos et al., (2020) there are about 14.6 million global episodes of self-harm annually representing approximately 60 in 100000 people in a year. Despite this, the numbers of those who self-harm are still reckoned as an underestimate because not all those who self-harm may require the support of healthcare professionals or present to services (Knipe et al., 2022) where records can be updated.

According to Hawton et al. (2007), the annual hospital presentation in England (2000-2001) due to self-harm was about 220,000 patients. However, recent data estimates the annual hospital admission rate for self-harm in England to be about 68,468 cases, which is approximately 117 per 100,000 populations (GOV.UK, 2025). This suggests a decrease in the number of hospital admissions in England due to self-harm compared to the previous study by Hawton et al. (2007). However, the cost and pressure of self-harm on families, friends, communities, and especially NHS England remain a big concern. For example, there is an estimated annual cost of £162 million to the NHS England due to self-harm hospital admissions (Tsiachristas et al., 2017). Research on resilience to self-harm remains critical, from the perspectives of the adult mental health patients with the lived experience.

The voices of mental health patients may have been marginalised (Kong et al., 2020) because they may have been regarded as irrational by those in a position of power and authority (Rossler, 2016). However, in mental health, user involvement has been gaining attention in policy, practice and research (Millar et al., 2016). Nonetheless, despite the emphasis on user involvement, there remains the need to integrate the experiential knowledge of patients in evidence-based practice (Rosenberg & Hillborg, 2016; Semrau et al., 2016; Stacey et al., 2016). It is therefore important to explore the under researched subjective experiential views of those with the lived experience of self-harm to inform effective evidence-based provision of care.

Though there has been an increase in research on self-harm over the past few decades, notably, there are few published studies conducted with methods that focus on participants who self-harm compared to research that focused on clinical hypothesis and healthcare professionals' objective approach and views of others on self-harm. Again, few studies on self-harm have been conducted using quantitative methodology, rather than qualitative. Self-harm studies have focussed more on the experiences of health care professionals (e.g.self-harm in children and young people has been conducted (Morgan et al., 2017; Hawton et al., 2020; Steinhoff et al 2020), yet very few -studies have been conducted with adults who self-harm. The extensive focus on young people compared to adults may be due to the higher prevalence rate of self-harm in young people (Griffin et al., 2018; Borschmann and Kinner, 2019). Consequently, significant numbers of adults who self-harm remain under-researched, especially research that focuses on their perspectives on resilience to self-harm. This research addresses this gap by focusing on the lived experience of adults who self-harm.

Systematic reviews have previously explored the topic of self-harm (Carter et al., 2016; Witt et al., 2021; NICE, 2023) yet little attention has been given to the perspectives of people with lived experience (Moran et al., 2024) and to date there remains the need for a comprehensive synthesis of the literature on self-harm and resilience factors in adult mental health patients. Having more research that focuses on their subjective experiences and explores their direct accounts would be beneficial.

Part of the rationale for this study, is the professional background of researcher as a mental health nurse who have gained some work experience with adult mental health patients with the lived experience of self-harm. The researcher's professional background shaped his understanding of the subject under investigation and provided valuable insights to the research topic.

It is acknowledged that researcher's personal desire, background and motivation may potentially introduce some assumptions, expectations or biases to the research process and

may also offer some advantages in the research. For example researcher's work experience can be advantageous in facilitating rapport with participants and enhance data collection and nuanced interpretations. To account for all these, the researcher have engaged in reflexivity throughout the study. Details are presented under reflexivity (4.9)

1.6 **Scope of the research**

In referring to the concepts of self-harm and resilience, their respective definitions adopted in this research detailed in Section 1.2, would be the scope of coverage. Socially acceptable forms of self-injury such as ear piercing and tattooing are excluded from self-harm in this research, as the reason for the intentional harm caused is cosmetic or aesthetic**.** Body modifications done because of religious persuasions, in contexts of spirituality or cultural belongingness, are also excluded. This is because the primary intent or purpose is not aligned with known reasons for self-harm but is validation of spirituality, religious belief or cultural identity. Though this may be argued as self-harm by people of different cultures or religious beliefs, in this research, they are excluded. Self-harm due to eating disorders, substance misuse or alcohol abuse, are outside the scope of this research. Self-harm associated with autism or other neurological developmental disorders are also excluded and beyond the scope of this research (Ross et al, 2009; Fong et al., 2024). The reason for the exclusion is because harm to self by patients with this condition may not be clearly categorised as intentional harm to self. The harm to self has to be intentional, and it may be difficult to ascertain intention in some people with neuro-developmental conditions. The scope of self-harm is wide (see Section 1.4 for details), and the inclusion and exclusion criteria reinforce the scope of this research, which is a qualitative investigation into adults (18-64yrs) with the lived experience of self-harm. The research took place within the UK with no geographical limitations, though all data collection and analysis took place within England.

1.7 **Structural overview of thesis**

This thesis consists of eight chapters: Chapter 1 provided the introduction to the research topic, explores the key concepts and terms, indicated the respective definitions adopted in this

research and gave the rationale for the definitions. It provided the aim and objectives for this research, the research questions and the rationale for the study, highlighting gaps in the existing knowledge. It provided the scope of the research and finally presented the structural overview of the thesis.

Chapter 2 covers the background to the research topic and highlights the following: prevalence of self-harm, self-harm methods, reasons for self-harm behaviours, attitudes towards self-harm, service provision and self-harm management. The chapter also in the context of the research topic provides an in-depth discussion of resilience.

Chapter 3 provides a systematic review of literature on self-harm and resilience factors in adult mental health patients, bringing to the fore the key gaps in knowledge and understanding that this thesis addresses.

Chapter 4 offers a rationale for the choice of research methodology. It clarifies the theoretical framework underpinning this research and the rationale for the choice.

Chapter 5 expands on Chapter 4 and provides a detailed description and critical review of the study design and methodology. It explores the recruitment, data collection and data analysis. This is followed by details of ethical considerations for the research, and reflection on the trustworthiness and limitations of the research.

Chapter 6 outlined the research findings, with description of the key themes: thinking of the consequences of self-harm, relationship with family and others, connecting with those with lived experience of self-harm, responding to stressful life events, understanding my illness and resilience journey, seeking professional support, and using coping strategies and skills.

Chapter 7 is the Discussion chapter, which provided critical discussion of the key findings, related them to the existing literature, and unpacks new or incremental knowledge.

Chapter 8, the Conclusion chapter, provided the clinical implications of the research findings, and the distinctive contributions to knowledge. It highlighted the limitations and the future research directions. This is followed by the researcher’s reflective account and conclusion.

Chapter 2: Background to the study

2.1 **Introduction**

This chapter provides the background to the study, highlighting some of the key areas of existing knowledge. These are: prevalence of self-harm, self-harm methods, reasons for self-harm behaviours, attitudes towards self-harm, service provision and self-harm management. It also provides an in-depth discussion on resilience, outlining the ways in which it is understood and how it links to self-harm and wellbeing.

2.2 **Prevalence of self-harm**

Self-harm can be seen in both clinical and nonclinical populations (Nock, 2010; Horvarth et al., 2020). Self-harm is prevalent in both males and females across different age groups. However, there are different views on whether there are gender differences in the prevalence of self-harm. While some report no differences (Klonsky et al., 2003), others hold that self-harm is more prevalent among females (Madge et al., 2008; Gillies et al., 2018). This appears to be linked to female predominance in mental health conditions such as depressive and anxiety disorders, which could precipitate self-harm (Campisi et al., 2022; Hosozawa et al., 2021). Self-harm preponderance in females has also been argued to be due to males' under-reporting of their experience of self-harm (Mars et al., 2014; Fenton and Kingsley, 2023).This may be because many males perceive self-harm as a female problem and a sign of weakness, according to Sagar-Ouriaghli et al.'s (2020) qualitative study on male help-seeking attitudes. Nonetheless, the gender difference in self-harm is argued to be a non-static gap, which disappears by early adulthood (Wilkinson et al., 2022).

A higher prevalence of self-harm is reported in England than in other parts of Europe (DH, 2017; Rayner et al., 2019). However, statistical findings are limited by the fact that not all who self-harm may present to the health care services. Hence accurate epidemiological data is

difficult to achieve due to under-reporting. In the UK, it is suggested that 60% of adults and 90% of young people do not contact medical or psychological services after self-harming (Knipe et al., 2022). Some self-harm cases are not reported for various reasons, such as fear of stigmatisation (Nearchou et al., 2018; Knipe 2022) and unwillingness to disclose for fear of being perceived as weak and negative (Lloyd, Blazely, and Phillips, 2018) which may be more pronounced with males than females (Claes et al., 2007).The gap closes with age, resulting in males being more likely to self-harm with higher suicidal intent (Lee et al., 2019). Also, not all self-harm may require hospital or medical attention. Again, depending on the population under study and the assessment tools used, estimates on the prevalence of self-harm remain difficult due to different concepts and terminologies used in referring to self-harm (Mangnal and Yurkovich, 2008; Knipe et al., 2022; Jakobsen et al., 2023). For example, studies that conceive self-harm as "suicidal attempt" may leave non-suicidal self-injury outside its scope.

2.3 **Self-harm methods**

There are various ways or methods of self-harm which include: poisoning with corrosive domestic products such as bleach, overdoses of recreational drugs, hanging, suffocation, strangulation, drowning, discharge of guns/firearms directed to self, use of explosive materials to cause harm to self, and inhalation of dangerous smokes/fumes such as carbon monoxide (Mantinieks et al., 2022). Self-injuries from fire, hot objects, sharp/blunt objects, jumping from heights, lying before a moving object, intentional crashing of motor vehicle (Hirot et al., 2022), and other specified and non-specified means to harm self are also included (Skaggs et al., 2022; Philips and Grindrod, 2022; Anderson and Dawson, 2016; Spyres et al., 2019).

The method of self-harm often depicts how it is referred to. For example, self-cutting and self-poisoning, shows respectively that the methods used for self-harm are cutting of self and ingesting of poisonous substance. Self-harm comprises some types of behaviours among which cutting is the most common self-harm method in the general population, although self-

poisoning and self-battery are also frequently used (Moran et al., 2012). According to Geulayov et al. (2016), the most common forms of self-harm are medication overdose and self-cutting (Rabi et al., 2017; Hawton et al., 2012; Neupane and Mehlum, 2022). Skin cutting appears to be the most common type of self-harm, with wrist cutting being recognised as most widespread (Rabi et al., 2017). According to Cully et al., (2019), minor (superficial)self-cutting is the method associated with the highest repetition risk and remains more common than intentional drug overdose, which is the most common method observed at emergency departments (Geulayov et al., 2016; Campeau et al., 2022).

2.4 **Reasons for self-harm**

Reasons for self-harm are varied, and complex (Hetrick et al., 2020). Self-harm can be a way of responding to deep feelings of worthlessness or a way of dealing with psychological pain from past abuse (Mohan et al., 2023; Kong, 2019). Physical pain caused by self-harm have been reported by some people as help to distract them from their emotional pain (Claes, 2010; Nester et al., 2022). In some who self-harm by cutting, letting blood out is symbolic of release of negative energy or feeling from the body (Glenn and Klonsky, 2010) or can help to relieve periods of numbness or dissociation, when they feel disconnected from their body; self-harm helps them reconnect and feel themselves again. This suggests part of the reason for self-harm as self-help or coping strategy, though it is positioned as a negative way of coping. Self-harm is also reported as a way to communicate (Borill et al., 2011; Motz, 2009) with others, to make demands or protest. For example, some asylum seekers used self-harm at immigration detention centres to protest the condition of their detention and express their frustration over uncertainty of their immigration status (Aitchson and Essex, 2022; Nock, 2008). In a survey of seven European countries (Australia, Belgium, England, Hungary, Ireland, the Netherlands and Norway), it was found that about 67% of self-harm was undertaken to draw the attention of others (Scoliers et al., 2009). For example, from the perspective of the person self-harming, self-harm was used due to the frustration or feeling of not being heard or listened to by others, especially when not able to articulate feelings in

words (Reece, 2005), or when the person believes that they will not be heard (O'Keeffe et al., 2021). Therefore, to lend voice to those who self-harm this research explored their perspectives on self-harm and resilience factors. A survey of women with eating disorders suggested that different methods of self-harm may have been used for different purposes. While bruising was predominantly used as a form of self-punishment, self-cutting was used to regulate emotions (Claes et al., 2010; Gyori and Balazs, 2022).

Amongst theories and approaches attempting to explain the functions of self-harm, there is a common denominator. In response to SLEs and interpersonal challenges, self-harm functions as a coping strategy. However, hopelessness, helplessness and feelings of neglect appear to be the common combinations underpinning the complex reasons for self-harm. Self-harm is viewed by Psychodynamic theories as "anger turned inwards" (Iskric et al., 2020) or as a type of response to distressing emotion. The nature of self-harm is the focus of Behavioural theories which view self-harm as learned behaviour that is self-augmenting. Socio-cultural theories emphasise the role of society, trauma and culture.
Nonetheless, self-harm can be viewed in all the three models as a self-soothing strategy (Ogden and Bennett, 2015; Hasking, 2023).However, it is important to explore the direct accounts of those with the lived experience of self-harm, to gather their views on the reasons for their self-harm behaviours as self-harm is a private but complex phenomenon which may be subjectively construed.

2.5 **Staff attitude towards self-harm**

Negative experiences of care across all clinical settings have been reported consistently by people who self-harm (Taylor et al., 2009; Lindgren et al., 2018), especially limited understanding of self-harm, and lack of sympathy amongst clinical staff (Knipe et al., 2022; Quinlivan et al., 2021). These issues have been identified as significant barriers to the provision of quality care in several research reports (Royal College of Psychiatrists, 2010 and National Institute for Health and Care Excellence (NICE), 2011). Studies using self-report

(Likert Scale Test) found that staff have a mixture of positive and negative feelings towards those who self-harm (Conlon and O'Tuathail, 2012; Gibb, Beautrais and Surgenor, 2010). This mixture of positive and negative attitudes of staff to self-harm appear to persist (Knipe et al., 2022; Quinlivan et al., 2021; McGough et al., 2021), warranting further investigation on the perspectives of adults with the lived experience of self-harm. Positive attitude towards those who self-harm was found associated with staff training in self-harm and registration as a mental health practitioner (Dickinson and Hurley, 2012; Dickinson, Wright and Harrison, 2009). The quality and outcome of care from health care professionals are dependent on the attitude of the healthcare professionals towards self-harm. Amongst healthcare professionals, nurses are the ones that spend the highest amount of time with patients and are most affected with professional burnout (Pintar-Babic et al., 2020). Pintar-Babic et al., (2020) investigated the attitudes and feelings of psychiatrist nurses (n = 76; 20 males, 56 females; mean age=42) working with patients who self-harm in different psychiatric hospitals. Their study showed that the emotions of psychiatrist nurses towards patients who self-harm were positive. This is in contrast with the negative attitude of anger and despair reported by nurses from non-psychotherapeutic units. The result, as per Pintar-Babic et al. (2020), suggest that nurses without psychiatric education have a poor understanding of self-harm and have more negative attitudes towards patients who self-harm.

Qualitative studies exploring the views of practitioners with those who self-harm suggested some complex issues, such as describing people who self-harm as attention- seeking and manipulative (McHale & Felton, 2010; Sandy, 2013), lack of confidence in supporting people who self-harm, and difficulties understanding their behaviour (Dickinson et al., 2009; Friedman et al., 2006). Hence, working with people who self-harm can evoke emotions such as anger, fear, frustration, and powerlessness in achieving desired clinical outcomes (O'Keeffe et al., 2021; Hadfield et al., 2009). A better understanding of the support needs of those with the lived experience of self-harm may enhance collaborative working with the

healthcare professionals and promote a healthier working relationship as staff's limited knowledge and understanding of self-harm have been associated with their negative attitudes, which consequently affect patients' outcomes (Masuku, 2019). This suggests the importance, of understanding resilience to self-harm from the perspectives of those with lived experience. Again, this research seeks to address this by exploring the self-harm and resilience from the perspectives of those with the lived experience.

2.6 **Service provision**

The National Health Service (NHS) provides most care in the United Kingdom (UK) to those who self-harm. According to Cooper et al. (2015) about half of those that attend Emergency Departments (EDs) may be admitted to the hospital for treatment. Despite a strong association with mental health problems, around 60% of people attending emergency departments following self-harm will not be in contact with specialist mental health services (Owens and House, 2019). In UK, clinical guidance states that rather than focusing on the self-harming behaviour, specialist services for self-harm should seek to support people with any underlying problems which may be causing the behaviour, such as depression or past trauma (National institute for Health and Care Excellence, 2022).

Self-harm is one of the most common reasons for admission to psychiatric in-patients' services (Tsiachristas et al., 2017). The mental health in-patient services provide 24-hour care for people with severe and complex mental health needs, which may involve the management of challenging behaviours such as suicide attempts and self-harm (Bowers, Simpson, and Alexander, 2003). In addition, in-patient services have notable challenges such as high admission bed demands, administrative duties and understaffing issues (Braithwaite, 2006; Royal College of Psychiatrists, 2011). Reports over the past decade have critically highlighted in-patient services to lack the therapeutic interaction between staff and patients, recovery-focussed care, deficits in leadership and clinical skills (Braithwaite, 2006).

These issues reduce help-seeking from care services by those who self-harm warranting further studies.

2.7 **Self-harm management**

Type or method of self-harm can affect the severity of harm caused and will determine how it should be managed. For example, those who self-harm by minor cuts are less likely to be admitted to hospital (Vichianchai and Kasemvilas, 2022) than those who self-harm by self-poisoning.

The NICE guidelines on self-harm recommend completing a mental health assessment for individuals who presents with self-harm (NICE, 2022; Kapur, 2005). The assessment has to be undertaken by a trained professional such as mental health professional who has the skills to conduct the assessment. However, Kapur (2005) reports a lack of appropriately trained and supervised staff in most acute medical settings and long waiting lists for intensive therapeutic interventions. An evidence-based psychotherapy, dialectical behavioural therapy (DBT), which works through developing the skills of mindfulness, distress tolerance, interpersonal effectiveness and emotional regulation, can be used in treating personality disorders and interpersonal conflicts, and their risks of self-harm (Chapman, 2006). According to Clarke et al. (2019), DBT is a recognised treatment option for patients who self-harm and are at a high risk of suicide. However, DBT is a time-consuming treatment that appears not to be cost effective due to the required extensive training for therapists and the time demand from families/carers (McCauley et al., 2018). The full DBT model involves two 24-week cycles of skills training groups, individual weekly psychotherapy sessions, and telephone contacts with the therapist between sessions (Linehan, 2015). Therefore, psychological interventions for people who self-harm, such as dialectical-behaviour therapy (DBT) or group therapy, would greatly depend on individual settings and engagement of patients. It will then be helpful to assess whether other less intensive treatment options can be established as evidence-based treatment for patients

who self-harm with high suicidal risk, and to consider what those with the lived experience say is helpful to them. This research, again. focuses on the perspectives of those who self-harm to find out what they consider helpful and effective in resisting self-harm, reducing how often they self-harm, the severity of their self-harm behaviour or stopping self-harm.

As Kapur (2005) observes, attention is paid more to risk assessment than assessment of needs of individuals presenting with issues of self-harm. This prioritises the few individuals at higher risk of committing suicide and neglects the majority who are at lower risk of suicide but at higher risk of repeat self-harm. Although the introduction of Improving Access to Psychological Therapies" (IAPT) services in 2008 means access to the Cognitive Behavioural Therapy (CBT) interventions, there remain delays in the service provision due to long waits (Williams, 2011). IAPT, currently referred to as Talking Therapies continues to experience this long waits. Williams (2011) posits that self-harm without suicidal intent can be managed with other common mental health problems, such as depression and anxiety, by using CBT to explore coping mechanisms and address issues such as low self-worth. However, the duration of CBT interventions appears to be an issue in providing effective services, especially in cases involving complex mental health needs which require referral to appropriate services for further support. As per Williams (2011), there is lack of research in self-harm without suicidal intent, which leads to lack of clarity as to appropriate interventions. It would therefore be necessary to explore the perspectives of the adults with the lived experience of self-harm to address this gap, by understanding what they perceive as help to resist, reduce or end their self-harm behaviours.

Apart from the evidence of a range of psychological interventions as problem-solving skills, and dialectical and cognitive behavioural therapies (Hawton et al., 2015; National institute for Health and Care Excellence, 2011) that can help to reduce repeat self-harm by improving patients' outcomes of depression and hopelessness; there is currently no evidence for the effectiveness of pharmacological interventions for self-harm. Nonetheless, it may be argued

that there is pharmacological intervention for anxiety and depression which may lead to self-harm. However, this is not a direct self-harm pharmacological intervention.

Another approach in self-harm management is harm minimisation. This refers to “accepting the need to self-harm as a valid method of survival until survival is possible by other means…and is about facing the reality of maximising safety in the event of self-harm” (Pembroke, 2009, p. 6). Harm minimisation is grounded on the premise of causing or allowing necessary or wanted lesser pain as means of distraction from deeper or bigger (psychological) pain. Harm minimisation practices ensure safety for people who self-harm by providing advice and support on how to self-harm safely. This can be done by providing advice on wound care and encouraging use of clean blades (for self-harm by cutting) to avoid or minimise infection. Though some argue that harm minimisation appears to be unconventional, controversial, and unethical, it remains acceptable to most adult mental health patients who self-harm. This is because they found it to be helpful in getting a sense of relief from deep negative emotion, while stopping or preventing them from self-harm may cause them more harm as they need self-harm as means of survival (Duperouzel and Fish, 2008).

Means restriction is another way of managing self-harm. This is through ensuring a safe environment which involves removing or limiting access to potentially life-threatening settings or objects, like firearms, tall buildings, bridges, trains/traffic, sharps medications and toxic substances that could be used to overdose and corrosive agents that could cause harm (Miller, 2013). To achieve this would be difficult without supervision. This intervention hence appears connected to the intervention of supervision (one-to-one enhanced level of observation), which makes provision for a close therapeutic engagement with patients at very high risk of self-harm in a more controlled environment, such as mental health wards. This is one of the reasons those who are actively self-harming or at high risk of self-harm or suicide are admitted as in-patients. Despite all the highlighted ways of self-harm

management, it remains important to explore the direct views of those with the lived experience of self-harm to ensure collaborative person-centred care.

2.8 **Understanding resilience**

In the preceding chapter (Section 1.2), the concept and the operational definition of resilience adopted in this research were provided. Further understanding on resilience will be presented in this section.

The word 'resilience' was derived from the Latin word, "resilio", meaning ''to jump back" ("bounce back")(Willans and Stewart-Brown, 2021).This was first used in physics and mathematics to illustrate strength of materials in bouncing back or returning to original shape and form after being stretched (Sliwinski, 2020).It was illustrated that there is a limit to which a material can be stretched, beyond which the material will lose the "elasticity" (ability to bounce back).Resilience is considered as a positive adaptation after a stressful or adverse situation(Fullerton, Zhang, and Kleitman, 2021). A sense of balance or stability (internal and external) is disrupted when a person is faced with daily stress. Though daily stress can have a positive impact in promoting resilience by the sensitising effect to withstand later stress or adversity, it is not certain the level of stress an individual is able to handle, and some individuals can adapt better to a higher level of stress than others (Rutter, 2012).

Resilience includes both the process and the outcome of successfully adapting to or adjusting to challenging life experiences to maintain stability. Lopez et al. (2019, p. 108) describe resilience as "a class of phenomena characterised by patterns of positive adaptation in the context of significant adversity or risk". Resilience involves three components: adversity or some traumatic or stressful event, healthy functioning following adversity, and the mechanisms through which the individual was able to recover from adversity (Hamby et al., 2018; Hamby et al., 2020).

Though resilience is often seen as a process, it is mistakenly assumed to be a trait of the individual (Rutter, 2012). On the contrary, it is the result of individuals' ability to interact with their environments and available resources that either promote well-being or protect them against the influence of risk factors (Pemberton, 2015). In the face of adverse conditions, individuals could respond in the following three ways: respond with anger or aggression; become overwhelmed by negative emotions, go numb and shut down; feel upset about the situation but appropriately handle or adapt the emotion to promote wellbeing. Amongst the three responses, only the third approach promotes well-being and characterises people who are able to adapt well in the face of adverse conditions(Pemberton, 2015; Duckworth, 2016; Neenan, 2018; Southwick and Charney, 2018; Boniwell and Tunariu., 2019).They may be upset about the situation but will resort to their coping strategies to deal with it . The first and second responses will lead to negative adaptations (LouisonViry, d'Arripe-Longueville& Chaumeton, 2015)

The first response can lead to anger towards others or to self. Negative emotions, such as self-destructive anger, can culminate in self-harm behaviours, perhaps through people instinctively reacting, rather than responding to the situation in other ways. The second response can lead to a depressive condition which may have some element of low self-worth, self-neglect and anger towards self with the possibility of self-harm. The response with negative emotions involves fear, anger, anxiety, distress, helplessness, and hopelessness, which decrease a person's ability to adapt to deal with the challenges they face, weaken their resilience, and increase the possibility of self-harm. Though the third response may also involve similar negative emotions some people are able to adapt well in the situation by resorting to their coping strategies, which might include self-harm. Though self-harm is socially unacceptable, it is arguably a coping strategy in suicide prevention by those in a state of hopelessness (Klonsky, 2007). This is because self-harm has less consequences compared to suicide so may mitigate suicide in some cases. As already mentioned, self-harm has strategic position in suicide prevention in many countries (Tsiachristas et al., 2020).

2.9 **Importance of resilience**

Resilience is an important factor in dealing with adversity or life challenging situations. When resilience is lacking, one can easily be overwhelmed and may turn to an unhealthy negative coping mechanism such as self-harm behaviours. To be resilient would mean to rely on the inner and external abilities, available resources and supports, to overcome the challenges and bounce back to maintain stability. The ability of individuals to draw from their inner and external abilities and available resources to overcome adversities varies. This explains why some people are found to be more resilient than others in facing or dealing with the same life challenges or adversities (Stainton et al., 2019).For an example, loss of a loved one may lead to self-harm in some whereas the same adversity may not in others, because they were able to resist self-harm through accessing available supports such as taking advantage of bereavement counselling.

There are different types of resilience. They include emotional resilience (Southwick and Charney, 2018), which enables a person to draw on realistic optimism in dealing with life events, even crisis. There is physical resilience, which refers to the ability of the body to adjust to demands or challenges and make a quick recovery. Community resilience is the ability of groups of people to respond to and recover from adverse situations such as natural disasters, war and economic downturn. According to Ginsburg (2011), irrespective of age there are seven skills and factors (7Cs) required to build inner strength (psychological resilience) to access outside resources. These are competence, confidence, character, contribution, coping and control. He maintained for example that connecting or having close ties to friends, family and community groups is likely to give better sense of security and belongingness, with less likelihood to engage alternative, destructive behaviours. On the hand, compromising any of the 7Cs may affect resilience. For instance, when confidence is lacking, resilience may be compromised.

Two concepts central to resilience theory are learned helplessness and stress inoculation. Learned helplessness is where individuals believe they are incapable of changing or controlling their circumstances after repeatedly experiencing a stressful event. Unsuccessful attempts have the tendency of conditioning the mind to a state of helplessness as confidence gradually fades away. Stress inoculation “...is where individuals can develop an adaptive stress response and become more resilient than normal to the negative effects of future stressors” (Southwick & Charney, 2012, p. 80).

The American Psychological Association (APA) 2014 suggests ten ways someone can build and maintain resilience which include:

- Maintain good relationships with close family members, friends and others.
- Do not see stressful events as unbearable problems.
- Accept circumstances that cannot be changed.
- Set realistic goals and pursue them.
- Take decisive actions in adverse situations.
- Seek opportunities for self-discovery after a struggle with loss.
- Build self-confidence.
- Learn from the past
- Take care of yourself
- Maintain a positive attitude

It may be quite challenging for an example, for those that had childhood trauma who are experiencing psychological distress to engage some of the above listed ways. However, APA also suggested adopting a holistic approach to stressful events, maintaining a healthy lifestyle, exercising regularly and paying attention to one's own needs and feelings. Maintaining a holistic approach to stressful life events may warrant individuals drawing on available resources to their benefit (Stainton et al., 2019). However, structural or systemic

inequalities may preclude some individuals from accessing some of the listed ways of building resilience.

2.10 **Domains of resilience**

Rossouw et al. (2017) explored resilience as an enabler in job satisfaction in adult professionals and found that those who reported higher job satisfactions were more resilient. The relationships of resilience to job satisfactions informed better ways for organisations to train and develop resilience capacity in people as resilience is a critical dynamic life skill that can be improved (Herrman et al., 2011). Rossouw et al. (2017) posit six resilience domains each of which represents a key skill set of focus (see table on next page for details).

Rossouw et al. (2017) six domains of resilience with their key focus

Domain	**Key Focus**
Vision	Purpose-driven motivation and meaningful direction. This provides the drive or reason to persevere even in adversity
Composure	Emotional regulation and mindful response to stress. This enhances the capacity not to be overwhelmed by adversity
Reasoning	Planning, adaptability, problem-solving, and reflective thinking. Supports skilful response under pressure
Tenacity	Persistence, optimism, and growth through challenges
Collaboration	Social support, healthy relationships, and collective resilience
Health	Foundational physical well-being, including sleep, nutrition, and movement. Provides the base for stability

According to Rossouw et al. (2017), clinicians, individuals, and researchers through the interrelated domains can formulate strategies to build resilience by targeting:

- Promoting clear goals (Vision)
- Emotional regulation and mindfulness (Composure)
- Developing problem solving skills and reflective thinking (Reasoning)
- Enhancing optimism and perseverance (Tenacity)
- Strengthening social connections (Collaborations)
- Improving healthy lifestyle (Health)

2.10.1 Resilience and health

Maintaining wellbeing in the face of stressful life events or adversities may demand adjustments or adaptations from individuals. This may be achieved through accessing the available internal and external resources. This appears to link the concepts of resilience and

Health. Health is an important domain of resilience (Rossouw et al., 2017). It provides the base for the interworking of other domains and if health is compromised, the likelihood is that other domains are affected and consequently resilience.

Health functions as an antidote to negative emotions and helps those feeling bound or engulfed by grief, pessimism, and isolation. Arguably, happier people show less psychopathology (Layous, Chancellor, and Lyubomirsky, 2014, p. 3). Similarly, Diener et al. (2018) posit that people with fulfilment of needs and robust social resources are happier and are associated with high subjective wellbeing, which helps to cushion effects of adverse life events and prevent potential progression to alcohol and substance abuse, depression, self-harm behaviours, or other mental health conditions. According to Layous et al. (2014), ensuring wellbeing improves mental health and can reduce the negative emotions which may lead to self-harm behaviours. Promoting wellbeing supports positive outcomes such as mental stability, which can buffer the adverse effects of risk factors. As already mentioned, some of the following activities have been shown to promote wellbeing: expression of gratitude, practicing act of kindness, practising the art of optimism, affirming personal values or self-worth, and having access to strong social resources to meet needs. Whilst these are interconnected to positive emotions and are protective against self-harm behaviours, negative emotions may trigger self-harm behaviours (Morris et al., 2014).

Summary

This chapter presented the background to the existing knowledge on key areas of the topic of self-harm and resilience in the adult mental health patients. It discussed prevalence of self-harm, self-harm methods, and the reasons for self-harm behaviours. It provided mixed negative and positive attitudes of different healthcare staff towards self-harm and highlighted the existing gap in knowledge about self-harm which results in negative attitudes that affects the quality of their care delivery. It covered different self-harm management and reported

psychology as the treatment of choice, notwithstanding the existing gap of psychological interventions of being time demanding and less cost effective, needing further investigation.

This chapter also provided various ways of building resilience, the seven ways of building resilience, and the importance of resilience. It covered the six domains of resilience, which has potential for further development and can be used to evaluate strengths and weaknesses across multiple dimensions to support holistic approach in resilience building.

Chapter 3: Systematic literature review

3.1 Introduction

The previous chapter outlined the background to the study. This chapter presents a systematic review of literature and focused on the lived experience of self-harm and resilience in adult mental health patients. The aim of the systematic review was to summarise current evidence in this field and identify gaps that may exist and areas for future research, some of which are addressed in this thesis. Most of the research around self-harm has focused on the function of self-harm, the correlations with suicide or self-harm prevalence in various populations. Rarely have research projects been dedicated to the experience of people who self-harm, and more specifically, resilience factors from the perspective of adult mental health patients with the lived experience of self-harm.

Abstract:

Background: A substantial body of research has been conducted on the subject of self-harm. However, limited research has focused on self-harm in adults, particularly in relation to their resilience factors against self-harm. This review explored self-harm and resilience factors in adult mental health patients.

Method: Main databases (PsychArticles, PsychInfo, CINHAL and Medline) were electronically searched on Ebschost platforms. Twelve articles that met the criteria for inclusion involved qualitative, quantitative and mixed method studies conducted in United Kingdom, United States of America, Europe, Canada, and Asia. The articles were appraised using a Critical Appraisal Skills Programme (CASP) tool and synthesised using narrative synthesis.

Result: Social connectedness and belongingness, socio-economic factors, psychosocial factors and religion/cultural belongingness all have been associated with self-harm in adult mental health patients.

Conclusion: Though social connectedness and belongingness, socio-economic factors, psychosocial issues and religion/cultural belongingness/identity affect self-harm in adult mental health patients, focus on resilience factors from their perspective would be strategic in their self-harm prevention and management.

Keywords: self-harm, resilience factors, adults, mental health patients.

3.2 **Aim of the systematic review**

This systematic literature review aimed to explore and synthesise evidence from previous studies on self-harm and resilience factors in adult mental health patients. It aimed to identify what adult mental health patients who self-harm consider as most common and most effective resilience factors to self-harm and to identify key gaps in knowledge and understanding.

3.3 **Background**

This systematic literature review would involve a systematic search and collection of relevant information about a self-harm and resilience factors in adult mental health patients to critically appraise and identify gaps and areas of common knowledge for a better understanding and identification of area for further research (Hart 2000; Hek et al., 2002; Snyder, 2019). Reviewing literature would not only be about the gathering of information but also about searching for answers to questions and solutions to problems (Aveyard, 2014)

The transparent guidelines by Moher et al., (2009) with the potential for reproducibility are followed to provide direction to the systematic review. This is referred to as Preferred Reporting Items of Systematic reviews and Meta-Analyses (PRISMA).

3.4 **Method**

Identification of existing literature was made by systematic search of the main electronic databases covering psychology and nursing, considered appropriate after consultation and advice of the University of Sunderland subject librarian was sought. The selected databases included the following:

- Psychology Information (PsychINFO)
- Cumulative Index to Nursing and Allied Health Literature (CINAHL)
- Ovid Medical Literature Online (MEDLINE), and
- Psychology Articles (PsychARTICLES)

These databases were considered because they contain relevant materials for the topic under review, in psychology and nursing.

3.5 **Literature search strategy**

The search was broken down to relevant search terms using the “PICO” format (Patient group (P), Intervention (I), Comparison (C), Outcome (O)). Following the PICO format, the subject under investigation was broken into keywords: “adult mental health patients,” “resilience factors” and “self-harm.” For a quick overview of the PICO formation, see Table1.

Table 1: Search terms using (**PICO**) format.

Patient group(**P)**	Intervention (**I)**	Comparison(**C)**	Outcome (**O)**
"Adults mental health patients"	"Resilience factors"		"Self-Harm"

P-Problem or Patient

I-Issue or Intervention

C-Comparisons (if any)

O-Outcomes

3.6 **Inclusion and exclusion criteria**

Research articles were included or excluded according to their relevance to the research aim.

Inclusion criteria:

- Qualitative, quantitative and mixed methods research papers, published in English between 2013 and 2023 (inclusive)
- Research articles on resilience to self-harm from the perspectives of adult mental health patients who self-harm
- Research articles on self-harm
- Articles on resilience factors and self-harm
- Articles on adults and self-harm
- Articles on self-harm in the adult (18-64yrs) mental health population

- Articles on intentional injury to self without suicidal intent, which includes for example cutting or severe scratching of skin, burning or scalding, hitting self or head banging, punching things to harm self, throwing self against objects to harm self, sticking objects into skin or piercing with objects to harm self, intentional picking and digging into wound to prevent healing, swallowing poisonous substances or inappropriate objects, and taking overdose of prescribed medication.

Exclusion criteria:

- Research articles not related to self-harm.
- Studies not published in English language.
- Articles not published within range 2013-2023
- Studies conducted within older adult, adolescent, or children's mental health services.
- Articles that describe self-harm as socially acceptable behaviours such as ear piercing and body tattooing
- Articles that describe self-harm associated with autism or other developmental disorders (Ross et al., 2009)
- Articles focusing on suicide or on self-harm with suicidal intent.

Boolean operators AND, OR and Truncation with symbol (*) were used to widen the search. Truncation application on a root word returns from the database results that will include any ending of the root word. Boolean operation using connecting words AND, OR, NOT acts as a bridge between keywords or concepts, which can narrow or widen a search.

Advance searches of the electronic databases PsychINFO, CINAHL, MEDLINE and PsychARTICLES were conducted simultaneously on EBSCOhost platform using the same search criteria. Keywords for **PICO** formation were searched. The search keywords for**" P**" (patient group) includes adult* mental health patient* OR psychiatr* patient* OR adult* OR patient*. The search terms for **"I"** (Intervention) includes: resilien* factor* OR resilien*. cop*

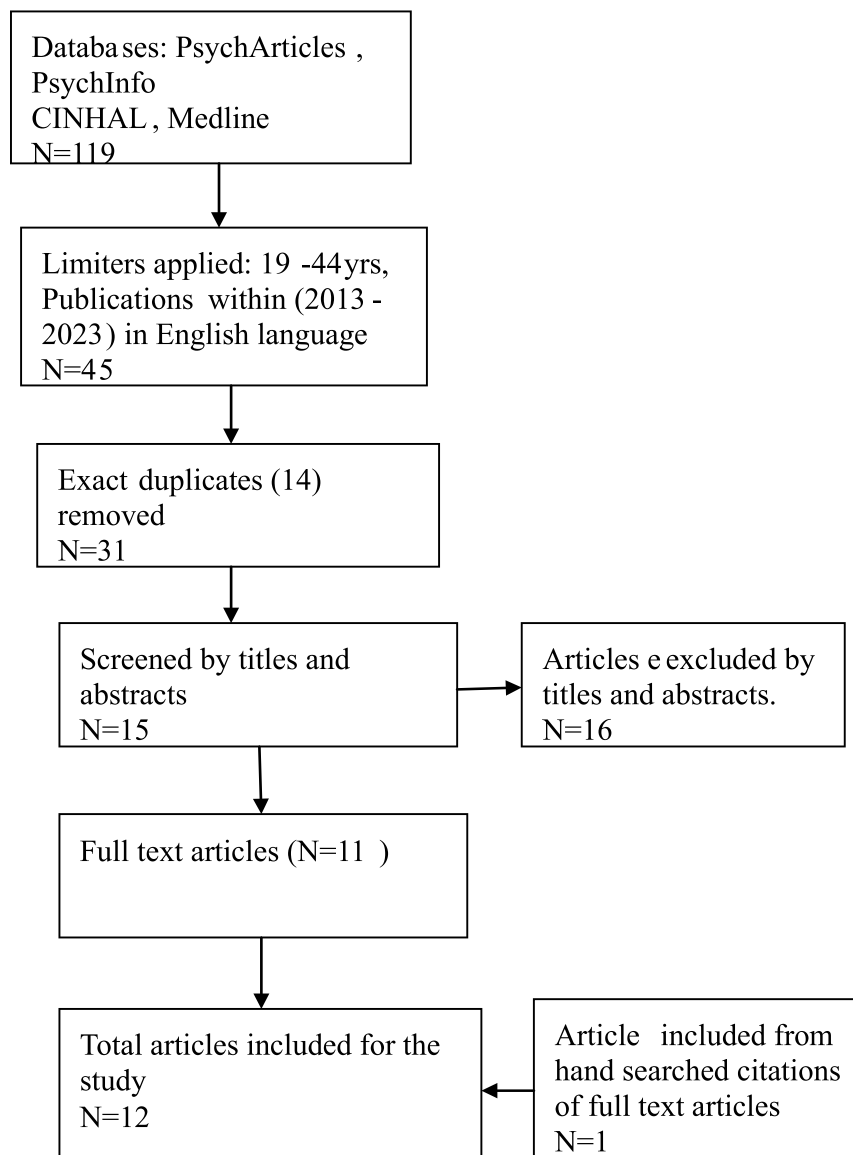
OR cop* strateg* OR adapt*. The search terms for **“O”** (outcome) includes self-harm* OR deliberate self-harm* OR self-injur* OR self-mutilat* OR intentional self-harm* OR nonsuicidal self-injur*.

The search results for “**P”** returned 1,767,584 results. The search for **“I”** returned 139,459 results, while the search for “**O”** returned 4,000 results. The results from the three components **“P”, “I”** and **“O**” (**“C”** component not implicated) were combined using the Boolean logic “AND”. The combination search (**P+I+O**) returned 119 results. This was reduced to forty-five (45) results by limiting the year of publication (2013-2023), and restricting the search to articles published in English and in academic journals. The reason for limiting the articles to 2013-2023 was to capture contemporary articles on the subject. Exact duplicates of articles (14 duplicates) were removed, reducing the result to 31 articles, carefully checked for relevance by looking at the titles. Fifteen articles were considered relevant based on their titles. The abstracts of the 15 articles were further checked for relevance, and eleven articles met the inclusion criteria.

Citations of the eleven articles selected for review were also carefully hand checked to see if there were further articles meeting the inclusion criteria that might have been missed. One article met the criteria for inclusion, making a total of twelve. See Fig.1 for study selection process (below) and Appendix 1 for search history.

Figure 1

Flow chart: literature selection process



3.7 **Characteristics of identified studies**

A total of twelve studies (six qualitative, five quantitative and one mixed) were identified for narrative synthesis. Among the twelve studies, four were conducted in USA, three were conducted in UK, two studies each were conducted in Asia and Canada, and one study was conducted in Europe. The studies were published in English language between 2013 and 2023 (Appendix 3A, Table 2). See next page for a brief overview of the included studies:

Author(s)/year/ Journal	Title	Research method
Hunter et al., (2013) Journal of affective disorders United Kingdom	Service user perspectives on psychosocial assessment following self-harm and its impact on further help-seeking	Qualitative Interpretative phenomenological Analysis (IPA) N=13
Turner et al., (2017) journal of Behavioural and Cognitive Therapies Canada	Characterising interpersonal difficulties among young adults who engage in non-suicidal selfinjury	Quantitative Comparative study Intensive micro-longitudinal method N=116
Wadman et al., (2017) Journal of health psychology United Kingdom	An interpretative phenomenological analysis of the experience of self-harm repetition and recovery in young adults	Qualitative N=6
Trepal et al., (2015) USA	A cross-sectional matched sample study of nonsuicidal self-injury among young adults support for interpersonal and intrapersonal factors with implications for coping strategies	Quantitative A cross-sectional study N=282
Jacobson et al., (2015) Archives of suicide research USA	The association of interpersonal and intrapersonal emotional experiences with nonsuicidal self-injury in young adults	Quantitative N=449
Steinhoff et al., (2020) Switzerland	Stressful life events in different social contexts are associated with self-injury from early adolescence to early adulthood	Quantitative Comparative study N=1,480
Turner et al., (2019) Suicide and life threatening behaviour USA	Experiencing and resisting non-suicidal selfinjury thoughts and urges in everyday life	Qualitative N=60
Macrynikola et al.,(2018) Comprehensive Psychiatry USA	Social connectedness, stressful life events, selfinjurious thoughts and behaviours among young adults	Quantitative Cross sectional survey N=1712
Liu, 2023 Journal of Psychological medicine United Kingdom	The epidemiology of non-suicidal self-injury: lifetime prevalence, socio-demographic, and clinical correlates, and treatment use in a nationally representative sample of adults in England	Qualitative Survey N=7,192
Lewis et al., (2019) Journal of Clinical Psychology Canada	Understanding self-injury recovery: Views of individuals with lived experience	Qualitative study using thematic analysis N=233
Kim and Hur (2023) Journal of the international academy for suicide research Asia	What's different about those who have ceased self-harm? Comparison between current and lifetime non-suicidal self-harm	Qualitative study N=490
Devassy et al., 2023 Frontiers in Public health Asia	Vulnerabilities and life stressors of people presented to emergency departments with deliberate self-harm: consolidating the experience to develop a continuum of care using mixed method framework	Mixed-methods study N=44

3.8 **Quality assessment**

The Critical Appraisal Skills Programme (CASP) is primarily designed to help healthcare professionals critically evaluate research studies. It provides checklists and guidance to assess the validity, results, and applicability of research across various study designs.

Critical Appraisal Skills Programme (2024) was adapted to appraise all the twelve studies included in this review. The qualitative and the quantitative checklists were used to appraise the qualitative and the quantitative strands of the mixed studies respectively. It was used to evaluate the credibility of each study design selected for inclusion. CASP is a 10-item tool that has the first two elements or items focusing on the aims and methodology of the research. A "yes" or "no" response is required for the first two questions, whereas the remaining eight questions are focused on the value of each of the twelve research articles that met the criteria for inclusion in this study. The rating scale as per Duggleby et al. (2010) was applied. This scale has score range of 1 to 3. Score of 1 indicates weak quality, 2 indicates moderate and a score of 3 indicates strong quality. See Appendix 2 for Table 3 on CASP score and an illustration on how the researcher applied CASP tool for quality appraisal. For the details of the included studies on Table 2, see Appendix 3A.

3.9 **Data synthesis**

A narrative, textual approach will be used to summarise, analyse, and assess the body of evidence included in this systematic review (Popay et al., 2006; Siddaway, Wood, and Hedges, 2019). This approach is suitable as it allows for the integration of diverse forms of evidence, including both qualitative insights and quantitative findings, enabling a more comprehensive understanding of complex or heterogeneous data. Narrative synthesis is particularly valuable when studies vary in design, outcome measures, or context.

Narrative summary shares some overlaps with thematic analysis (McAllum et al., 2019). It involves the identification of prominent or recurrent themes in the literature, summarising the findings of different studies under thematic headings, with tabulation providing descriptions

and summary of the key points (Mays, Roberts and Popay, 2004). Thematic analysis constitutes a versatile method of qualitative data analysis, renowned for its adaptability across a broad spectrum of research designs (Dixon-Woods et al., 2005; Mays, Roberts and Popay, 2004; Riger and Sigurvinsdottir, 2016). This flexibility, combined with its efficacy in synthesising commonalities across heterogeneous studies, underpins its utilisation within the narrative synthesis phase of the present research (Lucas et al., 2007; Popay et al., 2006; Mays, Roberts and Popay, 2004).

The synthesis of findings from the studies included in this review was systematically guided by the framework for narrative synthesis articulated by Popay et al. (2006). This involves:

1. Developing a preliminary synthesis
2. Exploring relationships within and between studies
3. Assessing the robustness of the synthesis

During the preliminary synthesis phase (Stage 2 of Narrative synthesis), thematic analysis was conducted employing the seven-step approach originally outlined by Noblit and Hare (1988).These sequential steps comprise getting started, determining what is relevant to the initial interest, reading the studies, identifying relationships among the studies, translating the studies into one another, synthesising these translations, and presenting the synthesis. This method resonates closely with the foundational principles of thematic analysis as elaborated by Braun and Clarke (2006), Clarke and Braun (2022) and Caulfield (2022), offering a rigorous yet adaptable framework for discerning and interpreting patterns across diverse studies.

After literature screening, the full text articles that were identified for inclusion to answer the research questions were carefully read several times by the researcher to familiarise himself

with the data. In each study, the researcher noted recurring themes and key findings. This was followed by extracting key themes and concepts relevant to the research questions.

Through constant comparisons between the studies, the themes and concepts were grouped together. This was accomplished by listing the themes and concepts side by side for comparisons and connections (see Appendix 3B, Table 4 Column1).

The overarching key themes were generated to capture the listed groups of themes. Then the themes were compared across studies to ensure key themes capture similar themes from different studies (Atkins et al., 2008). The next stage involved interpreting and translating studies into one another. This was done by comparing and interpreting the themes from Study 1 and Study 2, to achieve a synthesised finding, which was in turn, compared with Study 3. The process was repeated for the remaining 9 studies.

The next stage, development of the second order construct, was achieved by considering and interpreting each theme and applying them as building components (see Appendix 3B, Table 4 Column 3). The second order constructs were refined to achieve the third order interpretations, yielding an overarching model of findings. This generated four core concepts: social connection and belongingness; socio-economic factors; psycho-social factors; and religion and cultural belongingness.

3.9.1 Social connection and belongingness

Most of the studies included for analysis in this review have evidenced the need for interpersonal attachment, belongingness or social connection, lack of which has been associated with negative outcomes such as depression, emotional dysregulation and self-harm (Macrynikola, Miranda and Soffer, 2018; Wadman et al., 2017; Liu, 2023; Devassy, 2023; Turner et al., 2017; Jackobson et al., 2015; Kim and Hur, 2023).

Though some of the studies (Turner et al., 2017; Wadman et al., 2017; Devassy et al., 2023) have shown that social connection and belongingness are protective factors to self-harm

there are noted methodological differences especial regarding the applicability of findings to a wider adult population. For example, in the study that examined the daily interpersonal experiences of participants (n=60 with history of NSSI; n=56 without history of NSSI), participants with a history of self-harm reported multiple interpersonal problems and less contact with family and friends (Turner et al., 2017, p.366). However, this study appears to have limited demographic application. This is because it focused on adults aged 18-35 and may not be applicable to the older adult population. In addition, the research depended on the participants' diary reports of interpersonal problems. This may have introduced interpretation retrospective recording bias. Therefore, further research covering a wider adult population is desirable. Similarly, in another study interpersonal problems were highlighted as capable of precipitating self-harm, one participant reflected: "I felt a lot of guilt…for annoying my family…I just wanted to hurt myself because I felt like I deserved it at the time" (Wadman et al., 2017, p.1635).This quote agrees with the association of intrapersonal emotions such as self-criticism, low self-worth or self-hatred, and self-harm (Turner et al., 2017, p.368; Jacobson et al., 2015; Hunter et al., 2013; Kim and Hur, 2023). This is demonstrated in the participant's self-criticism "I felt I deserved it (self-harm)". The emotion of self-hatred appears to have culminated in the participant's self-harm. Though Wadman et al. (2017) used Interpretative Phenomenological Analysis (IPA) to explore participants' perspectives on self-harm, again they explored a young adult population (19-21years), hence the findings may not be applicable to a wider adult population. In addition, the study did not specifically discuss resilience in context of self-harm. In another study the interpersonal emotion of rejection was expressed by participant P2: "no one understands me, even my mother" (Devassy et al., 2023, p.5). Though this evidences interpersonal problem association to self-harm experience, the inclusion of participants less than 18yrs may have introduced bias.

In younger participants (<30yrs; mean age=28.8yrs), social and interpersonal issues such as failure of romantic and family relationships were also reported as stressors to self-harm:

“…my girlfriend cheated on me. I sacrificed a good job and a secure life for the sake of this relationship…” (Devassy et al., 2023, (P8), p.5). Similarly, P27 said: “we were in a relationship for four years, but I realised… for him, it was only a time pass”. P23 said: “my girlfriend avoids me, she blocked my contacts on WhatsApp, Instagram and Facebook” (Devassy et al., 2023, p.5). Although there appears to be an association of romantic relationships issues with self-harm in the unmarried participants, participants who were in marital relationships also experienced similar stressors. For example, a 31yr-old female said: “I am incompetent wife that is why he is into an extra-marital relationship” (Devassy et al., 2023, p.5). However, in his study, Liu (2023) reported higher NSSI among participants who were never married and those who did not grow up with both parents in the household. This implies that the marital relationship could also be a protective factor to self-harm and those raised by a single parent have higher propensity to self-harm. So, childhood experiences are important in building resilience to self-harm. It can be argued that children who experienced an abusive upbringing may have to deal with the emotional pain as adults, when they remember the traumatic experience, they suffered. Despite this, there appears to be disproportionately less research focusing on self-harm in the adult population, requiring more research on adults to explore their perspectives as already mentioned.

Macrynikola, Miranda and Soffer (2018) explored the relationship between stressful life events (SLEs) and risk for various forms of self-injurious thoughts and behaviours (SITBS), and the potential for cushioning effect of social connectedness. The study reported that high level of SLEs and low social connections were both associated with various forms of SITBs in various adults’ populations. Higher stressful life events may therefore require higher social connectedness to cushion the propensity to self-harm. Nonetheless, Macrynikola et al. (2018) clarified that increasing social connectedness, while it may decrease the risk of self-harm, it may not necessarily diminish the effect of SLEs on self-harm. Therefore, further

studies may be necessary to explore the perspectives of those with the lived experience to understand the effect of their SLEs and what would effectively protect them from self-harm.

3.9.2 Socio-economic factors

Most studies reported stressful issues such as failure to achieve or meet expected goals, loss of earnings/jobs, demise of loved ones, divorce, and unresolved debts as socioeconomic issues that are consistently associated with self-harm (Liu, 2023; Kim and Hur, 2023, Devassy et al., 2023, p.7; Wadman et al., 2017). In a cohort study of adult patients admitted to the hospital for self-harm, 57% repeated self-harm. The repeated self-harm was self-reported and associated with unemployment and divorce (Wadman et al., 2017, p.1632). Reducing the risk in different social contexts and improving coping skills was reported in reducing risk of self-harm (Steinhoff et al., 2020). However, there is no contextual linking of resilience and self-harm, warranting further exploration which this study also seeks to address.

In another study, prevalence of depression and anxiety were linked more with self-harm, especially in unemployed urban participants (Devassy et al., 2023, p.4). Economic factors such as unemployment and debts, insufficient earnings, and financial insecurity were highlighted as main stressors: “I am a salesperson, and my income is spent on my family….” Similarly, another participant, Mr S said: “I have been an incompetent provider…” (Devassy et al., 2023, p.7).

A hostile work environment was also highlighted to be a trigger to self-harm: “My boss takes advantage of me; he harasses me to get the work done” (Devassy et al, 2023, (P43), p.7). Yet another participant (P12) said: “My superior officers never acknowledge my contributions”. A recruit on the job said about his colleagues: “they never share the information required to complete my work. I struggled hard to get it…” Unhealthy work situations like poor interactions and mistrust were highlighted: “I don’t share. Whatever I shared in the past turned against me…” Though being employed has been reported as protective against financial stress and

self-harm, employment-related stressors can trigger self-harm. It would therefore depend on assessment of individual circumstances to identify from participants' perspectives their protective or resilience factors to self-harm.

Some participants reflected some socio-economic aspects of their self-harm experience. For example, a participant in Wadman et al. (2017, p. 1637) was concerned about scars from her self-inflicted wounds and her blood-stained clothes, and she wondered about the possible impact of her self-harm behaviour on her social life and the economic cost. According to this participant, there are social and economic consequences of self-harm. The social consequence is that the participant's self-harm could jeopardise her relationship, as she may lose her boyfriend because of her self-harm behaviour. The economic consequences are that she would have to deal with the costs of changing or washing her clothes and probably taking care of her self-inflicted wound or going to the hospital.

Similarly, reflecting on the socio-economic consequences of self-harm, another participant said: "I am sick of that (self-harm) and I don't want to do it anymore, and I get sick of all the blood and all the mess, and having to buy bandages and plasters and everything all the time…I' m sick of that and I don't want to do it anymore" (Wadman et al, 2017, p.1637).

According to these participants, thoughts of the socio-economic consequences of self-harm (by "cutting") could be a protective factor to their self-harm: "I don't want to do it (self-harm) anymore". However, this may not be the case as it could only lead to exploring other methods of self-harm such as taking an overdose of medication. It would be beneficial therefore to explore the perspectives of those with the lived experience for a deeper contextual understanding of their resilience factors to self-harm.

3.9.3 Psycho-social stressors

Some participants who self-harm tend to experience multiple difficulties, some of which are psychological in nature (Hunter et al., 2013, p.315). Hunter et al. (2013), in an Interpretative

Phenomenological Analysis (IPA), analysed interview data from 13 participants and posit that social interactions between staff and patients helped their psychological issues such as hopelessness and negative self-worth, which are triggers to self-harm behaviours. According to Steinhoff et al. (2020), chronic psychological stressors such as emotional stress, work stress, environmental stress and relationship stress are associated with self-harm behaviours.

Similarly, in another study by Lewis et al. (2019) psychological issues such as low self-worth were reported to be associated with self-harm. In coping with self-harm, one participant described recovery as: "Accepting myself, my thoughts and behaviour and learning to love myself again" (Lewis et al., 2019, p.2128). This evidences that self-acceptance can be a positive factor in building resilience to self-harm. Again, another participant described total acceptance of self and being happy as strategic in building resilience to self-harm (Lewis et al., 2019, p.2128). On the other hand, self-rejection or low self-worth may negatively impact resilience to self-harm. This view was echoed by a participant in another study: "…all these negative things are all triggered by, you know, my idiocy, my stupidity..." (Wadman et al., 2017, p.1635).

There are reported associations of psychological stressors and mental wellbeing in precipitating to self-harm, as evidenced by the following excerpt: "…recovery means being able to deal with my other problems along with self-harm because self-harm is often caused by other emotions" (Lewis et al., 2019, p. 2128). According to this excerpt, recovery would mean the ability to deal with other problems that could lead to self-harm, such as emotional disorder (e.g. depression). Recovery from self-harm, in this sense, appears to be in tandem with resilience to self-harm-"being able to deal" with the identified triggers to the participant's self-harm. However, Lewis et al., (2019) may have lacked the depth of participants' experiences of self-harm due to the method used in data extraction. The study used online open-ended questions which did not have the back-and-forth dialogue which is usually applied

in the interview form of data extraction to interrogate and explore participants' deeper experience.

In the study by Kim and Hur (2023), participants that have higher psychological resources were reported to have higher self-esteem, which is consistent with the findings of Lewis et al., (2019). In Lewis et al. (2019) and Kim and Hur (2023), resilience is viewed as the ability and dynamic process of adapting well and overcoming adversity to maintain psychological and physical functioning. Those who recently engaged in NSSI showed lower self-worth or higher self-criticism, suggesting association of self-worth or self-criticism to resilience. Kim and Hur (2023) found that the participants' group with current NSSI had lower resilience than the lifetime NSSI group. Nonetheless, it was reported that both those who continued and those that discontinued NSSI have significantly lower resilience than the controls without NSSI history. This may imply that resilience might not be fully recovered even after an individual had discontinued NSSI (Lewis et al 2019. p. 2129). Hence, caution is required in stating that resilience increases with decrease or cessation of self-harm. The finding in Kim and Hur (2023) may not also be generalised as the sample was predominantly female. Notwithstanding, overall, they maintained that psychosocial issues are associated with NSSI despite predominance of female as their prevalence in NSSI study is common (Bresin and Schoenleber, 2015). The findings in Kim and Hur, (2023) may also be limited as they are reliant on self-reports, which may be biased and different from objective psychological measures.

As stated earlier, patients with self-harm have multiple psychological and social problems (Kim and Hur, 2023, Lewis et al., 2019; Devassy et al., 2023), and due to the complex nature of their psycho-social problems, services are yet to make significant psychosocial interventions to reduce repetition of self-harm (NICE, 2022; Kapur et al., 2010). Few psychosocial interventions had success in reducing self-harm repetitions. Further research may be required to establish effective psychosocial intervention across patients' groups presenting with self-

harm (Hunter et al., 2013). Therefore, it would be helpful to explore the perspectives of adults with lived experience of self-harm to understand what helps them reduce or stop self-harm. This is because most studies included in this review did not explore this and the very few that did, either failed to use IPA for better depth or focused on younger age population.

Jacobson et al. (2015), in their study, reported that those who found it difficult to express their emotions were at higher risk of self-harm than those who do not. Similarly, this was noted in the study by Kim and Hur (2023), where those who have difficulties in expressing their emotions (alexithymia) were reported to have higher risk of self-harm than those who do not. This was the same after controlling for their depressive symptoms, indicating that emotional expressiveness is important in coping with self-harm and should be a target in the plan of intervention for those with self-harm behaviours. Furthermore, difficulties in expressing emotions may be linked to poor interpersonal skills in those with self-harm behaviours as already mentioned, suggesting the interconnections and complex nature of resilience to self-harm, which may need further study.

3.9.4 Religion and cultural belongingness

Participants who engage in NSSI reported low ethnic belongingness and interpersonal support and higher levels of intrapersonal issues (for example, depression and anxiety) than those who did not engage in NSSI. Individuals engaging in NSSI are significantly less likely to engage in problem-focused support or engage in religious or spiritual forms of coping (Trepal, Wester and Merchant, 2015b; Chaudhry et al., 2023). Adults of ethnic minority tend to deal with certain challenges as immigration issues, racial discrimination, unemployment and economic and psycho-social issues that can increase distress which may culminate to self-harm, and are unlikely to seek help (Trepal, Wester and Merchant, 2015). They face more economic hardships and may experience more SLEs than their Caucasian counterparts (Macrynikola, Miranda and Soffer, 2018; Trepal, Wester and Merchant, 2015).

Though discrimination is a peculiar stressor and increases the feeling of not belonging (Suc et al 2007; Welter et al., 2023). Nonetheless, the disproportionate distribution of the ethnic minority groups in a dominant Caucasian community may be argued as the reason for feeling excluded and not necessarily due to discrimination.

For the relationship of self-harm and ethnic groups, lower rates of black people of African origin compared to Caucasians were found with self-harm. This suggests more communal lifestyles of people of African origin, their ethnic belongingness and cultural affiliation as protective factor to self-harm (Chatters et al 2011; Hunter et al., 2013). However, it is worth mentioning that general applicability of religious beliefs as protective factor to self-harm has the potential limitation of not having a standardised measuring instrument to measure or compare religious beliefs, especially in a multi-ethnic population with different religions (Kannan et al, 2010).

Despite the growing recognition of religion and cultural belongingness as potential resilience factors, the perspectives of adult mental health populations on this remain scarce. Future research that would focus on this belongingness is desirable to assess the protective functions of ethnic identity, culture, and spirituality. This will enhance theoretical understanding and inform the design of more effective, culturally responsive clinical interventions.

3.10 **Discussion**

This systematic review of relevant literature around self-harm and resilience factors in adult mental health patients examined, critically appraised and synthesised existing knowledge to identify gaps in knowledge and understanding.

Common association of self-harm and social connectedness such as support or connection with families, peers, and friends, were highlighted across most of the studies that were reviewed (Macrynikola, Miranda and Soffer, 2018; Liu, 2023; Devassy, 2018; Turner et al., 2017; Jackobson et al., 2015; Kim and Hur, 2023, Hunter et al.,2013; Trepal et al., 2015).

Interpersonal and intrapersonal issues such as interpersonal deficits, rejection, resentment, anger, self-criticism, anxiety, and depression were reported to impact on social connectedness, a protective factor to self-harm. Building on or improving on adults' social network (social connectedness) was found to reduce the risk of self-harm behaviours. However, this was not reported to mitigate the effect of SLEs on the risk of Self-harm (Macrynikola et al., 2018).

Adults who find it difficult to express emotions are at increased risk of self-harm than those who can manage their emotions well by relying on their coping strategies such as the application of good interpersonal skills (Colleen McClain et al 2013, Turner et al 2017, Chaudhry et al., 2023). Participants with history of self-harm report multiple interpersonal problems (Turner et al., 2017, p. 316), evidenced in their interpersonal functional deficit such as difficulty in initiating and sustaining relationships, communicating emotional information, express supportive interactions, regulate unpleasant outcome in interpersonal engagements and to ask for support when in distress (Claes et al 2010, Hoff and Muehlenkamp 2009, Buhrmester et al 1998, Macrynikola, Miranda, and Soffer, 2018).

Socio-economic factors such as unemployment, debts and other financial stress are associated with self-harm. However, being employed may not necessarily be a protective factor to all as it may depend on individuals' employment circumstances. Some work environments are hostile and are potential triggers to self-harm (Devassy et al., 2023). Economic issues such as poverty and inability to meet financial commitments in the family have been linked to divorce and poor parenting, which has also been associated with self-harm (Kim and Hur, 2023). Self-harm has been reported by some as providing relief from emotional pain also repeat self-harm have been noted with some measure of economic impact due to the practical costs and stress of self-care following self-harm (Wadman et al., 2015, p.1637; Brown and Kimball, 2013).

Kapur et al. (2008), Wadman et al., (2017); and Kim and Hur, (2023) found no clear association between psycho-social assessment and repeat self-harm. Nonetheless, psychosocial assessment remains central to self-harm management and intervention (Hunter et al., 2013). This is because it both provides the opportunity for patients with self-harm behaviours to be assessed by care professionals, to identify and meet their needs, and at the same time, provide therapeutic engagement. Interpersonal support from care professionals provides the opportunity to patients for one-to-one therapeutic engagements, builds rapport, improves trust, brings re-assurance, and encourages openness in expressing emotion by the patients.

According to Steinhoff et al., (2020), stressful life events (SLEs) or social distress can occur in all social contexts, including peer network, intimate relationships, and family network. This study also suggests that multiple SLEs over a period could be a trigger to self-harm irrespective of the social context of SLE. Thus, protective factors or resilience factors could be overwhelmed by certain magnitude of SLE. Nonetheless, it can be argued that this might not be applicable to all, as some patients may never be overwhelmed by certain types of SLE to the extent of resorting to self-harm. Notwithstanding, targeting patients' perceived effective resilience factors to self-harm behaviours will be beneficial in reducing self-harm by building on their reported effective protective factors. This research seeks to address this gap by exploring the perspectives of those with the lived experience of self-harm on their protective factors. Therefore, it is not only important to focus on reducing patients' perceived SLE magnitude to reduce their propensity to self-harm but also to target building on their reported coping strategies or effective resilience factors to self-harm.

Engagement in NSSI is less likely to be associated with individuals of ethnic minority than the ethnic majority or Caucasians. However, it has been argued that the difference in the NSSI engagement is not necessarily due to the individuals' ethnicity but rather due to their self-identified ethnic belongingness. The sense of belongingness appears to be the main

protective factor. Cultural identity, spirituality or belief and religion tend to share values that are protective against NSSI, as individuals who do not engage in NSSI are more likely to engage in problem or emotion focused coping than those who engage in NSSI.

In some cultures, and religions, according to their shared values, NSSI is prohibited hence belongingness to such culture and religion may be a protective factor to NSSI. However, due to the prohibition some NSSI are less likely to be disclosed. Belongingness (connectedness) to people, or belief, irrespective of race appears to be the key in building resistance to NSSI (Trepal et al., 2015; Nock et al., 2010). Intrapersonal problems such as anxiety and depression are found to be more associated with NSSI and less with ethnic, cultural and religious belongingness. Promoting spiritual and cultural wellbeing could therefore increase resilience to self-harm.

Overall, there are observed interconnections or associations across the four main themes that were highlighted after the synthesis of the reviewed literature (Hunter et al., 2013; Devassy et al., 2023). For example, economic factors such as unemployment and financial crisis could trigger intrapersonal conflicts as anxiety, depression, and low self-esteem (psychological stress), which may affect social connection. Overtime, the common effect of the active stressors could result in being overwhelmed. This may eventually lead to the selfharm as a maladaptive coping strategy. The inter-connection of the risk factors or triggers to self-harm depicts the complexity of self-harm and the multi-factorial nature of the protective or resilience factors and the self-harm interventions. In this review, few studies show the existing knowledge of self-harm protective factors as it provides an interpretative synthesis of the adult mental health patients' lived experience of self-harm. However,the findings of most studies were limited by their scope of coverage of the adult population. Further research is warranted, to focus on a wider adult population and explore their perspectives of self-harm and resilience factors. Addressing this gap will be beneficial in developing more effective care and better patient outcomes.

3.11 **Implications for clinical practice**

Those who actively self-harm or repeat self-harm are at high risk of suicide (Knipe et al, 2022; NICE, 2022; Mann et al., 2005). Clinically, they are better managed in a secure or controlled hospital setting where for example the environment is structured to reduce access to the means of self-harming, offer opportunity for a closer observations and interventions of care professionals. Psycho-social assessment is imperative and core in planning interventions by professionals to offer interpersonal therapeutic engagement, explore needed support (Hunter et al., 2013) and re-enforce coping skills (Wadman et al., 2017). Clinical services should provide information on self-harm and psycho-social resources and how to access the available support. Professionals should have regard to the complexities of self-harm behaviours; the shame, feeling of guilt, sense of worthlessness, frustration, and the challenge of expressing emotions by patients (Colleen McClain et al., 2015). Support and information on self-harm behaviours should also be shared with patients and their carers (NICE, 2022).

Management strategies of those who self-harm are not well documented in literature. Health care professionals often resort to use of effective communication skills to verbally de-escalate and manage the patient. It is therefore essential to understand the relationship between psycho-social factors and self-harm behaviours in people with mental illness. This is to take advantage of the protective or resilience factors such as intrapersonal and interpersonal skills, good social support network by friends, families and people that share religious beliefs or cultural background (Trepal et al., 2015, Turner et al.,2017, Macrynikola et al., 2018, Steinhoff et al., 2020).

Health care professionals and other professionals involved in provision of holistic care should be made aware in training, the importance of understanding the relationship between interpersonal relationships, psycho-social, socio-economic, ethnicity and cultural factors and self-harm. This is to support a better assessment and management strategies of self-harm behaviours and facilitate possible multi-disciplinary approach to caring for people at risk. To

provide effective care to those who self-harm, health care professionals should engage in inter-professional practice and learning. This is because self-harm is a multi-faceted problem that require multi-disciplinary input (Liu et al 2006; Liu, 2023; Anderson, 2007). As highlighted in the study by Wadman et al. (2017), focus should not be on eradicating self-harm behaviours but on developing and building on coping strategies and skills.

3.12 **Future research**

This systematic literature review focused on self-harm and resilience factors in adult mental health patients and was guided by PRISMA and raises areas requiring further research. Qualitative research that will seek to explore details of protective factors to self-harm behaviours from the perspective of adult mental health patients is desirable as it remains grossly understudied. The review of literature shows that previous research focused more on self-harm in children, young adults, on the views of careers and professionals. Yet few of the studies employed appropriate methodology to explore details of the lived experience of self-harm. Further research is needed to use appropriate methodology to explore detailed perspectives of adult mental health patients with the lived experience of self-harm to identify the common and the most effective resilience factors to self-harm. This gap is addressed in the qualitative research in this thesis. It is hoped that this will help in precision management of self-harm for the target group (adult mental health patients).

3.13 **Limitations/challenges**

The topic under study is not without limitations or challenges- “Self-harm and resilience factors in adults’ mental health patients” has some complex concepts which share a wide representation in literature. The subject of self-harm attracts global interest and presents some challenges regarding definition, scope, and terminology.

As already discussed, self-harm is referred to or described using various phrases. For example, in the United Kingdom (UK), the term “self-harm” is commonly used whereas in the United States of America (USA) “Non-Suicidal Self Injury” (NSSI) is preferred (Caine 2012,

Kapur et al., 2013). Self-harm is referred to as: self-injury, intentional self-injury, self-mutilation, intentional self-wound, non-suicidal self-injury and so on. Further to the complexity of the concept of self-harm, there is no global consensus on the definition of self-harm (Allen, 2007). Therefore, it remains challenging to capture all representations of “self-harm”, especially in an electronic database literature search.

Similarly, “resilience” has different related words. Though rigorous search strategies were applied, all representations and meanings of “resilience” might not be captured. The same is also true and applicable to the concept of “adults” because the age range referred to as “adults” are not generally or universally applicable. For instance, in the United Kingdom the adult age is 18yrs and above. This may vary from one country to another. Nonetheless, for consistency and transparency 18-64yrs age bracket was applied in this study.

In Steinhoff et al. (2020), participants were referred to as “adolescents” albeit; the researchers in that study included the age range 18-20yrs in their sample. Therefore, based on the chosen age bracket of (18-64yrs) in this research, Steinhoff et al. (2020) met the inclusion criteria and researcher was able to extract relevant data from the study. Excluding this article based on participants being referred to as “adolescents” could have introduced some level of researcher bias as some vital information might have been missed.

The articles were searched in English language. All research articles that were not communicated or published in English language were excluded. The exclusion of these articles could limit access to valuable information on the research topic. This could also be a source of bias in this study. The articles that met the inclusion criteria were studies published in English language from United Kingdom, United States of America, Europe, Canada and Asia. An article from Netherlands (Europe) published in English language met inclusion criteria. Articles that were not originally written in English language were left out as they may be open for translation limitation.

This study is limited to adults within the 18 to 64 age bracket. Therefore, generalisation of findings must be approached with caution. Some relevant articles were excluded only because of not falling within identified age range for this study. Therefore, some relevant articles might have been excluded in this study.

3.14 **Conclusion**

Having systematically reviewed the literature in this study, consistencies have been found in the association between self-harm in adults and social network or connectedness, psychosocial factors, socio-economic factors, religion, and cultural belongingness. Religious attendance, spirituality, culture and belief systems are associated with reduction in self-harming behaviours, while socio-economic factors have both direct and indirect effects on self-harm. Strong social networks and connectedness serve as protective factors, reducing the likelihood of self-harm, whereas psychological issues such as stressful life events, interpersonal and intrapersonal conflicts, are triggers to self-harm.

Targeting the preceding associated factors would be strategic in self-harm prevention, minimisation and management in adult mental health patients. However, due to the limited scope of the adult age covered by most studies reviewed and the ambiguity of the concepts involved in this study (see 3.12), with regards to terminology and concept of “self-harm”, “resilience factors”, and “culture/spirituality”, further research may be required, as discussed under Section 3.13. Most previous research reviewed either focused more on self-harm in young adults or did not apply suitable methodology to explore the detailed experience of self-harm.

3.15 **Reliability**

Unlike other literature reviews, a systematic literature review is well structured and guided by the check list from Preferred Reporting Items for Systematic review and Meta- Analysis (PRISMA) (Moher et al., 2009). This ensures high reliability and transferability as it checks different sources of bias.

This study was based on literature accessed from reliable databases. As already discussed (under Section 3.6), the materials were accessed from psychology and nursing fields which relate to the subject under study. The databases: PsycArticles, PsycINFO, CINAHL and Medline were searched according to the stipulated guideline of research and literature search (Centre for reviews and dissemination 2009). Many relevant articles, journals, and books were identified and studied.

Necessary consultations and advice of expert subject librarians at the University of Sunderland were sought regarding literature search strategies and techniques. Articles used were from known authors, peer reviewed and published in standard and recognised journals of international recognition.

Articles selected for inclusion in the review were carefully screened for relevance using the exclusion/inclusion criteria. The articles were appraised using a CASP tool (Critical Appraisal Skills Programme, 2013), which provided guideline through a set of questions to facilitate quality assessments of articles included in the study. Part of the set of questions from CASP guidelines reflects on the ethical issues in research design and method. The application of CASP tool in systematically appraising of articles of various research designs was fundamental in remaining focused to the aim of the research (Aveyard, 2007). The CASP tool also helped to avoid researcher bias (Knock and Harrington 1998).

The methodology used in this study was in accordance with PRISMA, a detailed and consensually agreed protocol for conducting and reporting a systematic review of effectiveness (Centre for reviews and Dissemination 2009; Kahn et al 2003; Pawson et al 2005)). The methodology has been sufficiently rigorous with potential for replication or transferability by another researcher (Khan et al., 2003).

3.16 **Ethical issues**

Ethical issues must be considered in all research. In a systematic review of literature there is no contact with human participants. However, in this type of research, there are still some

ethical issues to consider. For example, this study was conducted and written up in accordance with the established review methodology, Preferred Reporting Items for Systematic review and Meta-analyses (PRISMA) as per Moher et al. (2009).

Harvard author-date system of referencing was used to acknowledge all the sources referred to in this study. Original sources of information used in this study were acknowledged. Direct quotes were properly referenced in accordance with the Harvard author-date referencing guideline. Good referencing is important because it shows the sources used in the study, allows easy access to the sources used, gives weight to the facts and claims made in the study and avoids plagiarism. The support and contributions of others in this review were specified, duly appreciated, and acknowledged.

In accordance to CASP tool, the protocols of seeking and obtaining informed consent from participants were considered in appraising studies to be included in this review. Sources of bias that could hamper the trustworthiness of this research were also taken into consideration and reflected in the CASP scores of the literature included for study.

Chapter 4: Methodology

4.1 **Introduction**

This chapter outlines the philosophical foundations of this research. It also engages with reflexivity; that is how the position of the researcher, such as professional role, beliefs, biases, ethnicity, religion, and gender has or might have impacted on the research.

4.2 **Research methodology**

Research is “an activity that involves finding out, in a more or less systematic way, things you did not know” (Walliman and Walliman, 2011, p.7). According to Brown (2006), research methodology can be referred to as philosophical framework and the foundation upon which research is conducted. It is described as the process, principles, and procedures by which a researcher seeks answers to questions (Kumar, 2019). According to Creswell and Creswell (2017), research methodology should meet the criteria of being the most appropriate to achieve the objectives of the research, should be replicable in other research of the same nature and will use specific technique(s) to answer the questions (Langdridge, 2007). Qualitative, quantitative, and mixed methods are the three main approaches to research. Quantitative research involves systematic scientific investigation of quantitative phenomenon using mathematical representations in testing hypothetical assertions and theories (Croswell, 2009). Qualitative research focuses on collecting data in form of words and not numbers through in-depth interviews, focus groups and participant observation (Patton, 2015). Mixed method allows researchers to use multiple methods in a single study to collect and analyse data. Suitable methodological approaches and methods are informed by research questions (Smith et al., 2009; Willig, 2008). A qualitative approach is appropriate in the study of complex phenomenon such as self-harm behaviours as it can use in-depth interviews of participants to generate rich data for analysis. Qualitative approach helps researchers understand a social construct through interpretation of participants’ subjective reasons, words, images, and perceptions of phenomena under investigation.

Qualitative methodology is not the same as the objective quantitative methodology which requires rigidity of data (Gunzenhauser and Gerstl-Pepin 2006). Qualitative methodology portrays a world in which reality is socially constructed, contextual, subjective, complex, ever-changing, and not absolute, (Denzin and Lincoln, 2018). Qualitative methodological approaches tend to be based on recognition of the subjective, lived experiences of human beings (Patton, 2015). Qualitative research: …"is inquiry aimed at describing and clarifying human experience as it appears in people's lives" (Polkinghorne, 2005, p157). This is consistent with the current research.

4.3 **Philosophical underpinning of research methodology**

Philosophical underpinning of research methodology is essential, as it provides guidance on the choice and rationale of the methodology adopted, ensuring the research process is thorough, credible and trustworthy. This provides the framework for the interpretation of findings to contribute to the wider knowledge of the phenomenon under study.

4.3.1 Epistemological and ontological assumptions

It is necessary to understand the epistemological and ontological assumptions underpinning how knowledge and reality is constructed in the choice of research methodology, as the researcher's; beliefs, personal thoughts, convictions, and interests can affect the choice of research design, analysis, interpretation, and findings. To explore self-harm and resilience factors from the perspectives of those who self-harm, the researcher's position on how knowledge and reality is construed is epistemological constructivism and ontological relativism, detailed later in Section 4.4.

4.3.2 Epistemology

This refers to the nature of knowledge, and how knowledge can be understood as meaningful. It is the study of knowledge, asking questions such as: "what is knowledge?" and "how do we know something?" (Couper, 2020, p. 275). This is important as it influences how

researchers frame their research in pursuit of knowledge (Moon and Blackman, 2014). According to epistemological subjectivism, reality can be expressed by individuals in a variety of ways using a range of communication methods and skills to interpret and give meaning to their experience, as they perceive it in their own world (Edirisingha, 2012; Moon & Blackman, 2014). However, according to epistemological objectivism, reality is independent of individuals' minds, implying that reality exists outside individuals' minds and are not dependent on individuals' perspectives (Edirisingha, 2012). This view is important due to its consistency, reliability, and provision of stable foundation for verification of truth claims against evidence. Epistemological objectivism is supported by ontological realism, which proposes one single reality as truth and espouses the existence of a real world independent of human experience. On the other hand, epistemological constructivism does not agree with the view of objective reality or truth. It argues that there is no pre-existing truth waiting to be discovered; rather, truth is encountered or will emerge consequent to our interaction in and with the world around us. This rejects the view of a pre-existing "real world" without human interaction or activity to generate or construct meaning to the problem, topic, or encounter. Participants' lived experiences of self-harm may vary, likewise their perspectives of "reality". This research focuses on exploring participants' individual accounts of their lived experience of self-harm and resilience factors from their perspectives, subjectively as "experts by experience", instead of the researcher exploring objectively participants' self-harm and resilience factors.

4.3.3 Key epistemological approaches in research

The three key epistemological approaches in research are positivism, constructivism and pragmatism. These will be discussed briefly to locate the researcher's approach.

Positivism (Objectivism)

Positivism concerns itself with observable facts based on scientific methods (Flick, 2018). Positivism holds that there are facts about the external world to be discovered, and our knowledge is based on our sensory experience, which can be accessed only through

observation and experiment (Cohen et al., 2018; Flick, 2018; Gray, 2021). It also holds that any research should aim to achieve objectivity, representativeness, and generalisability (Flick, 2018). Positivist research is essentially quantitative and dependent on statistics and large numbers of research participants. The research is conducted in a way that researcher values or influences are excluded to avoid bias and maintain objectivity (Cohen et al., 2018; Gray, 2021). However, the positivist approach has been criticized for not being suitable for all research (Flick, 2018; Cohen et al., 2018). For example, it is not suitable for research about human behaviour, such as self-harm behaviour, which is a complex, elusive and intangible phenomenon (Flick, 2018; Cohen et al., 2018). According to Flick (2018 p. 35) "If you want to understand such experience from the viewpoint of your research participants, you will need to set up an open research situation in which you will apply methods like a narrative interview". This will help to explore subjectively the perspectives of the participants.

Constructivism (Interpretivism)

Constructivism's epistemological position is in contrast with the view of positivism (Gray, 2021). Constructivists posit that our knowledge of the world depends mainly on our interpretation or understanding of human actions, experiences, and environment (Gray, 2021; Sol and Heng, 2022; O'Reilly, 2009). In this way, the interpretative role of researcher is required to make sense of the subjective accounts of participants (Alharahsheh and Pius, 2020; Andrade, 2009). This supports the researcher's choice of interpretative phenomenology, which is a common approach under interpretivism (Gray, 2021). The researcher will engage qualitative approaches to collect and analyse data.

Pragmatism

Pragmatism's focus is on practical solutions to problems. It posits that any ideas or principles are true if they are workable (Savin-Baden and Major, 2023). Pragmatism opposes the view that truth about the real world can only be accessed through a single research method. Instead, they hold that knowledge can be accessed through different methods (Savin-Baden

and Major, 2023; Kaushik and Walsh, 2019).Pragmatist research focuses on solving problems or answering questions by considering available suitable methods to collect and analyse data to understand and address the research question (Creswell and Creswell, 2018; Savin-Baden and Major, 2023). This philosophical view supports the use of mixed methods in research (Creswell and Creswell, 2018). “Indeed, pragmatists emphasize the importance of trying different methods and then evaluating them based upon their effectiveness, therefore good research is a trial-and-error process” (Savin-Baden and Major, 2023, p. 61).

4.3.4 Ontology

Ontology (the study of being) is the branch of philosophy that interrogates the nature of reality, particularly how we interpret the world around us (Braun and Clarke, 2013).
Researchers commonly refer to three main ontological views: ontological realism, relativism, and critical realism or ontological constructivism. Ontological realism maintains that truth is singular and assumes there is one singular truth which can be accessed through research, typically quantitative research where truth is objectively construed and absolute. Ontological realism assumes that what is observed in research is of this single truth (Braun and Clarke, 2013). Relativism is in direct contrast to realism. Relativism suggests that there is no absolute or singular truth but rather there are multiple realities. Relativists posit that truth is subjectively construed and contextual (Raskin, 2001). Ontological relativism draws from the philosophical view that reality is constructed within the human mind according to their individual experience. It maintains that reality is relative and that there is no true or one reality (Moon and Blackman, 2014). Constructivism views truth as socially constructed. However, it acknowledges that there is a universal truth which can only be partially accessed through research due to influences on perception of truth (Braun and Clarke, 2013).

The ontological position of researcher in this current study is ontological relativism which posit that truth is subjectively construed and contextual (Raskin, 2001) Researcher has adopted this view because of the topic under investigation where individuals’ experiences

and perspectives of truth in context of “self-harm and resilience factors” may not be singular but multiple and contextual.

4.4 **Choice of research methodology**

Qualitative methodology is most appropriate for this research, to explore the subjective lived experiences of self-harm and resilience factors from the perspectives of adult mental health patients and the factors they consider help to prevent or minimise self-harm behaviours.

According to Creswell (2003), no research methodology per se has advantage over another. However, the choice of appropriate methodology in this research is guided by research question(s), research objectives, existing knowledge, available time, and resources (Saunders et al., 2009). In this study, the research questions are designed to seek subjective accounts of the lived experiences of participants’ self-harm behaviours and how they manage them.

Researcher understanding of the research question and the aims and objectives underpin the methodology (Kumar, 2018; Ryan, 2022). The researcher’s philosophical stance of epistemological constructivism (interpretivism), where truth is subjectively construed, favoured the choice of Interpretative Phenomenological Analysis (IPA) to engage with the subjective account of participants’ lived experiences of self-harm. IPA involves the researcher trying to make sense of what participants are trying to make sense of. This is referred to as double hermeneutics (Smith and Eatough, 2007). The details for the researcher’s rationale for choosing IPA are provided under Section 4.7

4.5 **Constructing knowledge in qualitative research**

In qualitative research, there are various ways of constructing knowledge by applying a range of analytical techniques. However, in this research, IPA is considered the most suitable approach. Phenomenology offers an explicit focus on understanding individuals’ unique experiences (idiographic) (Cutcliffe, 2003) and enjoys a wider flexibility as it allows the use of

known or existing knowledge in analysis (Willig, 2008). Hermeneutic phenomenological approaches such as interpretative phenomenological analysis (IPA) clearly acknowledge researchers' influence and their theoretical position and do not diminish the influence of the researcher (Cohen et al., 2018; Gray, 2021). Phenomenological analysis is based on discussions and reflections of direct sense, perception, and experiences of the researched phenomenon. Therefore, either the researcher's own or other people's experiences and perceptions of the phenomenon can be crucial in phenomenological analysis (Gray, 2021; Sol and Heng, 2022; Alharahsheh & Pius, 2020). To this effect, IPA, which does not diminish the influence of researcher in the research process, is considered ideal for this study. However, the researcher is expected to account for how he might have or have influenced the research. This is covered under Reflexivity in Section 4.9

4.6 **Philosophical foundations of phenomenology**

As phenomenology is the methodology of this research, a brief account of the contributions of the key thinkers in the field is provided within this section. This includes Husserl, Edmund (1859-1938); Heidegger, Martin (1889-1976); Sartre, Jean-Paul, (1905-1980), and Merleau-Ponty, Maurice (1908-1961).

Early 20th century attributed Phenomenological Analysis (PA) to the philosophical works of Edmund Husserl (a professor at Freiberg University, Germany) and Martin Heidegger (Smith et al., 2009). Their work later developed in psychology, education, and nursing (Lopez &Willis, 2004). It is considered that there are two main approaches to phenomenology: descriptive and interpretive, both of which are valuable in conducting analysis.

Descriptive phenomenology was developed by Edmund Husserl and interpretive by Martin Heidegger (Connelly, 2010). Descriptive phenomenology captures the gross view of essences under investigation without the fine, minute, or detailed view of the essences to reflect the objective meanings of human experiences (Smith et al., 2009) whereas interpretative focuses on the fine details.

Edmund Husserl (1850-1938) defined phenomenology as the science of the essence of consciousness, with focus on intentionality, approached explicitly “in the first person”. Intentionality is a central concept that refers to the directedness of consciousness. This is the idea that every act of consciousness is always about or directed toward something. Phenomenology is referred to as the study of consciousness, that is, conscious lived experience from the first-person point of view. In this phenomenology, as per Edmund Husserl, different forms of experience are studied as they are experienced, from the perspective of the subject living through the experiences. According to Husserl, we are to practice phenomenology by “bracketing” the question of the existence of the natural world around.

Martin Heidegger (1889-1976) progressed his own philosophical view, referred to as existential phenomenology (Spinelli, 2005) or hermeneutic phenomenology (Smith et al., 2009), which was an “offspring” of Husserl’s descriptive phenomenology. Heidegger defined phenomenology as the art or practice “to let that which shows itself be seen from itself in the very way in which it shows itself from itself” (Heidegger, 1927, p. 7C.). This suggests phenomenology as the appropriate research methodology for exploring lived experience from a first-person perspective (see Section 4.4).

According to Heidegger, we and our activities are always “in the world”; our being is being in-the-world. Following this, he argued that we do not study our activities by bracketing the world rather we interpret our activities, and the meaning things have for us, by looking to our influence of the world. This is because our knowledge of the world depends mainly on our contextual relations to things in the world. The implication of Heidegger’s interpretative phenomenology is, studying phenomenon without setting aside (bracketing) the interpretation or understanding of human actions (e.g. self-harm behaviours) and experiences (Gray, 2021; Sol and Heng, 2022; O’Reilly, 2009). Therefore, this supports interpretative role in making sense of participants’ accounts (Alharahsheh and Pius, 2020; Andrade, 2009).

Max van Manen was of the philosophical view that language reveals the being within some historical and cultural context. This is understood by participant and researcher in interviews to generate textual data (Langdridge, 2007). The researcher moves in the 'hermeneutic circle', between part of the text and the whole of the text, to make essences of the phenomenon under investigation to establish truth (Langdridge, 2007**).** The researcher goes back and forth to the text, in "part" and "whole" to make interpretations. This is employed in analysis of data generated from in-depth interviews of participants to support emergence of themes. Max van Manen's hermeneutic phenomenology can be used to clarify phenomena, and it is useful in nursing and health research (van Manen, 2007; Smith et al., 2009) where it is used to explore complex phenomenon stressing openness and respect in engaging with stigmatised lived human experience such as self-harm behaviours.

Jean-Paul Sartre (1905-1980) believed that human beings live to make choices and that choices define our very 'essence'. This supports freely accounting for personal lived experiences as in this research, which seeks to explore the lived experiences of self-harm from those who self-harm. Sartre's theory states that "existence precedes essence", that is, only by existing and acting in a certain way do we give meaning to our lives. According to him, there is no fixed design on how human beings should be. Therefore, it falls on us as humans to define ourselves by ourselves. This philosophical view supports subjectivity in accounts of lived experience as in the phenomenon of self-harm. Sartre's phenomenology in "Being and Nothingness" became the philosophical foundation for his popular philosophy of existentialism, found in his famous lecture "Existentialism is Humanism" (1945), where he emphasised the experience of freedom of choice. This supports subjectivity and individualistic approach in lived experience of the complex phenomenon of self-harm behaviours.

Maurice Merleau-Ponty (1908-1961): Maurice Merleau-Ponty's work is commonly associated with the philosophical movement called existentialism and focuses on experiences,

perceptions, and difficulties, of human existence. Merleau-Ponty understands perception to be an ongoing dialogue between one's lived body and the world which it perceives. He developed a rich variety of phenomenology, emphasising the role of the body in human experience. He argued that the body and the mind are interconnected and are the seat of knowledge that gives us sense of self. This view helps to make sense of the experience of self-harm.

4.6.1 Summary

The works of the early thinkers on phenomenology appear to have commonality in relation to acknowledging phenomenology as the study of conscious experience from the first-person point of view that is, from the perspective of the person experiencing the phenomenon. Though this appears to be the core assumption underpinning the subject of phenomenology, the early thinkers tend to have in addition their individual different views to phenomenology. According to Edmund Husserl (1850-1938), we are to practice phenomenology by "bracketing" the question of the existence of the natural world around us. His descriptive phenomenology tends to give the gross view of the phenomenon under investigation but failed to give the detailed view to communicate the "real" meaning of the experience (Smith et al., 2009). The "bracketing" approach was challenged by Heidegger who argued that as we and our activities are not separate from the world, we should rather interpret our activities and reflect the meanings they have for us. In this way, details or fine views of the experience would be provided. The interpretative approach is shared by thinkers as Max van Manen in the application of "language" interpretation, where the researcher moves in the 'hermeneutic circle' between part of the text and the whole of the text, to make essences of the phenomenon under investigation to establish truth (Langdridge, 2007). The language interpretation supports narrative synthesis, thematic analysis and emergent themes (van Manen, 2007; Smith et al., 2009). Jean-Paul Sartre and Maurice Merleau-Ponty also maintained that there is no fixed reality, as their philosophical views support subjectivity in

accounts of individual's lived experience, which align with the application of epistemological constructivism and ontological relativism adopted in this research.

4.7 **Rationale for Interpretative Phenomenological Analysis (IPA)**

IPA approach was used because it explores how participants make sense of their lived experiences, focusing on understanding the subjective conscious lived experiences from their perspectives (Neubauer et al., 2019). IPA supports the free expression of participants' lived experiences, focusing on each unique and detailed experience, instead of making broad generalisations. This design is a key component of research focusing on lived experience. Phenomenology research approach is suitable in exploring important nursing phenomenon (Arrigo and Cody, 2004; Chapman and Francis, 2009). It is particularly suitable for the current study of the complex and emotionally challenging subject of self-harm behaviours.

A phenomenological study "describes the meaning for several individuals of their lived experiences of a concept or a phenomenon" (Creswell, 2007 p. 57). Interpretative phenomenology, employed as a research methodology, provided the best opportunity to 'give voice' to lived experiences of the phenomenon under study, to find from participants' individual accounts what they perceive as the most effective resilience factors in self-harm.

4.8 **Interpretive Phenomenological Analysis (IPA) key components**

IPA anchors on the following three core components: the study of human experience (phenomenology); the interpretation of human experience (hermeneutics); and (idiographic) the focus away from the general onto the particulars of individual experiences (Smith et al., 2009).

Phenomenology as a philosophical approach helps us to understand our human experiences, especially in the context of what matters to us and the world around us (Smith et al., 2009). As already mentioned, phenomenology has two different approaches: descriptive and interpretive. Descriptive phenomenology aims to describe a lived experience without making

any interpretation to accord meaning to it (Smith et al., 2009). This is unlike interpretative phenomenology which is grounded in the world of things, people, relationships, and language. Hence in IPA, the interpretation and meaning-making of people's experiences is tied to the researcher's being in the world (Smith et al., 2009)

Hermeneutics is the theory of interpretation (Finlay, 2011). The three most important hermeneutic theorists for IPA suggested that interpretation involves both grammatical and psychological interpretation. The grammatical interpretation deals with the exact and objective textual meaning, while the philosophical interpretation relates to the individuality of the interpreter or researcher. According to Schleiermacher (1998), interpretation is not just about following a mechanical rule but rather an art which demands the researcher to engage a combination of skills, including intuition. However, it is important for the researcher to be aware of his own bias, so that during analysis, the text can present itself and assert its own truth (Smith et al., 2009). Schleiermacher argued that if a detailed holistic analysis is engaged, participants' explicit claims would be displayed.

'Idiographic' means the contextual approach of detail, depth of analysis, and sense of understanding of how a particular experience has been understood from the perspective of particular people in a particular context (Smith et al., 2009). In the current research, idiographic approaches show how self-harm has been understood from the perspectives of those with the lived experience in the context of what helps them reduce or stop self-harm.

IPA, the appropriate analytical tool in this research, is idiographic and focused on exploring personal meaning and sense-making of a person's lived experience (Smith et al., 2009; Smith and Eutough, 2007). The idiographic approach involves the in-depth study of individuals, and it is found to be common in qualitative methodology (Smith, Flowers and Larkin, 2009). In IPA, it is possible to make specific comments about participants, whereas in nomothetic approaches, analysis is made of groups and populations and claims about individuals can be based only on probability.

IPA can be applied to examine cognitions and emotions underlying experience (Brocki and Wearden, 2006), and to learn more about "persons-in-context" (Larkin et al., 2006, p. 106). Focus on subjective experience can help to reveal information about the individual's broader social context (De Visser and Smith, 2007, p. 599).

IPA has a focus on the person as a cognitive, linguistic, affective, and physical being, and connects to their talk, thinking and emotional state. This can be challenging as people attempt to express what they are thinking and feeling and may have reasons for not wishing to self-disclose. The researcher interprets participants' mental states and emotions by what they say. Cognition stands as central analytical issue in IPA as it concentrates on the researcher making sense of what sense participants are trying to make of their experience which may be subjective, complex, requiring interpretations and in-depth analysis. The method of conducting IPA is not single, albeit the procedural steps of IPA adapted in this research is Smith et al.'s (2009) framework as shown below:

1. Initial reading and re-reading

2. Initial note taking and coding

3. Developing emergent themes

4. Check for connections across emergent themes to develop higher order themes

5. Developing super-order themes from higher order themes

6. Pooling together super-order themes to develop master themes

7. Return to participant's interview account when not clear to validate descriptions.

4.9 **Reflexivity**

Reflexivity has been in use for decades in nursing, psychology, and social work research. It is one of the ways for researchers to ensure rigor and quality in their work (Mitchell et al. 2018;

Dodgson, 2019). Reflexivity is a good device in safeguard of transparency and trustworthiness (The and Lek, 2018).

As required in qualitative research, researcher has been clear and transparent on his stance on beliefs, perceptions, assumptions, professional role and experience regarding the topic under study. This is because of the potential impact on the research process that may affect the findings (Dodgson, 2018; Berger 2015). Reflexivity in this research started early, through the planning and design of the research, interpretation of data and continued throughout the research. This is because reflexivity in qualitative research should be an on-going process, with the researcher clearly giving an account throughout the study on how his position or role has or might have impacted on the research.

In this study, the researcher's professional role led to interest in the topic under study and is linked to the associated knowledge, skills and experience on the subject under investigation (Neubauer et al., 2019). The choice of research design, the formulation of inclusion and exclusion criteria were influenced by researcher's knowledge of self-harm as a complex phenomenon that may require interpretations of the participants' subjective experiences of their self-harm behaviours. Small sample size was considered suitable for IPA involving self-harm because the researcher is aware of the anticipated challenges in recruiting mental health patients who self-harm, due to the stigma attached to mental health patients and self-harm behaviours. Inclusion and exclusion criteria were carefully worded to reflect the sensitivity of the subject and the vulnerability of (mental health patients) participants. Again, due to the knowledge and experience of the researcher, inclusion and exclusion criteria were also carefully worded, to be purposeful and targeted towards the samples that will provide answers to the research questions and meet the research aims and objectives. The design of semi-structured one-to-one interview was chosen because the researcher is aware of the private nature of self-harm and the need for confidentiality to encourage sharing of sensitive personal experience of self-harm. The interview guide was influenced by the researcher's

knowledge and experience of the importance of good communication skills and empathy that would encourage participation and navigate through the sensitive subject of self-harm. The researcher's professional role and experience, made it easier to show empathy, build rapport and have good understanding with the participants which enhanced their openness in sharing their sensitive self-harm experience. The interview guide has questions that were carefully considered by the researcher to ensure sensitive histories capable of bringing back strong negative emotions to the participants were carefully worded. Due to knowledge of the psychological emotions that may be associated with self-harm, the researcher had a contingency plan and distress protocol to address issues that may arise during or after the interview, such as emotional distress that participants may express when sharing their experiences of self-harm (Druacker et al., 2009).

Phenomenological researchers are required to remain consistently neutral about their pre-existing knowledge, belief, or disbelief of the phenomenon under investigation. Nevertheless, IPA acknowledges the role of the researcher (Smith, 2007). It promotes transparency, reflexivity, and requires the researcher's interpretations to be anchored or evidenced in verbatim quotes (Smith and Eatough, 2006; Smith and Osborn, 2008). The researcher's knowledge and experience of the subject under study may have contributed to the richness of data interpretation as it was easier for researcher to make sense of what the participants were trying to make sense of especially when familiar clinical terms/languages and jargons common to self-harm and mental health were used by the participants. However, the researcher has the ethical requirement of ensuring that the participants are protected from any adverse interpretation which may introduce researcher's personal or political biases (Langdridge and Flowers, 2005). For example some participants' views that they used self-harm as a coping mechanisms against intense emotions were not overridden by the researcher's bias that healthier alternatives can offer similar relief with fewer risks.

The researcher had to ensure that his own clinical impression or bias, even when at odds with participants' accounts, does not override participants' accounts. The researcher had to constantly remind himself of the need to limit his interpretations and sense-making of participants' experiences of self-harm to the views of the participants. The issues surrounding the researchers' reflexivity are multifaceted. Therefore, in conducting this qualitative research, the researcher carefully explored the complex lived experience of self-harm phenomenon (Mitchell et al., 2018, p. 673). Although the researcher is a qualified mental health nurse, it was intentionally disclosed that he has experience working in mental health settings, without disclosing the detailed clinical role. Though, it is acknowledged that participants' informed consents may be affected due to the ethical implication of non-disclosure of researcher's detailed clinical role. However, while some participants may choose to participate with the assumption of getting a clinician-patient relationship, others may choose not to participate. Knowing the detailed clinical role of researcher may make the participants feel intimidated to speak freely and give the account of their lived experience in the interviews, which may compromise phenomenological focus and introduce bias. The rationale for partial disclosure was methodological neutrality, as revealing researcher's detailed clinical role could change the researcher-participant relationship into one resembling a therapeutic encounter. Such a shift might have inadvertently introduced bias and compromised the epistemological stance of the research (see Section4.7).

Summary

This chapter provided a brief overview of different research methodologies, the choice of research methodology for this study and the rationale for the choice. It gave various ways of constructing knowledge in qualitative research. It explained and justified the appropriateness of qualitative approach, outlined and justified the researcher's theoretical orientation, and outlined how this has been applied in the study. It gave a brief historical account of

phenomenology and tried to show that the phenomenology of self-harm as lived experience is best studied using IPA.

Chapter 5: Method and design

5.1 **Introduction**

The purpose of this chapter is to describe and justify the research design. It will explore the recruitment of participants, guided by inclusion and exclusion criteria. Data collection and analysis will be explained. This will be followed by the details of the ethical issues involved. Finally, this chapter will reflect on the trustworthiness and the limitations of the study.

5.2 **Method**

To ensure a rigorous project, the researcher used a method appropriate to his theoretical orientation to generate and analyse the data (Willig, 2008). This section provides the rationale for the collection and analytical choices in terms of their suitability to researcher orientation and the types of knowledge considered, as discussed in Chapter 4.

5.3 **Semi-structured interviews**

This qualitative study employed one-to-one, semi-structured interviews as the primary mode of data collection. This approach is widely recognised for its depth and flexibility in exploring lived experiences (Alshenqeeti, 2014; Stuckey, 2013). Semi-structured interviews remain one of the most utilised methods in qualitative research, particularly within phenomenological frameworks such as Interpretative Phenomenological Analysis (IPA), where the aim is to examine how individuals make sense of their lived experiences (Alshenqeeti, 2014; Smith et al., 2009). This method is especially suited to IPA, given its emphasis on rich, idiographic exploration of participants' lived experiences. As Kvale and Brinkmann, (2015) assert, the qualitative interview enables researchers to access the world from the participant's perspective, an epistemological orientation that aligns with IPA's focus on understanding how individuals interpret and construct meaning around lived experience such as self-harm behaviours.

Participants were given the opportunity to choose their preferred interview options, and all the six participants opted for one-to-one telephone interviews. Each semi-structured interview

lasted between 20 and 55 minutes and provided the opportunity for a dialogue and flexible exchange. This allowed clarification and deeper probing of participants' lived experiences through open-ended questioning (Knox and Burkard, 2009).

Participants were first engaged with open-ended questions. In this way, participants were able to freely give their views, with prompts from the researcher in specific areas to further elicit their views and guide them through, especially when struggling with providing answers to questions (e.g. Eatough and Smith, 2008; Smith, 2008; Smith and Eatough, 2006, 2007; Smith et al., 2009; Smith et al., 1999; Smith and Osborn, 2008). Apart from the questions asked, participants could talk freely about things important to them, regarding their experience of self-harm. Though the interview schedule was structured with time allocation, there was discretional time allowed by the researcher to provide briefing to the participant before commencing the interview, and at the end of the interview, to check if the participant has any question or anything to add or say about the interview.

Some answers provided by participants were explored further, when deemed relevant and important. The interviews include an outline of questions prepared by the researcher to target research aims and objectives (Stuckey, 2013). Unlike structured interviews, semi-structured interviews have no rigid adherence, as this gives flexibility within interviews to explore topics raised by the participants that they deem important.

The one-to-one interview was to give participants the privacy to encourage them to speak freely and raise any sensitive issue which they may not be willing to share with others. This is an important quality of a one-to-one interview, as a group interview will not accord the privacy that encourages sharing of personal and sensitive information. However, the main disadvantage of a one-to-one interview is that, unlike the focus group interview, it does not allow participants to interact with each other to share their views and insights. Nonetheless, the one-to-one semi-structured interview allowed participants to speak freely to share their views and insight. It provided more flexibility for both the participants and the researcher

(Merriam, 2009). Focus groups allow for the exploration of different thoughts and ideas and may reveal important information not volunteered in individual interviews. However, in focus groups different opinions from different participants may be difficult to record and analyse and time constraints for participants and researcher may limit the number of questions that can be covered. Focus groups tend to generate major themes, often not suitable for isolating individual opinions (Silverman, 2004). One-to-one interviews were felt to be more appropriate than a focus group. This is because focus groups have the propensity to bring in peer pressure and group dynamics which can affect how participants can freely share their individual experience of self-harm. There is also the danger of shifting the focus of the research to another agenda by strong characters in the group as people's views can become homogenised or ineffective in the group (Memon& Bull, 1999).

The option of structured interviews was not thought suitable because the questions in the structured interviews are very specific and rigid, not giving participants opportunity to freely speak of their own experience (Smith and Osborn, 2008). In the structured interviews, the researcher appears to dominate, asserting power and control. In a sensitive subject as self-harm, this can bring negative outcomes, as the subjective lived experience of participants may not be fully explored from their own perspective (Dickson-Swift et al., 2007). Semi-structured interviews are flexible and can address views or issues if they arise during the interview (Gill et al., 2008). The option of one-to-one interview made it possible for the researcher to respond quickly to any issue. For example, asking for clarification of what was said. Semi-structured interviews have the flexibility to accommodate open-ended questions to access more information from participants.

5.4 **Inclusion Criteria**

Adults aged between 18 and 64years with a history of self-harm were recruited. The following inclusion criteria were applied:

- Mental health patients
- Mental health patients (male & female, 18-64years) with a history of self-harm
- Mental health patients with mental capacity to give informed consent for research participation
- Mental health patients not in an acute phase or mental health crisis
- Mental health patients with intentional injury to self without suicidal intent. This includes for example, cutting or severe scratching of skin, burning or scalding, hitting self or head banging, punching things to harm self, throwing self against objects to harm self, sticking objects into skin or piercing with objects to harm self, intentional picking and digging into wound to prevent healing, swallowing poisonous substances or inappropriate objects, taking overdose of prescribed medication.

The inclusion criteria were broad to encourage wide participation of target sample, eliminate bias and ensure good sample representation (Faulkner, 2004). It was clarified that to be included in the study the participants need to speak and understand English. Though arrangements could be made for interpreters for those who do not speak English but wished to participate, this was not considered in this research. This is because the use of interpreters in qualitative research may raise issues around representation, language and ethics in a detailed IPA (Raval and Smith, 2003; Smith et al., 2009). Consideration was also given to the issue of additional costs of using an interpreter. The option of providing an interpreter as part of the study commitment to patients will not be considered.

5.5 **Exclusion Criteria**

The following exclusion criteria applied to participant recruitment:

- Mental health patients in crisis or acute phase of their illness
- Mental health patients who lack the capacity to give informed consent to participate in the research

- Mental health patients with capacity who have not given informed consent
- Mental health patients with history of self-harm not within the age bracket (18-64yrs)
- Self-harm associated with autism or other developmental disorders (Ross et al., 2009)
- Self-harm associated with eating disorders
- Self-harm associated with alcohol abuse and use of illicit drugs
- Mental health patients with intentional harm to self with suicidal intent
- Mental health patients who have not satisfied the inclusion criteria
- Mental health patients known to the researcher in a non-professional context

People under 18 were excluded, as the mode of service delivery for children and adolescents is considerably different from that of adults (Royal College of Psychiatrists, 2004). Also, a significant body of research has focused on self-harm in children and adolescents (Hawton and Harriss, 2008b; Hawton et al., 2002; Lloyd-Richardson et al., 2007). Older adults (over 65) are excluded as they may have higher rates of physical health conditions and comorbidities or cognitive impairment such as dementia which can complicate consent and participation. Older adults are not the target group in this study.

5.6 **Sample size**

The concept of saturation provides a guide to sample size in qualitative research (Hennink et al., 2019; Saunders et al., 2018). The point in data analysis at which additional data collection adds no new insights, themes, patterns, concepts or perspectives relevant in answering the research question, is referred to as analysis saturation (Guest, Bunce & Johnson, 2006; Moore et al., 2024).This is when researcher observes repetition in data with further data collection and analysis.

In this study, during the process of coding and theme-development, analysis saturation was assessed. The analysis of the sixth one-to-one semi-structured interview, revealed no new information as the existing themes adequately captured the participants' various accounts.

However, the emergent information reinforced what have already been identified indicating that saturation have been reached.

There appears to be no right answer to the question of sample size as it normally depends on factors such as, the research question, time, resources, the degree of commitment to the case under study, level of analysis and reporting, the richness of the individual cases, and constraints such as the challenges in recruitment of participants as in this research which involved recruiting participants who have self-harm behaviours (Brocki and Wearden, 2006; Smith, 2004).

In IPA, studies are conducted on small sample sizes to gather rich and in-depth descriptions of participants' lived experiences, followed by detailed analysis of the transcripts. The aim here is to get a detailed account of participants' perspectives and understandings of the phenomenon of self-harm, rather than making more general claims which could reasonably be attempted only after making a careful cross-comparative interpretative study of participants' individual accounts. The amount of time and resources available were considered suitable for qualitative research involving smaller sample size.

IPA studies have been published with various samples such as one, four, nine, fifteen and more (Eatough and Smith 2006). However, a distinctive feature of IPA is its commitment to a detailed interpretative account of the cases. Many researchers are recognising that IPA can realistically be done only on a very small sample as one is sacrificing breadth for depth (Smith, 2004) and a sample of five or six has sometimes been recommended as a reasonable sample size for a student.

In IPA, the sample size is small because the analytic process is detailed and idiographic, and therefore time-demanding (Smith, 2004; Smith et al., 2009). The idiographic and in-depth analysis can be hampered by larger samples, with the possibility of compromising details for broader themes.

5.7 **Sampling**

A purposive and homogeneous sample has been followed in this study as proposed in IPA (Langdridge, 2007; Smith et al., 2009; Willig, 2008) to answer the research question (Palinkas et al., 2015). The sample size in this study is six and all of them have experienced self-harm. Sampling was purposively drawn from participants who are adult mental health patients, so that the experiences are more likely to be homogeneous (DiCicco-Bloom & Crabtree, 2006). In context of age, gender, or sexuality, the sample was not homogenised (Alexander and Clare, 2004; Brocki and Wearden, 2006; Crouch and Wright, 2004). For the participants' demographics, see Table 6. Again, self-harm is a complex phenomenon erasing barriers of age, gender, sexual orientation, ethnic belongingness, and social circumstance. Homogeneity of sample was guaranteed by recruiting only adult mental health patients with a history of self-harm. This purposive sampling strategy is consistent with Interpretative Phenomenological Analysis (IPA), which prioritises idiographic depth over breadth in order to illuminate how individuals make sense of phenomena under investigation (Smith et al., 2009).

5.8 **Recruitment and participants**

Recruitment of participants was guided by the inclusion and exclusion criteria (see Sections 5.3 & 5.4). Recruitment was undertaken in accordance with ethical considerations of conducting research with vulnerable adults, as this research involved mental health patients with emotionally laden, complex self-harm behaviours who may have multiple needs and are vulnerable due to increased risk of suicide (Knipe et al., 2022; Liu et al., 2022; Morrissey, Doyle, and Higgins, 2018).

The inclusion and exclusion criteria were made available to the potential participants by the researcher with the participant information packs. The information pack consists of interview guide, participant information sheet, consent form, and distress protocol (see Appendices 12, 11, 10, and 9 respectively). The recruitment of participants were made from the NHS and non-NHS organisations. The names of the organisations are withheld by the researcher to maintain

confidentiality as this thesis will be a public document. However, details of the types of organisations have been provided.

Initial contacts were made with an NHS Involvement Bank which has the initiative that supports involvement of those with lived experience in decision-making rather than being passive recipients of services and lets them share their perspective to ongoing research. Contacts were also made with a non-NHS peer-led mental health independent organisation which though independent, works closely with NHS organisations set up to provide support for those with experiences of mental health.

After the initial contacts were made, those interested to participate in the research contacted the researcher to inform him. The researcher responded by sending to each participant the research Participant Information Pack. This was sent only once to each participant to avoid putting them under undue pressure to accept participation. A total of eight adult participants, four from the NHS organisation and four from the non-NHS organisation met the inclusion criteria. Of the NHS volunteers, two withdrew prior to their scheduled interviews; one withdrew because she changed her mind and the other withdrew because of an undisclosed personal reason. The remaining two completed the process and were interviewed. All the four participants from the non-NHS cohort proceeded with their interviews. In total, six adults (four males and two females) within the age bracket 18 to 64 years (mean age = 40) were interviewed (see Table 6 for participants' demographics).

Recruiting people who self-harm to research is challenging (Hawton & Sinclair, 2003; Horrocks et al., 2005) due to the stigma attached to mental health and self-harm. Most potential participants that were contacted either indicated no interest or disengaged after the initial interest was communicated. Also significant are the challenges of safeguards and protocols adopted by different authorities (especially the NHS) in obtaining ethical approval.

Table 6: Participants' demographics

Participant	Age	Gender	Marital status	Ethnicity	Religion	Employment status
P1	50-60	Male	Divorced	White British	Catholic	Employed
P2	60	Male	Married	White British	Roman catholic	Employed
P3	30-40	Male	Single	White British	Catholic	Student
P4	21	Female	Single	Other White Background	Christian	Employed
P5	40-50	Female	Widow	White British	No Religion	Employed
P6	40-50	Male	Single	Other White Background	Pagan	Employed

5.9 **Interview guide**

An interview guide (Appendix 12) was developed to ensure each participant was asked the same questions, whilst being allowed the freedom to express self (Kvale, 1998, p. 1). The interview guide adapted was in line with IPA studies and was designed to allay anxiety and encourage rapport. It helped participants know key questions to be asked in the interview and reflect on the answers they may want to provide. The interview guide was designed to carefully word potential direct questions capable of uncovering traumatic experiences that participants may not feel comfortable to talk about.

The interview guide provided structure and the opportunity for the researcher to think through questions to ask (Stuckey, 2013). It also helped the researcher prepare navigation of difficult questions (Osborn, 2008). Questions could be poorly worded because no preparation was made before the interview, and because the researcher failed to formulate an interview guide (Smith and Eatough, 2006; Smith and Osborn, 2008). The interview guide also helped the researcher to plan to ask relevant questions. The potential impact of interviewing vulnerable participants about their experience of self-harm was considered in the interview guide. This was reflected in the design of the interview guide and by debriefing after the interview.

According to studies, people with mental health issues who self-harm often found it therapeutic and helpful to talk about their experiences (Alexander and Clare, 2004; Taylor et al., 2009; Taylor et al., 2010).

The design of the interview guide was informed by the research aim and questions. For example, some questions were focused on strategies to minimize or prevent self-harm. These questions included: 'What or what way(s) do you feel helps you reduce or resist how often you self-harm or the severity of your self-harm?'; 'Which way(s) do you feel are effective and which way do you feel is most effective?'; and 'Can you think of support, coping strategy, types of strength and abilities that you feel helps people like you to reduce, resist or stop self-harming? The design, again, was reinforced by the researcher's professional experience in working with those who self-harm.

Due to the sensitive nature of this study, and the interview questions, the interview guide was sent to participants before the date agreed for the interview. This was to give the participants the opportunity to familiarise themselves with the questions and reflect on their responses and gain a sense of control of the interview questions. The interview guide was intended to reduce anxiety and enhance participants' confidence during the interview. In addition, this approach allowed the participants to make an informed decision about whether their experience was relevant to the study, and to reflect prior to the interview date on what it would be like to take part. Another aim of sharing the interview guide with participants before the date of the interview was to treat participants as partners and experts within the interview (Kvale, 2015), and as co-creators of knowledge (Brandon, 2025; Lowes & Prowse, 2001).

5.10 **Data collection**

Among the available interview options, face-to-face and telephone interviews are the frequently used platforms (Jackle, Roberts, and Lynn, 2006). Virtual platforms have also been used recently, especially during the issue of COVID-19 pandemic when it was considered a

good alternative to face-to-face interviews. In this study, as already mentioned, all the six participants chose the telephone interview option. Though this is a more comfortable and preferred interview platform for these participants, it has the downside of not capturing participants' non-verbal communications. Notwithstanding, audible effects such as tone of voice, emphatic repetition and pause or hesitations could be picked up during the interview. Telephone interviews also have the possibility of distractions as the participant may be multi-tasking at the time of interview. However, this is not peculiar or limited to telephone interview as some degree of distractions are also possible in other forms of interview. Face-to-face interviews have the disadvantage of being costly and time demanding (Doyle, 2005). Sometimes, researchers and participants may be required to travel to the booked site for the interview. This may attract additional costs to research budgets and cause some level of discomfort and anxiety to participants who might have preferred a telephone or virtual interview. It is also worthy of note that at the time of planning this research the risk of COVID-19 infection was given consideration in face-to-face interview.

5.11 **Data transcription**

The six recorded interviews were electronically transcribed verbatim by the researcher, using the secure University of Sunderland's Microsoft-based electronic transcription platform. The researcher listened to the interviews one at a time whilst reading the transcripts, to ensure correct representation of interview data. Care was taken regarding linguistic expressions, as idiographic analysis requires interview transcriptions to be thorough and undergo careful reading and re-reading (Smith and Osborn, 2008, Smith et al., 2009), with extensive coding focused on experiential meaning (Smith et al., 2009). The analytic process required a substantial amount of time. This was due to the micro-details of the transcript, the focus of the analysis and the developing experience of the researcher.

Transcriptions were carried out using participants' pseudonyms. Participants were given a unique identifier to maintain anonymity. A careful check of all the transcripts was conducted to

ensure any information that could identify the participant was anonymised. The list of unique identifiers against names was stored using the password-controlled University drive. Direct quotes from the participants were maintained to reflect transparency and support trustworthiness. Quotes from participants were linked to participants' pseudonyms to maintain confidentiality. Transcribed data were double checked by listening carefully again to the interviews, to ensure accuracy and that nothing is missed.

5.12 **Data analysis**

Data analysis in qualitative research involves exploring issues, understanding phenomena, and answering questions. Again, IPA is idiographic, requiring data analysis to be conducted on each case, with the eventual linking of individual findings (Willig, 2008). The idiographic analysis enables detailed coverage of the participants' individual lived experiences (Willig, 2008). Smith et al.'s (2009) IPA guide was followed. The analysis involved the following stages:

1: Initial reading and re-reading: This stage of the IPA process required careful reading and re-reading of the transcribed textual data (Smith et al., 2009). All the six transcripts were individually carefully read one at a time to get the essence of the "whole" before understanding the "part" (Smith, 2007).

2: Initial coding: Relevant descriptive annotations were made (Smith et al., 2009) (see Appendix 6 for some examples) to capture the content of talk, the language used by participants, and the concepts highlighted. Notes were made to highlight areas that require further interpretation (Smith et al., 2009).

3: Developing emergent themes: After the annotations and initial notes, focusing on the researcher's understanding and impressions, the researcher engages in the interpretive process by refining and interrogating the initial impressions to aggregate into themes which

may at first, be descriptive in nature. This is the beginning of a deeper interpretation (Smith et al., 2009, p. 91).

Though NVivo12 qualitative data analysis software provides efficient means of organising, managing, and engaging data analysis securely (Banner and Albrran, 2009), manual coding was used by researcher. This is because manual coding, though time-consuming, offers the researcher an opportunity to remain as close as possible to the data for a deeper analytical view.

4: Checking for links across emergent themes: This stage involved the linking or arranging of the emergent themes to form higher-order themes (super-ordinate themes). Examples of some of the processes followed were grouping similar themes under an overarching theme (abstraction), grouping other themes under an existing theme (subsumption), and pooling together themes of particular contexts within the narrative of the participant (contextualisation)(Smith et al., 2009, p.97). The creation of higher-order themes is not limited to the preceding processes, as it can be achieved through other comparable processes. The higher-order themes were then organised into master themes. This stage helped distinguish relevant and irrelevant themes (Storey, 2007).

5: Idiographic exploration: Each transcript, again, is considered on a singular basis (Smith et al., 2009). In this stage of the IPA process, Stages 1-4 (above) were followed to achieve master themes for all the six cases.

6: Checking for patterns across cases: In this final stage, the researcher pooled the themes across all cases (six accounts), and looked for comparisons and contrasts (Smith et al. 2009) this resulted in some themes being renamed and merged to form master themes. For example, the participants' different themes: "stressful life events and way of relief", "stressful relationship", "stressful life events" and "overwhelmed and out of control" can all be collapsed into the final master theme as "responding to psychosocial stress". This process

was similar to the creation of higher-order themes. However, the aim here was to have concepts that straddle the six accounts to develop group master themes (see Appendix 4, Table 5).

To increase credibility, the researcher ensured that he carefully reflected on the process and how his knowledge of self-harm as a mental health professional might have affected his interpretation of the data. The researcher engaged in reflexivity (4.9) throughout the research process and kept a reflective account (see details in Section 8.5).

Only the data relevant to the research topic was analysed. Extracts and participants' quotes have been used to buttress participants' narratives and maintain transparency in the analysis. The quotes are in parentheses and are referenced in brackets with the participant's pseudonyms. It was also decided not to make changes to grammatical errors, hesitations, repetitions and pauses, to safeguard transparency. The findings are reported in Chapter 6. Following some extracts and quotes from participants are analyses, comments or interpretations, to bring clarity or make sense of what the participants were trying to make sense of, as per double hermeneutics in IPA (Smith and Fieldsend, 2021) (see Chapter 4).

5.13 **Credibility/Trustworthiness**

Qualitative research has no clear standards by which trustworthiness (validity) can be judged (Rolfe, 2006). The criteria used to judge this in quantitative research cannot be used in qualitative research where the focus is on the subjective account of participants' lived experiences (Smith et al., 2009). Smith et al. (2009) recommended criteria suggested by Yardley (2000) for evaluating credibility (trustworthiness) in qualitative research. This is followed in this study in the following four criteria: sensitivity of context; commitment and rigour; transparency and coherence; impact and importance.

5.13.1 Sensitivity of context

According to Yardley (2000), researchers can demonstrate sensitivity to context by systematic awareness of their methodology and relevant literature, in addition to sensitive relationships between researcher and participants. In this study, the systematic literature review revealed gaps in the literature, to be addressed through qualitative research. The relationship between researcher and participants prioritised confidentiality in the research design. The semi-structured interviews respected participants' privacy by interviewing them privately and respecting their autonomy as regards choice of date for the interview, the time and the interview option. In the presentation of the analysis, participants' quotes were present to anchor the context and ensure that the reader can identify the researcher's interpretations alongside the raw data. The reflexivity section was included and made clear how researcher beliefs, assumptions, and experiences had or might have impacted on the research.

5.13.2 Commitment and rigour

This is phenomenological research, involving one-to-one interviews that generated a significant amount of data. This requires the researcher to be committed to the study. The researcher demonstrated this by studying relevant materials, accessing current literature, and by attending seminars/workshops, supervision meetings and other relevant events such as Local NHS Trust organised trainings on risk formulation on self-harm and suicidality. Data collection required persistence and patience, due to the stigma attached to self-harm and reluctance of participants to come forward. Recruitment of participants was purposive, to address the research aim and objectives. This allowed in-depth interviews to take place and rich interview data to be collected. The research process is detailed to demonstrate that the study was rigorously conducted. Participants' quotes are present in their accounts (see Chapter 6), demonstrating rigour and transparency. Research supervision was used to ensure that the analysis maintains a balance between the idiographic element and researcher interpretation. To reflect credibility of the analysis, the researcher sought regular

consultation from the academic supervisory team, along with a reflective diary. The emergent main themes of the whole data set were checked and discussed with the supervisory team.

5.13.3 Transparency and coherence

The clarity and detail of research is referred to as transparency (Yardley, 2000). To ensure transparency, the details of the research, including process and researcher positionality, were provided. Qualitative research, unlike quantitative research, has criticisms for lack of empirical rigour, poor methodological strategies and lack of transparency in analytical approach, with findings being riddled with researcher bias (Sandelowski, 1993; Rolfe 2006). Nonetheless, in this research, trustworthiness was considered as follows:

Interviews were transcribed verbatim, and the transcripts were double-checked with participants' digital audio recordings. The researcher checked/discussed the transcription with the supervisory team to ensure correct representation of participants' digital recordings and ensure nothing is missed; data in each transcript were analysed independently; coding was done manually by the researcher to have close association with the data and ensure nothing is missed; and codes and emerging themes were discussed with academic supervisors.

The researcher's experience and background as a mental health practitioner with experience in providing care to adults with the lived experience of self-harm was an advantage in understanding the meaning of some interview responses that might have been difficult to understand otherwise, especially when jargon commonly used in mental health and self-harm behaviours were used by participants.

Details of the research process and information affecting this research have been shared at different times. The researcher's reflexive account makes it possible for the researcher to be open about how his beliefs, thoughts, assumptions, knowledge and skills and personal experience impact the research. Reflexivity is engaged throughout the research to enhance transparency. Research write-up was structured for coherence and easy read. The chapters

were connected logically, to flow cogently. The researcher had regular supervision consultations to help ensure IPA is followed as per Smith et al. (2009). Issues requiring clarification were addressed in supervision. The researcher method was systemically shared with the supervisory team and discussed to ascertain clarity at each step. Detailed supervision, internal and external, has been an independent audit device (Smith et al., 2009).

5.13.4 Impact and importance

This is considering the usefulness or importance of the research. This research will lend voice to a patient group whose voices have been silenced as they have some level of stigmatisation and exclusion in research (Barker& Stevenson, 2000; Rossler, 2016). As already mentioned, this research is important because self-harm thoughts and behaviours are documented as precursors of suicide, a global public health problem (Kokkeci et al 2012; Karen et al 2012; Kapur et al 2013; Mughal et al 2020). Self-harm remains the most important single risk factor to suicide (Murphy et al., 2012; Bernnadi et al., 2016). It is hoped that this study will enrich the current understanding of self-harm from the perspective of those who experience it and will contribute towards its effective management.

5.14 **Ethical issues**

According to National Health Service (NHS) standards for research, the dignity, rights, safety and wellbeing of participants must be the primary consideration (Department of Health, 2005, p. 7). This section will discuss key ethical principles and issues involved in this study which include: ensuring participants' confidentiality and anonymity; ensuring consent is fully informed; safeguarding participants from emotional distress; and ensuring researcher safety. The participants included patients of the National Health Service (NHS) and therefore required approval from the Health Research Authority (HRA) approval prior to commencing recruitment. An application for approval was made through the Integrated Research Authorisation System (IRAS). Prior to proceeding with the IRAS application, the approval of

University of Sunderland ethical review group was sought and obtained (see Appendix 8). Contact was established with Research and Development (R&D) of the NHS Trust, a proposed site for participants' recruitment.

5.14.1 Confidentiality and anonymity

To protect the participants, the data was managed to reflect the principles outlined in the Data Protection Act (2018). Interviews were held on one-to-one basis in a secure environment. All the six participants opted for telephone interviews and were interviewed on their individual chosen date and time in their own private environments. Though they might not necessarily be alone at the time, this was clarified by the researcher. This was to ensure they were cognisant of the need for their privacy to be respected and were happy to be interviewed at the time. The interview was also in a secure environment, free from interference, to accord respect to the participant and avoid breach of confidentiality.

Participants' interview data was anonymised using unique identifiers to ensure confidentiality (Nabors, Ramos and Weist, 2001) and stored in the University drive, which is password controlled and accessible only to the authorised research team. Direct quotations from participants used in data analysis were always anonymised. Direct quotations from participants were linked to their unique identifiers or pseudonyms in any report, presentation, or intended publication (Kaiser, 2009; Nabors et al., 2001).

Participants were assured that all data would be kept in accordance with NHS Trust and University guidelines and all information would remain confidential and anonymised. Participants were provided with the opportunity to discuss any issues they had prior to the interview commencing. They were also given some time to reflect on their decision to participate in the research before agreeing on the interview date and time. Each interview commenced with a brief chat about the participant information sheet (see Appendix 11) to ensure the participants understood the reason for the interview, their rights as interviewee to withdraw at any time and to confirm consent to proceed with the interview. As already

mentioned the brief chat with participants was intended to help the interviewer to break the "ice of silence", allay any anxiety and encourage a relaxed atmosphere for the interview to ensure responses to questions are not pressured.

5.14.2 Informed consent

Once potential participant responded to indicate interest, a Participant Information Sheet (PIS) (see Appendix 11) was sent to them, providing details of the research. This ensured that those who agreed to participate in the study were fully aware of the nature of the study before recruitment (O'Connor, Ashley, Jones and Ferguson, 2014). The information sheet detailed the purpose of the study, what they were expected to do, and their right to withdraw from the study at any time without having to provide any reason. Information packs were sent to the potential participants once interest was indicated. The researcher made contact to answer any questions that might exist after participants indicated interest. Another contact was made in the next 24hrs to seek and obtain consent (see Appendix 10 for Consent Form). The 24-hr period was to allow potential participants time to cool off and reflect on their decision before being contacted again to provide full informed documented consent. A valid consent should be voluntary, void of undue pressure and based on clear disclosure of information. To ensure legitimate informed consent, steps were taken to avoid covert or overt influence in recruitment. Mental health patients have the tendency of being marginalised in research by those involved in their care, without being given the opportunity to consider information and decide for themselves. This research ensured that participants were not automatically side-lined under the guise of vulnerability or risk (Faulkner, 2004) or subjected to undue researcher influence. According to the Mental Capacity Act (2005), everyone is assumed to have capacity unless there is reason to doubt capacity. Due to vulnerability of mental health patients, only the potential participants with mental capacity to give full informed consent were approached.

5.14.3 Participant protection

This study is on self-harm, a sensitive subject with vulnerable adult mental health patients. It is likely that during the research, which involves exploring participants' experience of self-harm behaviours, unpleasant experiences would be recounted. Therefore, there is possibility of psychological harm/distress to the participants. After the potential participant had indicated interest to participate, an explanation of the possibility of psychological harm/distress was given. A contingency/crisis plan was shared in the Participant Information Sheet (PIS) and Distress Protocol document (see Appendix 9), were made available to the participants. It was agreed that the contingency/crisis plan will be implemented if necessary. It was agreed that disclosed or observed distress of a participant during the interview would be managed by the researcher, who has the clinical skills and experience to offer support before contacting the participant's care team, who can consider follow-up or signposting to the relevant team for further support. However, if a participant appeared distressed, the "research interview distress protocol" (see Appendix10) should be followed (Druacker et al., 2009 p.349).Druacker et al. (2009) recommended that when a participant demonstrates distress, the researcher should discontinue the interview, ask if the participant is alright and allow time for participant to regain composure before continuing with the interview as may be agreed. However, should the participant still indicate distress and wish to discontinue with the interview, the researcher should follow the "Stage 2 Response" on the Distress Protocol. The researcher should encourage the participant to contact his/her key worker, care coordinator, care team or offer to make the contact on behalf of the participant. However, the Distress Protocol was not applied in this research as no participant was observed or reported to be distressed.

The participants were also protected to freely share their experiences during the interview. In qualitative research involving interviewing of participants, the researcher (interviewer) is typically viewed by the participant (interviewee)as the one in charge or the one that has the

power to control and lead the interview (Braun& Clarke, 2013). To mitigate this, rapport was built to ensure participants were comfortable in speaking freely about their experience of self-harm. This was achieved through showing respect and understanding to participants and their sensitive experiences (DiCicco-Bloom & Crabtree, 2006; Mason, 2002). In the Participant Information Sheet, it was stated that the research will gather accounts of participants' experience of self-harm. The invitation letter and interview guide also made participants aware that they were experts in their experience and that the interview focus is their account of their experiences, which they can feel empowered to speak about (Russell, 2000).

5.14.4 Right to withdraw

All participants were reminded of their right to withdraw from the study. It was made clear that this was both in terms of the whole study, and any questions they did not wish to answer (BPS, 2009). They were also told that they could remove their data before transcription. In this research, this would have been within six weeks of completing an interview, as after commencing data analysis, data cannot be revoked (Thorpe, 2014, p. 258). This is because quality of data could be affected, as in analysis data is referred to back and forth in comparative study (Braun and Clarke, 2013). However, this did not happen in this research as no participant withdrew after an interview was conducted.

5.14.5 Ensuring researcher safety

There was minimal risk for the researcher, as interviews were all by telephone. Risks associated with lone working were not indicated in this research, Hearing self-harm experiences could be distressing to the researcher. However, the researcher's role and experience as a mental health practitioner was helpful in providing emotional balance. Nonetheless, the researcher had the opportunity of debriefing with the supervisory team.

Summary

This chapter provided the justification of a qualitative design and outlined and justified researcher's theoretical orientation and how it was operationalised throughout the project. It established that one-to-one semi-structured interview was the appropriate design for data collection and that Interpretive Phenomenological Analysis (IPA) was suitable for the analysis. Finally, it explored some ethical issues across this study, with a specific focus on conducting research on self-harm as a sensitive issue. The following chapters would provide a presentation, interpretation and discussion of the research data.

Chapter 6: Findings

6.1 **Introduction**

The key findings from the data analysis are presented in this chapter. The analysis revealed seven main or master themes (see Appendix 5, Table 5): (1) “Thought of the consequences”, (2) “Responding to stressful life events”, (3) “Relationship with family and with others as a protective factor”, (4) “Connecting with others with the lived experience of self-harm”, (5) “Understanding my illness and resilience journey”, (6) “Seeking professional support” and (7) “Using coping strategies and skills”. These themes can exist in combinations, as resilience to self-harm is a multi-factorial process which may vary from one adult to another: “This isn’t one single thing. It’s like a process. It’s like lots of things” (Daniel). These seven key themes are presented below, followed by a summary of the findings.

6.2 **Thought of the consequences**

This theme relates to what participants perceived as the consequences of their self-harm behaviours and how the perceived consequences affected their self-harm. The consequences vary depending on the nature, or type of self-harm. Reflecting on the consequences of self-harm behaviour was perceived by most participants as a way of limiting or controlling their self-harm behaviours. Self-harm was reported as a negative way of coping with some stressful situations and thought of the consequences appear to motivate some participants not to self-harm:

“…to be a bit stronger and not to do it made me reflect upon the impact it has on other people and things like that...” I've thought of the consequences, which wouldn’t have happened in the past” (Jude).

According to Jude, the reason he did not self-harm was because of the consequences his self-harm would have on other people. Though Jude thought of the consequences of his self-harm behaviour on “other people”, he appears not to consider the direct consequences on

himself. Indirectly, his self-harm behaviour may jeopardise his relationship with other people but may also have direct consequences, such as pain, on himself. However, the direct consequences of harming self appear to be preferred over that of hurting others which may suggest preferred direct physical pain over the emotional pain consequences from hurting others.

Thinking on the consequences of self-harm was reported to be effective in resisting self-harm behaviour:

> "But yeah, I do feel that it is actually very effective. Obviously over the past year and a half I was cutting quite regularly, and I might go six weeks without it, but to have gone six months…you know, it's the longest I've gone since…" (Jude) "…I do feel that it is actually very effective. I've been in the last few weeks where it would have led to us cutting myself, but I just haven't done it. I've just sort of thought of the consequences" (Jude)

Jude felt that thought of the consequences was "very effective" in resisting his self-harm behaviour. He compared his resilience to self-harm when he thought of the consequences to when he did not and found thinking on the consequences of his self-harm behaviours to be an effective resilience factor. Despite being in the situations where he would have self-harmed, he resisted it for more than six months, because he thought of the consequences of losing his friends. Though Jude's self-harm in the past year and half have been quite frequent, thinking on the consequences has reduced the frequency which appears to suggest association of reduced frequency of self-harm with resilience.

Similarly, another participant shared:

> "…So, I don't get to the point of needing to self-harm because I know the consequences are bad… I tried to take control of my emotions before I get to crisis…I think I just don't

> deserve to be in pain anymore. So that's what I got to remember, so there are better things to do that don't hurt" (Medlin).

Medlin reported pain as the "bad" consequences of her self-harm behaviour. She self-harms to manage her emotional pain but considers engaging in mindfulness as a better alternative to self-harm. Engaging in mindfulness has no associated pain, which appears to be the reason it is preferred by Medlin. She appears to highlight engaging in coping skills as her resilience against self-harm

Another participant, reflecting on the consequences of his self-harm behaviour, stated:

> "…kind of deliberate sabotaging of your life, you know, has a consequence" (Joel).

Joel acknowledged self-harm as a deliberate act with consequences. He felt that his self-harm behaviour was deliberate sabotaging of life. However, he did not make clear the nature and the effect of the "deliberate sabotage". This contrasts with the narrative from Maria, who specified consequences of her self-harm:

> "I have children as well, so that's sort of like deterred us…I didn't want to lose them, even though I did lose them for a short while because of myself-harming, but I got them back"(Maria).

It is clear that at some point Maria's children were taken away from her because of her self-harm behaviour. The consequences of losing the custody of her children appear to be one of the reasons she resists self-harm. This also suggests the consequences of a deeper psychological pain that may be associated with losing the custody of her children compared to the physical pain that may result from her self-harm behaviour.

Some participants were deterred from self-harm by thinking of the level of risk involved. For example, Jude has a bleeding disorder and avoids making deep cuts because of the consequences:

> "…I was careful because I have a bleeding disorder. So, I mean, I suppose any cut could be quite dangerous for me…" (Jude).

From this account, Jude understood his health challenge (bleeding) disorder and the associated danger of having uncontrolled bleeding if he makes a deep cut. However, having a bleeding disorder appears not to deter his self-harm (cutting self) because he said he was being "careful" not to cut deep. This appears to suggest that thinking on the consequences of self-harm may not necessarily bring complete cessation of self-harm but rather a

decrease in intensity or severity of self-harm. His bleeding disorder only made him think on the severity of his self-harm. The consequences of self-harm may vary and could arguably affect deterrence from self-harm. Severe consequences would more likely deter from self-harm than less severe consequences. This appears to be demonstrated in the account from Jude, who avoided making deep cuts because of the severe consequences of uncontrolled bleeding. However, he made superficial cuts which have less severe consequences. Similarly, another participant thought of the severity of the consequences of his self-harm:

"…the doctor said if I keep cutting myself, I'm going to end up losing a limb" (Jacob).

The consequence of losing a limb due to self-harm appears severe and frightening to Jacob; following the doctor's expert opinion, Jacob said "I was fearful of actually losing the limb. I got an infection…" (Jacob). Jacob's fear of the risk of losing his limb appeared to deter him from cutting himself.

6.3 **Responding to stressful life events**

This theme relates to the responses of the participants to stressful life events, such as abusive relationships which were experienced by many, and how their responses impacted their lived experience of self-harm. It highlights the link between their responses to psychological trauma, stressful life events, self-appraisal such as self-esteem and their self-harm behaviours.

Medlin shared her view that working on a job can have both positive and negative effects on her self-harm coping strategy:

"Yeah, it's kind of both. It is positive because like co-workers would see you self-harmed, they would. You know it would affect my work negatively so that means it prevents me but it's also extremely stressful. So that could also be self-harm(Medlin)

This account shows that employment can either be a protective factor or a trigger to self-harm, depending on the prevailing circumstances. For example, good working relationships and conditions could be a protective factor, whereas work-related stress and demands could be a trigger. Another participant, Daniel, said:

> "… I want a new job. I mean…the job itself is quite heavy…it's been bad for my physical health, and alongside I had some harassment, and I was assaulted at work…I just don't feel comfortable being at work. I don't feel safe. It just feels like it could happen again…" (Daniel)

Apart from the nature of the work which may be physically demanding, an unhealthy work environment like emotional stress from colleagues and harassments could have a negative impact on resilience to self-harm.

Joel similarly said:

> "…I did a lot of work with trafficked people and people who had gone through lots of abuse and things, and I didn't get any supervision…I just couldn't handle this anymore…so I was doing his job and my job, and I just fell apart" (Joel)

Not having psychological trauma was viewed by some participants as what will prevent them from self-harm:

> "The first thing that would prevent me from self-harm is being able to prevent…being sexually abused back in the day, if something like that was happening you don't like to talk about it. It was all control the hush, hush…" (Jacob)

This suggests a link between childhood abuse, especially sexual abuse, and psychological pain. To relief the psychological pain may precipitate to self-harm. Jacob's psychological trauma following childhood sexual abuse could also have been made worse and linked to not being allowed to voice out: "it was all control the hush, hush". It could also be argued that

not being able to express emotion may lead to negative expression of emotion through self-harming behaviour.

Similarly, Maria talked about what would have prevented her self-harm:

"…well, not getting abused for starters, but because I was abused at such a young age, I don't think anything could have prevented myself-harm, to be honest, because I grew up with a lot of lack of self-worth and me parent like me mom suffered with mental health difficulties …and so, I don't think anything at all would have prevented us from self-harming because I would have always carried this"(Maria)

Maria noted that her self-harm would have been prevented by preventing the psychological trauma of sexual abuse she suffered. However, she also highlighted growing up with low self-worth, which signifies self-worth as a protective factor that contributes to resilience to self-harm. Maria said she was not sure if anything could have prevented her self-harming behaviour, as she reflected on her mother having similar mental health issues and self-harming behaviours. This suggests the implication of inherent or intrinsic factors in resilience to self-harm.

Similarly, low self-esteem and lack of purpose were highlighted as some of the psychological factors that have negative impact on resilience to self-harm in the adult mental health patients:

"… you know, I would never amount to anything I didn't have any purpose in my life, I mean I never felt good enough" (Joel).

Similarly, another participant relates his response to the psychological trauma of his broken marriage:

"My first marriage kind of broke up after… years. She accused me of all these horrible things that I've done to her or done to my kids and I had to be investigated and that was when my world really fell apart…" (Joel).

This account suggests being overwhelmed by the impact of the stressful life event of a broken marriage which may have precipitated to self-harm. It also appears to suggest a threshold of stressful life event in individual's resilience to self-harm which arguably may be individual specific "this was when my world really fell apart".

Some participants' health issues were reported to affect their resilience to self-harm:

"Depression, anxiety, PTSD, and if those things become overwhelming, then self-harm helps me to regulate my feeling very sad…It helps to calm you down. So, I suppose feelings of being overwhelmed and out of control lead to self-harm for me" (Medlin).

Medlin made the connection between her mental health conditions and her self-harm behaviour. She associated psychological traumatic flashbacks of her PTSD, depression and anxiety with a decrease in her resilience to self-harm. However, Medlin acknowledged resorting to self-harm for relief only when she gets overwhelmed by the psychological pain.

6.4 **Relationship with family and with others as protective factor**

This theme captures the impacts of participants' relationship with their families and with other people on their self-harm behaviours.

Most participants reported connection with their families as protective factors against their self-harm behaviours. For example, a participant shared how his relationship with his children prevented him from self-harm:

"…the only thing that really stopped me… I saw a picture of my kids and that stopped me from jumping (self-harm) …" (Joel).

In this account, Joel stressed that “the only thing” that stopped him from self-harm was thinking of the impact of his self-harm on his children. Though there might have been other protective factors connecting with his family (children) at the time seems to have outweighed other protective factors.

Similarly, another participant said:

“Support-wise, I've got a massive like a really good family. My partner who I'm with, he is very supportive if it wasn't for him, I don't think I'll be this well with my mental health”(Maria)

In her account, Maria highlighted the importance of the quality of relationship as a protective factor “my partner-----very supportive”. It may therefore be argued that the nature of relationship with family is necessary in characterising it as a protective factor in self-harm behaviour.

As per Joel: “…but what's changed my life is the support I get from my children, the support I get from my wife, and the support I get from the people…and all the others… (Joel).

Joel clearly mentioned getting support not only from his family but from other people highlighting connecting to others as also significant in building resilience against self-harm.

Similarly, another participant also said: “for my coping strategies, I usually have people to talk to” (Medlin). Medlin highlighted how connecting with people helps her to resist self-harm. She stated that she would not self-harm because she does not want to disappoint those she is connected to:

“…you know having other people see this or know that and the disappointment that they feel… It's just it's kind of a cycle it makes you feel worse afterwards, and then it leads to depression, and I tried to just remember that before I even start the cycle and that usually helps” (Medlin)

Similarly, relationships with people were highlighted by another participant as having a positive impact on his resilience to self-harm:

> "It is just having a lot of people around me that reduces the urge to self-harm…I mean, you can take as much medication as you want, but you can't beat friendship and support from other people" (Jacob).

This account suggests that psycho-social support may be a preferred resilience factor in the participant's self-harm. This participant stated that having the support of people around him "reduces the urge to self-harm". This account also suggests that connecting with people or support from people may not guarantee cessation from self-harm but increases resilience to self-harm, as it "reduces the urge to self-harm". It portrays resilience as a dynamic process.

Though relationships have been reported as protective factors against self-harm however, some relationships could be a negative factor to self-harm. For example, being in an abusive relationship could be a trigger to self-harm:

> "I find that to be a huge trigger. It isn't really just the physical pain that I've been in as well as the emotional and mental psychological trauma from a bad relationship. Those are the only two things that have pushed me towards self-harm"(Daniel)

Similarly, another participant reported:

> "I suffered sexual abuse…. I was very vulnerable…where it (self-harm) more or less stemmed. And then when I met my first partner, he started to like abusing us as well. So, I think I self-harmed all them years because of how them relationships made us feel…"(Maria)

In this account, the nature or the quality of Maria's relationship is abusive and a trigger to her self-harm behaviours. Maria's self-harm behaviour "stemmed" from the sexual abuse she suffered in the past in her previous relationship. However, being in another abusive

relationship appears to trigger her old memory of sexual abuse which again may culminate to self-harm.

Among the six participants, only two appear not to experience connection with family as a support and coping strategy:

> "…a lot of family members did not hold the window open with this, so they just used to kind of block me out, which I kind of understand why they did that..." (Jacob).

Jacob did not necessarily imply that family connection is not a good support and coping strategy in self-harm. Rather, he said his family "blocked" him out and did not offer him support. Therefore, family relationship as a protective factor would depend on the nature or quality of the relationship as already mentioned. Another participant, Daniel, did not consider family as a source of support in coping with his lived experience of self-harm. On the contrary, his experience shows that his connection with family was possibly a trigger to his self-harm:

> "…I don't want anyone being able to find me and start bothering me or harassing me or asking me for money or whatever… it is what these people have done in the past. I'm LGBT club, so occasionally I'll get discrimination…and I have to make sure just for my mental health" (Daniel)

Due to his experience with family and other people, Daniel keeps away from them and does not want anyone to be "able to find" him. This experience includes financial stress, harassment and discrimination due to his sexual orientation, all of which appear to trigger his self-harm. Again from this account, relationship with family and other people as a protective factor to self-harm would depend on the quality of the relationship.

There is a thin divide between interpersonal relationships (relationships of self with others) and intrapersonal relationship. Intrapersonal relationship or relating with self, such as thinking on, or considering possible impact of self-harm on other people was mentioned:

> "…not to do it because it's made me reflect upon, you know, the impact it has on other people … seeing how it affects other people can also put you off doing it as well, because I feel like if I do It's gonna upset more people … You don't realise it at the time, but I learned quite a while after how much of the effect it had on my brother" (Jude).

In relating to self (intrapersonal relationship), Jude mused over or reflected on ("I feel like if...") the values of his relationship with family and people around him. This made him resist self-harm in order not to "upset" them.

6.5 **Connecting with others with the lived experience of self-harm**

Those who have lived experience of self-harm were reported by some participants as a good source of support. Participants shared that support from peers is helpful, as they have a better understanding of the issues of self-harm and are non- judgemental in their approach

> "…and there's no judge in that. There's care there and there's support and that's something I've never had in the past" (Jacob**).**

There is trust in sharing sensitive information with those going through stressful situations that could precipitate self-harm. The feeling of acceptance due to the non-judgmental approach appears to encourage trust and sharing of sensitive information. This account also buttresses the felt value of being non-judgemental in providing care to adults with the lived experience of self-harm. Another participant added:

> "It's lovely to be around people who understand because for the simple reason they've had their own experience and you and you don't feel judged" (Jude)

This account highlights the importance of “understanding” through having the lived experience which appears to be unique with peers with the lived experience of self-harm. It could be said that due to their experiential “understanding “of self-harm, they are non-judgemental regarding self-harm behaviours.

Upon offering peer support to those who self-harm, Jacob reckoned:

> “Yeah, people find me approachable, and people will open up and talk about the things that they are struggling with...” (Jacob).

Similarly, another participant highlighted the impact of peer support in coping with self-harm:

> “I've got a lot of support around at the moment. Seeing what their coping techniques is has helped me to be a bit stronger and not to do it…I've had people around us that not made us feel bad for it.... if you do slip up (self-harm), you're not going to get, you know, criticised for it or anything like that. It's quite powerful because they used to do it, but they've managed to stop doing it” (Jude)

Jude echoed that support from those who have lived experience of self-harm has a non-judgemental approach, which is valuable in encouraging learning from their coping techniques. Learning from those who did it and managed to stop not only demonstrates the effectiveness of their techniques and coping strategies, but also the value of learning from experts by experience.

Similarly, another participant narrated peer support experience as a coping strategy to self-harm:

> “You're talking to someone as well that's also experienced what you have really helps… I think that's what gives us the incentive to get better, because if people… have gone through all of that and…come through…“(Maria)

Maria in her account reckoned with the motivation and challenge to “get better” as peers with the lived experience of self-harm who have recorded success in their resilience to self-harm. Leaning on the support from peers appears to challenge her to maintain positive mind-set and courage. This depicts courage as an important domain in resilience building

Similarly, another participant expressed:

“…It's a peer support and everybody has got their own lived experience and I think the lived experience goes a long, long way …the support from peers who have lived experience of self-harm was better…I think the key thing for me would have been sitting down with somebody that cut themselves as well, and learn how they coped with it” (Jacob).

Comparing support from those with the lived experience of self-harm and other supports as resilience factor to his self-harm, Jacob said:

“… And to me, that (peer support) was the biggest support and the biggest coping technique” (Jacob)

Prevention of self-harm was viewed to be strengthened by connecting with quality positive relationships with family, friends and others. Therefore, it could imply that supporting the development and growth of such relationships would be beneficial in reducing or preventing self-harm.

6.6 **Understanding my illness and resilience journey**

This theme captures the participants’ coping in relation to understanding how their illness or wellbeing impact on their resilience. It highlights how participants’ understanding of their illness helps their resilience to self-harm. It shows the importance of understanding the role of health as a domain in resilience building. Some participants said that understanding the nature of their illness helps them cope better:

"I had a misdiagnosis for a long time, so I wasn't diagnosed with the right illness until….getting that (right) diagnosis helped us realise…a lot of the behaviours weren't me. It was me illness…"(Maria).

According to Maria, after getting the right diagnosis for her illness, she was able to understand that a lot of her "behaviour" (self-harm) stemmed from her illness (symptoms) and was not necessarily due to her personal traits.

Similarly, Daniel, in understanding and dealing with his self-harm triggers as a coping strategy, said:

"…so I think the main issue is finding out what triggers it(self-harm), what kind of thing makes me feel like that, and for a long time I live with chronic pain. I didn't know that the amount of pain that I'm in was causing me to have suicidal thoughts, which means that for years I was having negative thoughts, and I didn't realise it was down to my health…" (Daniel)

The nature of Daniel's illness (chronic pain) was causing him to have self-harm behaviour without realising the connection. Once he understood the impact of his chronic pain on his self-harm and received the right treatment (pain management) for the chronic pain, his self-harm behaviour came under control.

Understanding and addressing what triggers self-harm is reported as a good strategy in coping with self-harm. Daniel further said that keeping healthy makes him happy and helps him to resist the urge to self-harm. This suggests a significant link between health and building resilience.

"…one best thing that I've found is looking after myself. That's been definitely one of the best things because when I'm in better health…I'm not in as much discomfort and it is healthier, I'm happier…" (Daniel).

Similarly, Medlin claimed that insight into her mental health has been an advantage in building a better support and coping strategy. She appears to acknowledge that being mentally stable has a positive impact on her resilience to self-harm:

"…I tried to notice my mental health before it gets to that point of self-harm. I tried to take control of my emotions before I get to crisis" (Medlin).

Medlin felt she could have had a better coping strategy in limiting her self-harm behaviour if she had a better understanding of the nature of her illness:

"…could have prevented it (self-harm) in the beginning because I didn't know what was happening to me...." (Medlin).

Noticing or monitoring the mental state may require some knowledge of the condition in relation to the mental health relapse indicators, and understanding of the co-morbid factors of some mental health conditions on self-harm behaviours which may need professional support presented further in this Chapter under 6.7

Medlin did not only speak on the advantage of understanding her mental health relapse indicators in building resilience to self-harm but also spoke about the multi-factor approach and effectiveness in her resilience to self-harm. She adopted a combination of psychosocial support, understanding the nature of her illness and monitoring her mental state, as deterioration could trigger her self-harm behaviour. She found the multi-factorial approach to be about 80% effective in her resilience to self-harm:

"…and a combination of finding what was right for me. I suppose, but now that I Know what to do. It's very effective. Umm I would say 8/10" (Medlin).

Similarly, Daniel reckoned that his resilience to self-harm is multi-factorial. He noted that it is not only dependent on his understanding of his mental health issues but a process which is

dependent on multiple factors instead of “one single thing”. He appears to report resilience to self-harm as a process not just an outcome. He said:

“This isn't. It isn't one single thing. It's like a process. It's like lots of things” (Daniel).

Similarly, another participant reflected on the resilience to self-harm as a work in progress:

“…but that kind of self-worth and that self-esteem thing is still a work in progress, you know” (Joel).

Joel links self-esteem or courage as a resilience domain and acknowledged resilience to self-harm as a dynamic process which requires building on, a work in-progress.

6.7 **Seeking professional support**

Seeking professional input has been highlighted by some participants as part of the strategy in resisting self-harm behaviours. Jacob was seeking professional intervention to cope with his self-harm behaviour. However, he was dissatisfied with the input of some medical professionals, which he felt was not helpful. Nonetheless, the input of the non-medical professional, the social worker who sorted his need (accommodation issue), was felt helpful:

“… I went to the doctors to get support and all they did was push antidepressants towards us.… I didn't think that was very helpful …I just felt there was no care …then there was an off-duty social worker who took us to one side, made some inquiries, got me into supported housing and…”. (Jacob)

This highlights the importance of holistic assessment in identifying patients’ needs and factoring in their perspectives in providing effective support. According to this account, the social worker did psychosocial assessment and worked collaboratively with Jacob to find a solution to the need which might have been a trigger to his self-harm. The social worker’s input was felt to be more supportive of resilience to self-harm than the biomedical input. This

appears to support the preferred value and dominance of psycho-social input over biomedical approach in self-harm interventions.

Similarly, Joel reported professional psychological support to be strategic in coping with his lived experience of self-harm:

"**…**after that, our mental health was really poor…but luckily, I got referred to a lady who was a psychologist. The support from the psychologist…has been amazing and…I think the length of time of the support, like that of the psychologist, made a huge difference" (Joel).

Joel found psychological intervention to be adequately sustained for the length of time that it "made a huge difference" in improving his mental state, which helped him to cope better with his lived experience of self-harm.

Another participant valued the input of a mental health professional:

"…I've got a massive support, a really good support network with community mental health team… I' ve got a CPN(Community Psychiatrist Nurse) that I'm with now, who helped us, get me right diagnosis, and she's very supportive…" (Maria).

Maria acknowledged the input of her community mental health professional in coping with her self-harm. This shows the effectiveness of more than one professional in self-harm management. The two previous accounts mentioned the effectiveness of a social worker and a psychologist. In this account, the effectiveness of a CPN is added. Maria also made it clear that professional input is an effective support and coping strategy only when one cooperates and engages with the professional advice hence highlighting the importance of collaborative working in effective care:

"…but you have got to engage with the service for the treatment to work, otherwise it won't work…"(Maria)

Further to accessing professional input:

"I found that medically…when somebody is in a state where they might self-harm, the first thing that they might do is an assessment, then…" (Daniel)

Again, a professional, holistic assessment is important in identifying patient needs, including the risk factors and triggers to self-harm.

Participants accounted for the impact of their hospital experience and the input of professionals on their lived experience of self-harm. Participants' hospital attendance after self-harm mainly were either for treatment of self-inflicted cuts or treatment for a drug overdose. Some participants who self-harm did not go to the hospital because they only made superficial cuts which may not require stitching. Participants who had deep cuts attended hospitals to have their wounds treated by health care professionals:

"…I would end up in casualty, either getting my stomach pumped because of an overdose of tablets or… getting stitches in my arm or other parts of my body" (Jacob).

Medlin said she went to the hospital after self-harm because the cut she made was so serious that it required stitching and treatment to prevent infection:

"I cut myself. I cut my arms…got stitches…the cut was to such a degree that it needed to be stitched…it would just…got infected" (Medlin)

Similarly, Maria had a very deep cut, which made her sick and required a surgical intervention:

"…I'd cut my arm, but I'd gone right to the bone… So unwell I had an operation and…" (Maria).

There were issues that made some participants not to go to the hospital for professional intervention:

"…I've never been to the hospital because the cuts were never that deep but…I have mentioned it at the doctors when I thought it might have become infected" (Jude).

Another reason the participants avoided going to the hospital to seek professional support was feeling ashamed due to the stigma associated with self-harm. Joel had been to the hospital after self-harm on several occasions, so he eventually felt ashamed:

"…I was ashamed because I was kind of, I was constantly, to be honest and I couldn't get myself…" (Joel). Similarly, staff attitudes towards self-harm appears to be another reason people who self-harm loathe going to the hospital:

"…one night I got put in the hospital and they just left me in an empty room all night. And to me, that wasn't very supportive at all. And then of course, for the nurse to turn around and she said, 'you know, you're wasting our time.' That was like the final blow for me, and I lost all trust in hospitals" (Jacob).

Another participant narrated his experience of a negative attitude from staff in hospital:

"I think the experience I've had from the doctors, that's why I don't think I would ever have gone to the hospital…, just you feel like you're wasting their time" (Jude).

The lack of empathy from professionals made Jude feel that he is wasting their time, because it was a deliberate harm to self and not an accident:

"…It's because it was self-harm and not accident they think it's kind of preventable and a waste of resources and a waste of time if you're doing it to yourself rather than having an accident…"(Medlin).

On the other hand, Daniel felt that going to the hospital was not beneficial:

“It makes people worse and everyone that I've spoken to over the years who have been in hospital has said it was a bad experience and they are worse because of it and I've noticed that people who have been in hospital end up going back to hospital”(Daniel).

Daniel’s account appears to shade light on less valued biomedical approach in self-harm management. He feels hospital attendance has not been able to mitigate the repeat episodes of self-harm.

There is frustration and disappointment about the long wait to access specialist professional input:

…there's a waiting list as well so you might have to wait six months and I waited nine months to see a psychologist…I mean, by the time you've waited, you're either much worse or you just don't want to speak to anybody anymore” (Daniel).

Though some participants reported bad experiences at the hospital, attendance accorded professionals the opportunity to make relevant referrals to other professionals and services to meet participants’ needs. Participants found referrals to the mental health team and secondary psychological services helpful, despite the long wait. These services have professionals who understand the nature of mental health and self-harm, and are better placed to offer expert intervention.

6.8 **Using coping strategies and skills**

This theme presents participants’ various self-distraction techniques, beliefs and engagements that help them to shift their focus from self-harm. For example, Jacob and Maria mentioned shifting their mind away from self-harm to focus on simulating the effect of cutting their arms:

“I do know about…the stuff like making some ice cubes with some red food colouring in…you squeeze them, and the coldness of the ice cube gives you the same feeling

as if you cut yourself. And of course, the ice cubes melt with the red food colouring in, and then it looks like you're bleeding as well. Can be very effective" (Jacob).

Jacob perceived the effect of the pseudo-self-harm as an effective replacement or distraction from self-harm. He highlights the pseudo feel of pain and the sight of blood as needed components in self-harm by cutting. A similar distraction technique was narrated by Maria:

"Well, I do use a certain coping strategy such as a red pen when I'm feeling like to self-harm, I'll use a red pen and go on the old scars on the arms…and that tells me brains for a split second that I've already done it (self-harmed). So, it does help sometimes. The only problem with that is that I don't get any pain with it…and sometimes I use candle wax because that gives us the warm feeling which is what you get when you self-harm when the blood is releasing..." (Maria)

Maria noted that the pseudo self-harm distraction technique she narrated does not give the pain associated with self-harm, which she desired to replace deeper emotional pain. To feel pain, Maria used candle wax on her arm or use pinpricks to self-inflict pain and to let blood out. This may underscore the feeling of pain, sight of blood and warm feeling as desired features in self-harm by cutting.

Participants highlighted other self-distraction techniques such as meditation and using intrapersonal skills to create positive memories:

"…I've found that the best thing to do is to look at first of all what I'm thinking about, because I have to…guard myself and think…any memory that I have is in the past. It stays in the past... that really helps…and also creating positive memories to replace any kind of stress is really important to me" (Daniel).

According to this account, it follows that dwelling on the positive or good memories has the potential to instil hope and distract from self-harm, whereas reminiscing over bad or negative

memories could precipitate negative emotions, which could result in engaging in self-harm as a coping mechanism. This highlights the importance of psychoeducation in self-harm management.

Daniel mentioned his self-distraction technique of engaging in physical activities such as shopping and going to the restaurant or café:

> "…I might go out to a restaurant. I might go to a cafe. I might go out and buy some silly souvenir from a tourist shop. I might just do something like that, no matter how small it is. It's a positive memory…. helps to make whatever it is that's happening seem not as bad …" (Daniel).

Part of what Daniel does in responding positively to his self-harm trigger is occupying his time meaningfully, which he said usually helps:

> "…as long as it stays positive, I think it's very effective. I would say more than 50% effective at keeping me in a stable state if I have good things to do. If I have hobbies that I can give my time to, I think it has a huge impact on me …"(Daniel).

Positive memories, positive attitude, routine activities and relationships, all of which will enhance resilience, were highlighted by Daniel as the self-distraction techniques he used as coping strategies.

Jude, again, mentioned using "memory box" as a self-distraction device:

> "…and also, the memory box is actually quite good idea because it can be a distraction as well…it takes your mind off the reason why you might want to self-harm in the first place" (Jude).

Jacob reported similar experience with the memory box:

"…. I open that box and I've gotta go through me good memories before I get to work stuff to harm myself…" (Jacob).

Engaging in daily creative activities was found by Medlin to be helpful in her resilience to self-harm behaviour:

"I do something creative just to try and keep everything balanced sort of on a daily basis, so I don't get to the point of being needing to self-harm" (Medlin).

Occupying self with meaningful activities on a daily basis was similarly found by Maria to be helpful in her lived experience of self-harm:

"For me, like I've got to keep myself busy. I can't just sit and dwell on things because then that's when it makes us want to self-harm if I'm left to just be with me (Maria)...So, I think distraction has been the main key for me plus a really good support system, which I do get…" (Maria)

While some participants accounted their religion, beliefs or spirituality as part of their self-distraction and coping strategy, others did not:

"…I don't really have any beliefs. I'm not really religious as such; I'm more of a spiritual person…But I don't think that my religious beliefs have had any impact whatsoever on my self-harm or how I feel about myself…"(Maria).

On the contrary, Daniel narrated his spirituality as resilience factor in his self-harm behaviour:

"One of the main things tome throughout my life it's been my religion so I would pray I'm not Christian. I'm Pagan, which is the nature religion. I would. I would do whatever positive things within my religion…, so it could be going for a walk in nature it could be lighting a candle as a prayer as a blessing such a strong belief in my religion that it's the main thing that has kept me going" (Daniel).

Summary

The analysis revealed seven main themes: “Thought of the consequences”,” Relationship with family and with people as a protective factor “, “Connecting with those with lived experience of self-harm”, “Responding to stressful life events, “Understanding my illness and resilience journey”, “Seeking professional support”, and “Using coping strategies and skills”

Most participants’ thought on the consequences of their self-harm made them resist or minimise their self-harm. They reported resisting self-harm more when its consequences were perceived as more severe than when they are not. The consequences mentioned by the participants were either direct consequences for themselves or indirect consequences for people socially connected to them.

Relationships with people, family, friends and peers were reported by some participants to be protective factors against their self-harm. However, some abusive or stressful relationships were reported by other participants as triggers to their self-harm behaviours. Support from peers with the lived experience of self-harm was highlighted by some participants as being non-judgemental and effective. This enables them to share personal and sensitive information about their self-harm experience and effective coping and support strategies, as well as see examples of peers who had effectively managed their self-harm well. This was reported as an incentive to decrease or desist from self-harming by some participants.

Psychosocial issues as bullying, domestic violence, sexual abuse, divorce, and other relationship problems and stressful life events were highlighted by some participants who narrated the impacts on their lived experience of self-harm. Whereas some participants’ reported employment as a protective factor, others narrated how employment related issues precipitated their self-harm.

Some participants said that understanding the nature of their illness made them cope better with their self-harm and considered the inputs of some care professionals as a positive factor in their resilience to self-harm. However, the negative attitudes towards self-harm by some health care professionals were nonetheless highlighted as a negative factor. Through making the right diagnosis, identifying and meeting participants' needs, professionals' supports were reported as help in building resilience to self-harm. However, some participants highlighted delays in accessing specialist intervention such as psychological services. Most hospital attendance by the participants following their self-harm were either to get their wounds stitched and ensure they were not infected or to get treatment for their intentional drug overdose. Those who self-harm by making superficial cuts did not go to the hospital for treatment as they were not at significant risk. However, most of the reasons for not seeking professional support were the negative attitudes of the healthcare professionals, the shame and stigma associated with self-harm.

Most participants reported using different self-distraction techniques and approaches to resist self-harm. Participants described the use of the placebo effect of self-harm, such as using ice cubes, red ink, candle wax and pinprick to simulate the effect of self-harm. For long term self-distraction, participants engaged in activities such as daily exercise and routine, yoga and meditation -mindfulness, reflecting on positive memories, religion, culture and spirituality.

Some participants mentioned the multi-factorial approach in their resilience to self-harm. Most participants' explanations of their self-harm identified relief from, or regulation of emotional pain caused by psychological trauma, most of which were linked to the sexual abuse that most of the participants suffered in their childhood.

Chapter 7: Discussion

7.1 **Introduction**

The preceding chapter detailed the findings of the qualitative research that used IPA and provided the summary of the findings. It was found that various factors are involved in resisting or minimising self-harm in adult mental health patients. Though few previous studies included in the systematic literature review showed similar multifactor involvement in resilience to self-harm, the studies were largely focused on young adults. In addition to this, some of the studies also have methodological inconsistencies and lacked deeper nuance. The understanding of these factors and what is considered as help may require the subjective assessments of those with the lived experience.

This chapter builds on the findings of the qualitative research to explain, interpret, critique and ground them in the existing literature. This research aimed to explore the adult mental health patients' perspectives of self-harm and resilience factors to determine their effective common and most reported resilience factors to self-harm and how these work to prevent or minimise self-harm and promote mental well-being. The findings suggest that the adult mental health patients with lived experience of self-harm perceive the following as the common effective resilience factors to self-harm: thinking about the consequences of self-harm, relationship with family and with people, connecting with others with lived experience of self-harm, responding to stressful life events, participants' understanding of their illness and resilience journey, seeking professional support, and using coping strategies and skills. These would be critically discussed in this chapter under the following themes: consequences as deterrence in self-harm, relationships with family and others as protective factors, peer support as protective factor to self-harm, stressful life events as self-harm triggers, healthcare professionals as protective factor in self-harm, adults lived experience of resilience in self-harm and impact of methodological issues on findings

7.2 **Consequences as deterrence in self-harm**

Participants narrated being deterred from self-harm by thinking or reflecting on the consequences. This is consistent with previous research (Cliffe, and Stallard, 2023; Norman et al., 2022; Wadman et al, 2017). However, in this current study, all participants reported being deterred from self-harm by thinking or reflecting on the consequences, whereas in the previous studies only few participants reported this. In the study by Cliffe, and Stallard (2023), for example, 32% of the participants feared disappointing their loved ones by self-harming. These participants, as in the current research, also thought of the impact of their self-harm on their loved ones. However, unlike the current research, they did not categorically mention thinking on the consequences as the reason for not self-harming. Hence, current research provides a stronger illustration of self-harm deterrence by thinking about the consequences. In Wadman et al. (2017), the participants weighed the option of getting relief from self-harm against its economic costs and the possibility of negative impacts on their relationships. Albeit, thought of the consequences of self-harm as a resilience factor to self-harm was not clearly articulated in previous research from the systematic literature review as in the current research. For example, participant in the current research did not self-harm because he thought of the consequences. He said "…but I just haven't done it [self-harm] I've just sort of thought of the consequences". Another participant said "… I don't get to the point of needing to self-harm because I know the consequences are bad…" This sort of clarity in linking deterrence from self-harm to thinking about the consequences is lacking in previous research from the systematic literature review.

In addition to the lack of clarity of association of thinking about the consequences of self-harm to deterrence in the previous research included in the systematic review, the nuance of the association of the severity of the consequences of self-harm and resistance to self-harm is also not accounted. This is unlike the current research, which used IPA to provide a

more detailed account that suggests association of the severity of the consequences of self-harm and the resistance.

Within this current research, participants spoke about how reflecting on the severity of the harm they might experience deterred them from self-harming. Current research added that more severe consequences of self-harm provide stronger deterrence than less severe consequences. For example, the consequences of losing a limb, as reported in the current research by a participant (Jacob) or bleeding to death due to bleeding disorder reported by another participant (Jude) evoked stronger resistance to self-harm than the consequences of a superficial skin cut. Hence, there is less resistance to self-harm by a superficial skin cut than there is by a deep skin cut. This is especially so when there may be severe consequences due to an underlying medical condition. For instance, a participant with an underlying medical condition (bleeding disorder) said he was “being careful” not to self-harm by cutting deep into his skin to avoid excessive bleeding that might be fatal. The fear of dying counted for, is more than the fear of a superficial skin cut. Whilst participants in the current research clearly articulated the association of greater deterrence against self-harm with severity of consequences, this is not well explored in the previous research (Cliffe, and Stallard, 2023; Devassy et al., 2023). The present research, therefore, adds to knowledge that suggests physical implications as self-harm deterrence, particularly where they could exacerbate existing medical condition. For example, in the current study, one participant was deterred from self-harm by cutting because he has a bleeding disorder. The clinical implication is that a clear understanding of the consequences may be of benefit in building resilience to self-harm. Also, the present research fills a critical gap by suggesting that individuals weigh potential physical harm against their emotional relief by self-harm. For example, a participant weighed the consequences of potentially losing a limb by self-harming against getting emotional relief.

Severe consequences of harm to self that may lead to death sets self-harm aside from suicide. The intention to die distinguishes self-harm from suicide as self-harm is not done with the intent to die. In non-suicidal self-injury (NSSI), bodily harm is less medically severe and with unlikely death consequences (Muehlenkamp et al., 2012; Andover and Gibb, 2010). The present research therefore suggests from the adult mental health patients' perspective that there is no intent to die in self-harm. This does not align with the definition of self-harm as per the United Kingdom National Institute for Health and Care Excellence (NICE, 2022), which defines self-harm as self-poisoning or self-injury, irrespective of the apparent purpose for the act. The findings in this present research aligned with the concept of self-harm as NSSI (see chapter 1(1.2)). It sets suicidality aside from self-harm behaviours, which are often engaged to get emotional relief. The definition of self-harm supported in this current research agrees with the researcher's theoretical underpinning of epistemological subjectivism and ontological relativism (see Chapter 4 (4.1.4)).

This study makes a significant contribution to the literature on self-harm and resilience by establishing thinking about consequences, particularly severe ones, as a central and robust deterrent. Unlike previous studies, which highlighted thinking on the consequences of self-harm as a deterrent in a few participants, the current research shows consistency across the sample. Current research suggests that the severity of anticipated consequences correlates with the strength of resistance to self-harm, a relationship that may warrant further empirical exploration.

7.3 **Relationships with family and others as protective factors**

Relationship with family and with other people was reported by some participants as protective factor in their resilience to self-harm behaviours. This is consistent with the findings of previous research included in the systematic literature review (Macrynikola, Miranda and Soffer, 2018; Liu, 2023; Devassy, 2018; Turner et al., 2017; Jackobson et al., 2015; Kim and Hur, 2023).However, in the current research all participants did not report

relationship with family and others as a resilience factor to their self-harm, as some reported it as a trigger to self- harm. This characterisation of relationship with family and others in context of protection against self-harm is lacking in previous research shown in the systematic literature review. Therefore, the current research may contribute more depth to the understanding of the relationship with family and others as a protective factor in the adults with lived experience of self-harm.

Previous research in the systematic literature review explored the perceived support felt from family, friends and significant others and posit that individuals who engage in self-harm have low levels of interpersonal relationships (Trepal et al., 2015; Turner et al., 2015; Hunter et al., 2013). However, they failed to elucidate on the relationship with family, which may have been achieved by an in-depth analysis, using IPA which is used in the current research to provide deeper nuance. In Hunter et al. (2013), participants who lived alone suffered loneliness and expressed relief by having someone to talk to "when you're living alone you can't really talk to anyone". Though Hunter et al. (2013) acknowledged relationships with people as a resilience factor in self-harm, their study failed to provide characterisation of the relationships, such as living with family or the quality of relationship with family. Similarly, in Turner et al. (2015), participants who have fewer "contacts" with family showed lower resilience to self-harm when compared to those who have more "contacts" with family. Again, there is no indication of the quality of the relationship or characterisation that explicitly suggests relationship with family as trigger to self-harm or a protective factor. This is not consistent with the current research, where some participants clearly characterised and reported their relationship with their family as a trigger to their self-harm. Therefore, relationship with family may not be generalised for all the adults as a protective factor to self-harm. This is because being in an abusive or stressful family relationship may be a trigger to self-harm. Therefore, current research highlights that it would depend on the individual who self-harms to disclose what is applicable in the circumstance and what or whether

relationship with family is a protective or risk factor to the individual's self-harm. Again, this may require a subjective assessment which aligns with the epistemological subjectivism and ontological relativism underpinning this research. The implication is the need for a subjective assessment of a person with the lived experience of self-harm, to understand if the relationship with family is a protective or trigger factor. This also reflects the person-centred approach in provision of care in self-harm (Lewis and Hasking, 2021; Lindgren, Molin, and Graneheim, 2021), where care, again, requires a subjective assessment of the patient to meet the identified needs.

7.4 **Peer support as protective factor to self-harm**

Self-harm self-help groups, though underutilised, remain a valuable source of support for their members (Boyce, Munn-Giddings, and Secker, 2018). This is corroborated in this current research, which also adds to existing knowledge, since most participants explicitly characterised peer support as "very effective" in resisting self-harm. This nuance of the effectiveness of peer support is missing in previous research. Though previous research as current research reported peer support to be a non-judgemental safe space to learn and share self-harm coping strategies from those with the lived experience, previous research failed to explore their perceived effectiveness. Current research explored the effectiveness of peer support which was reported by most participants to be "very effective".

The previous and current research are consistent in finding talking to peers who have the lived experience of self-harm to be protective because they felt that peers are experts in their lived experience (Naz et al., 2021; Hetrick et al., 2020; Lewis et al., 2019). Nevertheless, current research adds the nuance that peers demonstrate a better understanding of self-harm than health care professionals. The current research also expands the knowledge on peer support in self-harm in adults as a means of coping with their self-harm by adding that peers are not only non-judgemental but can also be trusted in sharing some sensitive information in addressing their self-harm behaviours. This was also highlighted by some participants in the current research as one of the reasons they preferred peer support of

those with the lived experience of self-harm to seeking the support of healthcare professionals. This finding on peer support is unique as it adds the perspectives of adults that resilience to self-harm is inspired by seeing and learning some skills and coping strategies from peers who have the lived experience of self-harm and have managed their self-harm well.

7.5 **Stressful life events as self-harm triggers**

Stressful life events (SLEs), such as relationship breakdown, loss of job, failure, rejection, and other socio-economic issues were reported by most participants in the current research as triggers to their self-harm. This is consistent with previous research (Devassy et al., 2023; Wadman et al., 2017; Barnes 2016), which reported joblessness, low income, and an unhealthy and unsupportive hostile work environment as triggers of self-harm. However, current research added an interesting nuance that despite SLEs being reported as triggers to self-harm, some participants were still able to resist self-harm when faced with SLEs. Nonetheless, they became overwhelmed by the cumulative effect of SLEs. For instance, a participant (Joel) in current research remarked “this is when my world fell apart”. This suggests that the threshold of “falling apart” or being overwhelmed by SLEs leading to self-harm, is personal (“my world”). This implies that it varies between individuals, suggesting resilience to also vary between individuals. Some participants in current research described their jobs as stressful and a trigger of their self-harm, whereas others viewed being employed as protective against self-harm. Current research unlike previous research, shades light to the contextual understanding of SLEs as triggers to self-harm by highlighting that it is both individual and event or circumstance specific. This expands the existing body of knowledge on the adult mental health patients’ perspective on self-harm and resilience.

7.6 **Healthcare professionals as protective factor in self-harm**

There is ambivalence on how some healthcare professionals’ approaches to self-harm were perceived in this research. Whereas some participants perceived healthcare professionals as insensitive and judgemental, others found them supportive in building resilience to their

self-harm. According to most participants, negative staff attitude, shame and the stigma of self-harm made them reluctant to access professional support. This nuance, which is lacking in the previous research, reveals some reasons adults with the lived experience of self-harm may hesitate in seeking healthcare professionals' support or report their self-harm. Therefore, the current research appears to shed more light on the attitudes of healthcare professionals towards self-harm. For example, in the current research, a healthcare professional remarked "you know you're wasting our time" (see 6.6). This nuance suggests that the negative attitude of health care professionals towards self-harm is still prevalent, raising critical questions on the current level of awareness of self-harm among health care professionals. The current research also suggests that adult mental health patients may learn more about their illness if healthcare professionals are non-judgemental, sensitive and empathetic, which encourages the sharing of sensitive information that may help in identifying and meeting their needs to address self-harm. In current research, the reported reluctance in seeking professional supports due to staff negative attitude and stigma has an important clinical implication. This is because it may contribute to the challenges in keeping accurate records of self-harm prevalence (Knipe et al., 2022) which may be strategic in the plan of care.

Current research unlike the previous, reported psychoeducation offered by the health care professionals on the nature of mental health problems and the impact they may have on their self-harm as help in resisting self-harm. This highlights psychoeducation by care professionals as important in building resilience against self-harm. Some participants also reported good experiences and outcomes with healthcare professionals. For example, a participant reported a good experience with a Community Mental health Nurse (CPN), which aligns with previous findings that mental health nurses with better understanding of self-harm have a less negative attitude towards those who self-harm (McGough et al., 2021).This

suggests appropriate training for healthcare professionals as key to their improved attitudes towards self-harm (Gibson, Carson, and Houghton, 2019).

Current research also suggests waiting longer than the UK's average of six months for those who self-harm to get specialist psychological intervention (NHS Providers, 2025; Mind, 2024). This is important as it may suggest either increased demand for psychological services in self-harm management or a short supply of psychologists. Current research also adds to the existing understanding that the long waiting times are not only frustrating but also contributes to patients' disengagement from services.

This current research, unlike the previous studies from the systematic literature review provides unique information on the impact of understanding the nature of illness on resilience to self-harm in adult mental health patients, which was reported to be beneficial in developing their coping strategies. This is because some self-rejections or low self-esteem associated with self-harm as triggers were linked to lack of some participants' understandings of the nature of their illness. In the current study, a participant, as already mentioned in Chapter 6, highlighted the benefit of understanding the nature of his illness to building resilience to self-harm. Similarly, another participant [Maria] stated that she could have coped better with her self-harm if she had a better understanding of the nature of her illness.

7.7 **Adult lived experience of resilience in self-harm**

The findings of the qualitative research using IPA (Chapter 6) highlighted participants' views of resilience to self-harm as "a work in process", which is dependent on multiple factors instead of "one single thing". The current and previous research in the systematic literature review (Lewis et al., 2019, Liu et al 2023 and Wadman et al., 2017) are consistent in highlighting the complex, non-linear and dynamic nature of resilience to self-harm. However, unlike the previous research which did not refer to the term resilience directly, current

research referred to it explicitly and adds the critical nuance of the inter-play of multiple factors in resilience against self-harm. This nuance is lacking in the previous research.

The present research expounded on the study by Rossouw et al. (2017) (see 2.13.) which explored resilience as an enabler in job satisfaction in adult professionals and found that those who reported higher job satisfaction were more resilient. The study posits six domains of resilience: vision, composure, response, tenacity, collaboration and health. These domains will be re-visited in this section by looking at resilience through the lens of the adults with the lived experience of self-harm.

7.7.1 Vision (Self-harm resilience)

Looking through the lens of the adults with the lived experience of self-harm, “vision” refers to the purpose or the goal, which in the context of current research is “self-harm resilience” adult lived experience perspective. The set goal or “vision” helps to provide the drive in making hard decisions in tough times. It helps to focus and maintain set of values such as self-worth and guide how one may treat self or react in adverse conditions. Maintaining the vision or set goal may require individual’s regular reflection on why the goal matters to him or her as it may provide the reason to remain focused.

7.7.2 Composure (Responding to stressful life events)

This relates to the capacity to regulate emotions well and to stay calm in responding to stressful situations and maintain realistic expectations. This involves understanding and accepting that stressful events are part of life situations that are common to all. Emotional regulation may involve maintaining a sense of calmness through practicing mindfulness skills such as breathing exercise, pleasure seeking and avoidance of pain that may culminate in loss of emotional control. The loss of control may precipitate to maladaptive behaviour such as self-harm.

7.7.3 Reasoning (Thinking about the consequences)

This domain is about sound reasoning which is aimed at achieving the set goal. It is the ability to think and weigh up options available in the circumstance to make choices that would support the set goal (self-harm resilience). This is enhanced by good problem-solving skills which is associated with higher resilience. This may require self-appraisal, being skilful in making reasonable adjustments, and proactive planning.

7.7.4 Tenacity (Using coping strategies and skills)

This domain relates to being consistent in maintaining focus on the set goal. This involves building and using different coping strategies and skills in holding on to the set goal. Though skills' building may have some challenges and take some time, perseverance is needed to continue moving towards the set goal. Instead of quitting due to challenges and setbacks, lessons are learnt to continue.

7.7.5 Collaboration (Relationship with family, peers and others)

This domain requires accessing the available supports in achieving the set goal. This is because working alone has the potential of exposing one to a greater risk of missing the set goal. To build good collaboration, one can invest in supportive relationships, learn and practice social skills such as active listening. Collaborative working provides the advantage of having the access to variety of skills from different professionals to realise the set goal. A good support network is a source of strength and people who are connected with family, friends, peers and others are shown to have higher resilience than those who do not.

7.7.6 Health (my illness and resilience journey)

Health is an important domain (see Section 2.13.1) in understanding resilience journey as it provides the platform for the holistic approach that links all domains. The linking and complex interplay of domains implies that the strength or weakness of a domain may affect others and consequently impact on the set goal ("self-harm resilience"). Healthy lifestyle

such as healthy eating and exercise are essential in resilience building against self-harm. There is interconnection/interplay of the domains around the set goal ("vision" (resilience to self-harm)). Table 7(below) provides the adopted six domains of resilience and their associated adult perspectives' key skill focus.

Table 7: Adopted six domains of resilience: Adult perspective in self-harm

Domain of resilience	Adult perspective in self-harm
Vision	Resilience to self-harm
Composure	Responding to stressful life events
Reasoning	Thinking of the consequences
Tenacity	Using coping strategies and skills
Collaboration	Connecting with family, friends and peers
Health	Seeking professional support/understanding my illness and resilience journey

The subjective views of the participants on the concept of resilience again cohere with the theoretical underpinning of epistemological subjective constructivism and ontological relativism (see 4.3.1), where knowledge or truth is relative and subjectively construed. Therefore, understanding deterrents to self-harm to increase resilience would depend on knowing the deterrents from the individual which may require subjective assessment rather than focusing on biomedical explanations which may limit lived experience (Rebair, Harrison & Brandon, 2025). Also, it could be argued that focusing on the objective professional assessments using clinical guidelines, may gain dominance over an individual's subjective perspective (Quinlivan et al., 2017). Nonetheless, both objective and subjective lens are

needful as the objective lens ensures safety and clinical consistency, whereas subjective in addition ensures personalised care is respected. The implication of this is, to engage a holistic assessment, and set realistic and achievable goals, to address identified needs for effective self-harm management.

7.8 **Impact of methodological issues on findings**

Notably, some methodological inconsistencies were found with previous research in the systematic literature review which may have introduced bias to their findings. In the context of adding to the existing knowledge on self-harm resilience in adults, previous research may have less weight of evidence compared to the current research. For instance, current research has a wider adult age sample representation than previous research which may have less weight of evidence on: thinking of the consequence of self-harm as a protective factor (Wadman et al., 2017; Devassy et al., 2023), connecting with peers as protective factor (Boyce, Munn-Giddings, and Secker, 2018), and the participants' views on resilience to self-harm (Lewis et al., 2019; Hunter et al., 2013)

For example, Wadman et al.'s sample (N=6; Mean age=19) is young compared to the current research (N=6; Mean age=40). Therefore, the highlighted sample age difference may be significant in interpreting the association of self-harm with thinking about the consequences as a resilience factor. This may be because younger adults are less likely to consider the consequences of self-harm. Participants within the younger population may also be open to taking more risks (Bonem, Ellsworth and Gonzalez, 2015), whereas older participants may have a better understanding of responding to challenging life situations which may contribute to their lower self-harm prevalence (Van Hove, Facon, & Deliens. 2023).

In addition to the inconsistencies in the adult sample representation in the previous research, there are other methodological inconsistencies which may also affect the application of their results compared to the current research. For instance, unlike the current research, which

recruited both male and female and reported how participants either kept their self-harm secret or resisted self-harm to avoid the consequences of being stigmatised, previous research (Norman et al., 2022) recruited only females. This may have introduced gender bias to the findings. Therefore, the current research may add more to the existing knowledge in this context. Though previous studies have shown that various stressful life events are closely associated with self-harm (Qian et al., 2022; Steinhoff et al., 2020; Devassy et al., 2023; Hitchens, 2021) again, there are some methodological issues in the previous research which may have introduced bias and limit the application of their findings. For example, Steinhoff et al. (2020) despite reporting SLEs (especially chronic stressors) to be associated with self-harm, shows inconsistency in the sample by including participants aged below 18. Consequently, it can be argued that the sample in the previous research is not a true representation of the adult population (18-64yrs), which is the population of focus in this current research.

Further to the methodological issues, it can also be argued that the current research unlike the previous may have added to the existing knowledge on the views of those with the lived experience of self-harm on long waiting time to access psychological support (Quinlivan et al., 2023; McGough et al., 2022). While previous research (Quinlivan et al., 2023) recruited patients and carers (carers aged 52-73 years, median age= 50), current research recruited only adult patients with lived experience of self-harm. In the previous research, the response provided by the carers in the online survey may have introduced bias in the findings, as their views may differ from the views of patients with the lived experience of self-harm. Current research used IPA, where the target sample is purposeful and homogenous with idiographic deeper analysis. Therefore, the current research may be argued to be unbiased in this context and more reliable. Hence the current research appears to add more to the existing knowledge. Lewis et al. (2019) in addition to not having a wide adult population representation (mean adult age of 18.9yrs), used thematic analysis unlike current research

that used IPA which is idiographic. Therefore, current research may have greater depth of focus and analysis that provides more nuanced narratives.

Chapter 8: Conclusion

8.1 **Introduction**

This final chapter will summarise the main findings in this thesis and address the aim and the objective of the research. It will present the implications of the findings and the recommendations, the strengths and unique contributions of the research, followed by its limitations. Future research direction will also be presented. Then, the research journey will detail the researcher's reflective account. This will be followed by the conclusions.

The research aim was to explore self-harm and resilience factors in adult mental health patients and determine from their perspectives the common resilience factors to self-harm, the most common effective resilience factor and how they work to maintain well-being. The systematic literature review of self-harm and resilience factors identified twelve papers (six qualitative, five quantitative, and one mixed methods) for inclusion. After the meta-synthesis, the following four themes emerged: social connection and belongingness, socio-economic factors, psychosocial factors and religion and cultural belongingness.

Consistencies have been found in the association between "self-harm in adults" and the above four emergent themes. However, there remains limited IPA qualitative research on self-harm, especially on self-harm and resilience factors from the perspectives of adults with the lived experience of self-harm. Due to this in addition to the complex concept of "self-harm" and "resilience factors", a qualitative research using IPA was considered appropriate for an in-depth exploration of self-harm and resilience factors.

In this qualitative research, the data collected from the six participants in a semi-structured, one-to-one interview was transcribed verbatim and analysed using IPA (see Section 5.10). After the data synthesis, seven main themes emerged capturing the perspectives of the adult mental health patients' common resilience factors to self-harm. These are: "thinking of the consequences", "relationships with family and with others as a protective factor",

“connecting with others with the lived experience”, “responding to stressful life events”, “understanding my illness and resilience journey”, “seeking professional support”, and “using coping skills and strategies”.

8.2 **Clinical implications**

In this research the perspectives of the adult mental health patients with lived experience of self-harm suggests resilience to self-harm: “is not single, involves a lot of things”. Multifactorial resilience to self-harm, highlighted by some participants, is suggestive of the need for inter-professional and multi-agency approaches to self-harm intervention and management. Therefore, a holistic assessment is crucial. This is necessary to identify positive or negative factors and the needs that may impact the adult mental health patients’ self-harm behaviours.

The practical implication therefore may warrant multi-disciplinary team (MDT) collaborative working with patients, family/carers, friends and peers. A patient-centred plan where the perspectives of the patients are prioritised over the generalised healthcare professionals’ approach should be the agreed target. This is to address the needs identified by the patients, especially those they report as triggers to their self-harm. Through collaborative and holistic assessment, clinicians should objectively align patients’ perceptions of their resilience with professional assessment to establish realistic and achievable goals for managing their self-harm. This is to avoid having unrealistic plans which could lead to disappointment and lack of confidence in the health care professionals’ input and jeopardise patients’ engagement with them. The MDT involvement is essential to adequately address the outcome of the holistic assessment of patients and meet their identified complex and often interrelated needs. However, the subject of self-harm remains a challenge due to the poor knowledge even among clinical staff (Dillon et al., 2020). This knowledge gap persists as it is echoed in the current research and continues to present a significant challenge to the healthcare system and other care agencies. Various agencies, clinical and non-clinical, such

as the local housing authorities, social services, and law enforcement agencies, should be aware of self-harm's multifaceted nature, the implications and demands on various services, and consequently be open for collaborative working. Through this shared understanding, an integrated model of care can holistically mitigate risk, and promote sustainable pathways to recovery.

In this research, interpersonal connections reported by participants as resilience factors to their self-harm should be promoted. There should be openness whilst talking about their relationship with family and with other people who are perceived as triggers to their self-harm, to provide effective support. This is because not all participants reported their relationship with family and with others as positive factors in resisting self-harm. The implication is that assessing and discovering from individual patients if their interpersonal relationship helps them resist self-harm or is a trigger is essential in planning an intervention.

Some participants reported a better understanding of their illness as strategic in their resilience to self-harm. Therefore, seeking support of their healthcare professionals should be encouraged to enhance the understanding of the nature of their illness. Health care professionals should provide information to educate mental health patients about their health conditions. They should, for example, inform them about their diagnosis, explain what it may entail and clarify possible impact on their self-harm behaviours. For example, some of those with diagnosis of depression who have low self-esteem may be at risk of self-harm (Mohan et al., 2023; Harris 2000; Kong, 2019). Providing the patients with necessary information will increase their self-awareness and build on their confidence and self-worth, which could enhance their coping strategies. For instance, a participant shared that after it was clarified by her community psychiatrist nurse that what she was experiencing was one of the symptoms of her mental health condition she learnt to cope better with her self-harm. Therefore, this research suggests that clinicians should share easy-read information leaflets to mental health patients that address their individual conditions, highlighting the impact their

conditions may have on their self-harm behaviours and including advice on seeking help. Though NICE (2022) provide recommendations on training clinicians on the impact of other diagnoses and co-morbidities and their interactions with self-harm, it is also necessary to share this information with patients. The easy-read information leaflets should be provided to patients/caregivers after completing their psychological assessment, and should for example include:

- A plain-language explanation of the diagnosis
- Potential impact of mental health condition on self-harming behaviours
- Practical guidance on coping strategies
- Signposting to available supports e.g. peer support groups
- Advice on how to seek professional support

Participants who attended Emergency Departments (EDs) after their self-harm reported poor outcomes due to negative staff attitudes. This shows that more needs to be done to improve staff attitude towards self-harm, in ensuring good outcomes for patients. This could be by both supporting staff training and building staff morale through reducing their workload. This is because some of the staff attitudes to self-harm at the EDs can be associated with burnout due to their workload (Saunders et al., 2012; McCarthy et al., 2024).Staff training/ annual refresher mandatory training is crucial, especially for the ED non-mental health care professionals who may be front-line staff in contact with those who self-harm. This would improve their understanding of self-harm and minimise the negative attitudes towards self-harm. This is important as some of the participants in this research were told by the healthcare professionals that they were “wasting” their time.

Some participants reported spending long waiting times before they could be seen by the healthcare professionals. The implication of this is that patients with self-harm who seek healthcare professionals’ support may become frustrated and disengage from the service.

To mitigate this, staff training should be encouraged and supported for optimal performance. In addition, recruitment of new and experienced staff to manage staff shortages should be considered by different stakeholders. As a long-term plan to address staff shortages, responsible authorities should promote the training and education of the healthcare professionals that are in short supply. For example, this research highlighted long waiting of up to nine months to access psychological support, which may be an indication of short supply of clinical psychologists or increased demands for psychological input in self-harm management.

Psycho-education of adult mental health patients should also emphasise raising awareness of the consequences of self-harm. This is because all participants said that they are deterred from self-harm by thinking on the consequences. The consequences are either directly to self or indirectly to family, friends and peers. However, the consequences are individualistic and subjective, so would require individual focus and a collaborative engagement between the clinician and the patient. Thinking on the consequences of self-harm is a common resilience factor to those with the lived experience of self-harm. Therefore, it is necessary for clinicians and those who provide support to people with self-harm to share this knowledge. This may be done by displaying posters in the clinics and other relevant sites with the information to target the attention of those with self-harm behaviours and promote their resilience journey. Also, the pocket size card versions of the poster with brief information on how to seek help could also be made available at different sites, such as general practitioner (GP) surgeries, primary care centres, community mental health centres, accident and emergency departments and mental health hospitals.

In this research, coping strategies as resilience factors are not necessarily the same for all the participants. Therefore, in planning interventions person-centeredness is required. Psychological interventions, such as distraction techniques identified by adult mental health patients, should be supported. Participants used different distraction strategies or techniques

to resist or reduce self-harm. So, it is important to develop and improve some of the techniques highlighted by the participants to achieve optimal benefits. Different strategies mentioned by participants, such as physical exercise, should be encouraged. Although local authorities have few free facilities for exercise, more needs to be built and adequately furnished with ultra-modern equipment/gadgets. This would be to attract funding, with focus on receiving referrals from clinicians providing care to patients who self-harm.

Some of the participants found their families and carers and peers to be strategic in resisting self-harm. This suggests that professionals should work collaboratively when required with families/carers and peers of adult mental health patients who self-harm, to develop plans and strategies in building their resilience to self-harm behaviours. Psycho-education and training would also be beneficial to family/carers of those with self-harm behaviours to enhance their knowledge and understanding of self-harm and strengthen collaborative working with them. Developing more alternative practical strategies, such as peer support groups, is desirable, as most participants felt more confident with peer support, which they valued for being non-judgemental, “very effective” and “expert by experience”.

Most of the participants identified childhood abuse like sexual abuse as the main issue responsible for their deep psychological emotions which they carried to adulthood. Again, psychological trauma often culminated in self-harm which is done to exchange the psychological pain for a lesser physical pain from self-harm. This was described by participants as a “feel of relief”. Some participants, whilst talking about what would have prevented their self-harm behaviours, pointed to “not allowing this in the first place” (their experience of sexual abuse). It is therefore necessary to encourage early interventions that address childhood abuse. Agencies working with children should be supported in raising awareness on the availability of child-user-friendly means of information sharing that could promote and encourage children to talk about their worries and fears. Local authorities and agencies such as schools should work collaboratively with cultural community centres and

religious groups to support enlightenment programmes that would be child-user-friendly, to educate and encourage children to be open to professionals working with them and share their concerns without fear of intimidation or stigma.

8.3 **Future research**

This study explored the phenomenon of self-harm from the perspectives of those who have the lived experience. It used a semi-structured one-to-one interview to gather data from six participants (four males and two females) and employed in-depth idiographic interpretative phenomenological analysis to throw light on their experience. However, it can be argued that the findings may not be generalised due to the small sample size, notwithstanding being the ideal sample size in IPA (Eatough and Smith 2006; Smith, 2004). Nonetheless, this study has opened transferable opportunity to researchers who may wish to further explore the field. Therefore, some suggestions for future study will be given below to enhance better care experience for the adult mental health patients who self-harm.

- It would be beneficial to engage further research using similar methods at different sites with increased sample size, to explore the transferability of the themes that emerged from this study to check for a weightier evidence base that would enhance care outcomes in self-harm intervention and management.
- Data collection combining the use of questionnaire and semi-structured one-to-one interview may provide opportunities to further explore the complex nature of self-harm and resilience factors in the adult mental health patients.
- The current research employed IPA to qualitatively explore resilience without associated quantification. Therefore, further study may be beneficial to attempt measuring the adult mental health patients' resilience to self-harm using Resilience Scale for Adult (RSA) to compare and determine quantitatively most common

resilience factors and the most effective resilience factor to self-harm in adult mental health patients.

- Further study on the relationship between psychosocial issues and self-harm that would focus on the interpersonal factors/skills of the adult mental health patients to explore further why those who self-harm find interpersonal relationships difficult.

8.4 **Original contributions**

This research addresses critical gaps in the literature and makes several unique contributions to the subject of self-harm and resilience in the adult mental health patients

- To date and to the best knowledge of researcher, there is no comprehensive synthesis of literature on self-harm and resilience factors in the adult mental health patients. This research added to the existing literature, a unique systematic literature review on self-harm and resilience factors in adult mental health patients. This synthesis not only consolidates fragmented knowledge across qualitative, quantitative, and mixed-method studies, but also lays the foundation for more targeted future investigations.
- This qualitative research used IPA in a unique way to highlight the perspectives of the adult mental health patients on the phenomenon of the lived experience of self-harm and resilience factors. While self-harm has been studied through various methodologies, this research is distinctive in prioritising first-person narratives, thereby focusing on the voices of those with lived experience. This lens has allowed the emergence of previously underrepresented resilience factors that are both subjective and contextually more nuanced.
- This research highlighted various self-harm coping strategies as first-hand reports from the perspectives of adult mental health patients with the lived experience of self-harm. It added to the existing knowledge, and sheds more light on the multifaceted nature and complexities of “self-harm” and “resilience”

- This research challenges prevailing clinical assumptions, especially the generalisation that family relationships are protective factors against self-harm. Findings indicate that interpersonal dynamics, such as relationships with family members, may function either as protective or as triggers for self-harm behaviours, depending on individual circumstances. This insight affirms the need for a nuanced, person-centred, and holistic approach in care provision, underscoring that protective factor must always be explored contextually rather than presumed categorically.
- This research expands current knowledge by highlighting a resilience mechanism that was universally identified across participants. Reflective thinking about the consequences of self-harm, whether personal or relational, was cited as a key deterrent. This has important practical implications for psycho-education and therapeutic interventions.
- This research made an important contribution to the ongoing debate on the concept of self-harm by demonstrating, from a lived-experience perspective, that self-harm often occurs in the absence of suicidal intent. This finding is in contrast with the UK NICE (2022) definition of self-harm, which does not clearly differentiate between non-suicidal and suicidal self-harm. The voices of participants in this study support a conceptual separation between self-harm and suicidality.

Summary

This research added to the existing knowledge a systematic literature review on self-harm and resilience factors in adult mental health patients by offering a unique comprehensive synthesis of literature across qualitative, quantitative and mixed studies. It provided a more nuanced account of adult mental health patients' subjective lived experiences of self-harm and resilience factors, using IPA to shed more light on the complex interplay of multifactor self-harm resilience. It highlighted thinking about the consequences of self-harm as pivotal in

resilience to self-harm and added detailed insight into the subjective lived experiences of adults who self-harm, including how they perceive and navigate self-harm, resilience, and coping. This compliments existing research which may not have the depth regarding exploring resilience specifically.

8.5 **Limitations**

This research is not without limitations. This section (8.5) deals with the limitations of the qualitative research. The limitations of the systematic literature review were presented in Chapter 3 (Section 3.15).

This qualitative research used IPA, which requires that participants use language in communicating their lived experience (Willing. 2013). The researcher also has to make sense of what participants were trying to make sense of. Therefore, the interpretation may be limited by how well the participants can communicate their lived experiences. Consequently, there is the possibility of not capturing complete and clear picture of participants' lived experiences in IPA.

To collect data, all the participants in this research opted for telephone interviews. Arguably, the option of telephone interviews may potentially impact on the data richness and depth as telephone interviews appear limited to verbal expressions in communication. In this research, non-verbal expressions such as facial expressions, eye contacts, visual cues and gestures, which are also vital aspects of communication, are missing. This may have limited or minimised the effect of what the participants were trying to communicate and consequently the data analysis. Telephone interview may have affected rapport with some participants as it may be easier to build rapport with them in a face-to-face interview. On the other hand, due to the stigma associated with self-harm, some participants may feel more confident in providing information during telephone interviews than in a face-to-face interview. Nonetheless, participants in this research reported comfort as the main reason for choosing telephone interviews.

However, participants' emphatic expressions, repetitions, pause and tone of voice were captured, and clarity was sought when necessary to ensure nothing was missed. In IPA, where the researcher is required to make sense of what participants are trying to make sense of ('double hermeneutics'), there is possibility of researcher bias. However, to mitigate this, the researcher engaged in reflexivity (see 4.9).

Though the sample size in this research may have raised questions of sufficiency, saturation was reached in data collection(Hennink et al., 2019; Saunders et al., 2018), and according to previous studies the size is ideal in IPA (Smith, Larkin and Flowers, 2021; Smith et al., 2013; Eatough and Smith2006; Smith, 2004).Despite the encountered challenges in recruitment of participants who self-harm, six participants (four males and two females) were recruited to the study and provided data with sufficient depth to address the research question.

8.6 **My research journey**

I prefer to use the first-person noun "I" to reflect on my journey in conducting this research, as it helps me feel closer to my experience. In this section, I will reflect on the following key areas of my research journey: choosing my research topic, the methodology and design, recruitment process, data collection and analysis, the quality and originality of research. This will be followed by my personal and professional development.

8.6.1 The choice of my research topic

At the beginning, I was not sure the topic to choose for my research. However, reflecting on my experience working with those who self-harm, I decided to do background information check on self-harm. My findings made my interest on the subject to grow and I wanted to know more. This desire and passion culminated in the choice of my research topic.

Finding research direction as a beginner made me feel anxious as I was not familiar with the demands and challenges of conducting a research. However, the University Postgraduate Research Student Programme Handbook provided me with the initial guidance. The meeting

with my Director of Studies in my first supervision provided further guidance/direction and introduced me to available useful resources which helped me develop a plan with timelines. Looking back, developing clear plans with timeline was a significant stage in my research journey. It helped me to be focused and to work consistently in achieving set goals. This was quite helpful because I would have struggled without clear directions or set goals and may become frustrated and eventually start losing interest in the study. My initial assignment which was to conduct a systematic literature review was met with much anxiety due to my limited experience. However, I was guided and supported by the university subject librarian who helped me regain my confidence to complete the task. The initial confusion over literature review methods showed me how crucial it is to seek support rather than try to struggle alone.

8.6.2 Choosing research methodology and design

Initially, choosing the appropriate research methodological framework and design to address my research questions was intimidating for me as I lacked the experience and confidence in making the right choice. First, I was a bit apprehensive but soon picked the courage to read up articles on the subject. I attend postgraduate presentations on methodology and asked questions. I also had supervision where I sought guidance. On reflection, I noticed that as my knowledge on the subject grew, it boosted my confidence. Eventually, I chose IPA, semi-structured one-to-one interview design. Epistemologically, I adopted constructivism and aligned with ontological relativism and was able to provide the rationale for all the choices made.

8.6.3 Recruitment challenges

In the qualitative stage of my research which involved recruitment of participants, I was oblivious of the needed requirements. My initial thought was that I could start recruitment of participants whenever I was ready to do so. However, I soon realised that I needed to obtain some authorisations to safeguard the participants and ensure research integrity. This

realisation and the rigorous procedures required to secure the authorisations left me frustrated as I pondered the need for the lengthy process. However, as I reflected, I came to appreciate their importance for protecting participants. I found out that the requirement for ethical approval and formal protocols were actually necessary safeguards and not an unnecessary procedure that I once imagined. On reflection, I realised that I could have sought information on participants' recruitment in the qualitative research which would have put me in the right path. I felt happy when I obtained the HRA (Health Research Authorisation). However, on grounds of diminished capacity, the Participant Information Centre (PIC), declined to support recruitment of participants for my research. At this point, I remembered the amount of work I did to ensure the demands of that PIC were met and imagined the difference it would have made on my progress if they checked their capacity to support my research before making their demands. I also imagined directing my effort and time to approach another PIC, which might be favourable. Reflecting on these experiences have made me more aware of the responsibilities involved in conducting research that requires ethical approvals. In future, I will be well guided on the needed requirements and prepare on time to avoid unnecessary delays. I will not hesitate to ask relevant questions especially about unfamiliar tasks and seek guidance on time from my supervisory team.

8.6.4 Conducting the Interviews

As a first-time researcher with limited experience, in interviewing vulnerable adults, I was a bit apprehensive and concerned. I thought of making use of an experienced interviewer. On second thoughts, I considered the positive aspect of conducting the interview myself and that boosted my confidence. Hence, I started practicing the act of interviewing, which made me read a few articles, watched and listened to a few virtual interviews. Then, I thought of interviewing a mental health practitioner who has the experience of working with mental health patients who self-harm. I realised that practicing a couple of times helped me to familiarise myself with the interview questions and build more confidence. Again, on reflection, I realised that my professional experience with those who self-harm not only

helped me in structuring my interview questions but also raised my confidence. I felt a relief when I achieved saturation after interviewing six participants.

8.6.5 Data extraction and analysis

On reflection, I imagined encountering some problems, e.g. technical faults or, poor quality of recordings due to wrong settings during interview recording for data extraction, so I prepared in advance. I checked and practiced recording with the device to ensure good working condition and quality of production. In addition, I realised that despite ensuring all of these, that I needed to remind participants that the interview would be recorded and encouraged them to be reasonably audible and clear. I had to play back the recorded interviews a couple of times, especially where I needed clarity. Though I felt it was time consuming, I realised it was necessary to ensure accurate representation of data.

Not being convinced on the option to code the data left me wondering, However, I decided to weigh the options of manual coding and electronic coding using analytical qualitative software such as NVivo 12. As a first-time researcher, I felt it worthwhile not to miss the opportunity of exploring manual coding in qualitative research. Researchers, who use electronic coding, need to create the categories and codes, decide what to collate, identify the patterns, and draw meaning from the data (Sarhan and Manu, 2021). This realisation convinced me that it would be better for me to start getting more attached to the data through manual coding, as I would still need to engage the process that would require a critical and analytic approach. Coding requires making decisions based on the meaning of what is being said. This may not be captured in electronic coding (Belur et al., 2021) that merely takes over some of the tasks that qualitative researchers use to do in the traditional manual coding (Sarhan and Manu, 2021).

8.6.6 Reflecting on originality of research

I thought of what makes research findings acceptable and how I can achieve it. This is because without it, my work would not be acceptable. To address the issue of acceptability, I

first ensured that my research would be recognised as original and contemporaneous to the award of a Doctor of Philosophy degree. Secondly and closely related to the first point, I ensured the reliability and transferability of my research, as applicable in qualitative studies. At the beginning of my research journey, I thought of ground-breaking contribution to knowledge as the only criteria to award a PhD (Clarke and Lunt, 2014; Phillips and Johnson 2022). However, I realised that according to Cyer (2006), there are various possibilities that may be relevant in achieving originality in doctoral research. Nonetheless, the thought of high standard for originality in a PhD made me anxious about meeting the goal. However, my anxiety began to fade with the realisation "it is a PhD, not a Nobel Prize" as noted by Mullins and Kiley (2002). I became reassured that originality may not necessarily be "ground-breaking" research (Delamont et al., 2004; Locke et al 2007). Therefore, I thought of critically situating and integrating my findings in the existing body of literature to help ensure identification and clarity of any novel contribution to knowledge (Dunleavy 2003, Snowden 2006, Phillips and Pugh 2010).

8.6.7 Ensuring reliability and transferability

Ensuring reliability and transferability is required for research to be credible and applicable in practice (Nobel and Smith 2014). Though at the beginning I was not aware of how to ensure this but and later became guided through studies of relevant materials. I imagined the negative impact of not following some principles that would address trustworthiness in my research journey. I realised that ensuring true representations of participants' accounts of the phenomenon under study helped me maintain neutrality in interpretation to avoid researcher bias. Thought of protecting participants' accounts made me also support findings with participants' direct quotes. As I reflected on transferability, I ensured that the records of my research activities are clear, easy to follow in such a way that when the data is reviewed by another they would arrive at similar result. I built an audit trail of my research journey, detailing steps taken and decisions made and engaged reflexivity throughout the research. I had close engagement with the data, and critical supervisory discussions. Looking back, I

realised that I would not have been very mindful of all that I followed in ensuring trustworthiness, if I was not well guided.

8.6.8 Personal and professional development

My research journey has been quite challenging but worthwhile, as I have emerged a different person from when I first started. I have gained better insight about self-harm and resilience factors in adult mental health patients from the perspective of those with the lived experience of self-harm. Some of my personal beliefs and inclinations towards those who self-harm have been challenged by a better understanding of the participants' shared experiences of self-harm and resilience factors. I now have a better knowledge and understanding on what those who self-harm may perceive as help to them to resist, reduce or stop self-harm behaviour, and I hope to be part of the team that would make a difference in providing care and support to this vulnerable group (adult mental health patients who self-harm). I count it a privilege to have been given the opportunity to share their valuable experiences and I am very grateful to the participants.

8.7 **Conclusions**

This thesis presents a qualitative study that used IPA to explore the perspectives of adult mental health patients with the lived experience of self-harm, to understand the factors that help them resist, reduce or stop self-harm. This research, through a detailed idiographic engagement of participants' narratives, highlighted various resilience factors as first-hand reports from their perspectives to address key gaps in the literature. It provided the first comprehensive synthesis of literature across qualitative, quantitative and mixed methods on the subject of self-harm and resilience factors in adult mental health patients.

It found reflecting on the consequences of self-harm to be a common resilience factor for all the participants. This key message gained from participants' accounts in this IPA qualitative study was consistently reported as a pivotal resilience factor. The universality of this theme across participants underscores its potential as a clinically meaningful target in resilience-

focused interventions. It suggests that therapeutic strategies which enhance reflective capacity and future-oriented thinking may be particularly effective in reducing the frequency or severity of self-harming behaviours (see 7.2.1).

It also found that interpersonal relationships cannot be generalised as a resilience factor to self-harm as it was reported by some participants as a trigger of their self-harm, highlighting the clinical importance of an individualistic approach in self-harm management. The complex nature of self-harm and resilience factors were evidenced in the participants' accounts that shed more light and provided important nuances to the understanding of self-harm resilience in the adult mental health patients. For example, the narrative of no intention to die in self-harm due to an underlying medical condition suggests a call for clinical precision between self-harm and suicidality for a better policy and care management. The presence of physiological or medical conditions as unanticipated sources of resilience also signals the importance of biopsychosocial formulation in support of multifactor self-harm resilience, adult lived experience perspective. This adds to the existing knowledge and suggests a holistic assessment in understanding of the complex interplay of multiple factors in self-harm resilience.

Some participants reported their resilience to self-harm as involving "lots of things", multifactorial, complex, non-linear, and subjective. This reflects a broader epistemological challenge in defining and operationalising the concept of resilience to self-harm, with the clinical implication of a holistic individualistic approach and multi-professional, multi-agency involvement in management and intervention for better patients' outcomes.

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Appendix 1(Data Base Search History)

Print Search History

- Retrieve Searches
- Retrieve Alerts
- Save Searches / Alerts

Select / deselect all

Search ID#	Search Terms	Search Options	Actions
S1	AB resilien* factor* OR AB resilien* OR AB cop* OR AB cop* strateg* OR adapt*	**Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase	View Results (1,816,208) View Details Edit
S2	AB resilien* factor* OR AB resilien* OR AB cop* OR AB cop* strateg* OR adapt*	**Limiters** - Scholarly (Peer Reviewed) Journals **Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase	View Results (1,767,008) View Details Edit
S3	AB resilien* factor* OR AB resilien* OR AB cop* OR AB cop* strateg* OR adapt*	**Limiters** - Scholarly (Peer Reviewed) Journals; Date of Publication: 20120101-20231231 **Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase	View Results (1,011,958) View Details Edit
S4	AB resilien* factor* OR AB resilien* OR AB cop* OR AB cop* strateg* OR adapt*	**Limiters** - Scholarly (Peer Reviewed) Journals; Date of Publication: 20120101-20231231 **Expanders** - Apply equivalent subjects **Narrow by Language:** - english **Search modes** - Boolean/Phrase	View Results (987,483) View Details Edit
S5	AB resilien* factor* OR AB resilien* OR AB cop* OR AB cop* strateg* OR adapt*	**Limiters** - Scholarly (Peer Reviewed) Journals; Date of Publication: 20120101-20231231 **Expanders** - Apply equivalent subjects **Narrow by SubjectAge:** - all adult: 19+ years	View Results (139,459) View Details Edit

		Narrow by Language: - english **Search modes** - Boolean/Phrase	
S6	AB resilien* factor* OR AB resilien* OR AB cop* OR AB cop* strateg* OR adapt*	**Limiters** - Scholarly (Peer Reviewed) Journals; Date of Publication: 20120101-20231231 **Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase	View Results (1,011,958) View Details Edit
S7	AB self-harm* OR AB deliberate selfharm* OR AB self-injur* OR AB self-mutilat* OR AB intentional selfharm* OR AB non-suicidal self-injur*	**Limiters** - Scholarly (Peer Reviewed) Journals; Date of Publication: 20120101-20231231 **Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase	View Results (15,242) View Details Edit
S8	AB self-harm* OR AB deliberate selfharm* OR AB self-injur* OR AB self-mutilat* OR AB intentional selfharm* OR AB non-suicidal self-injur*	**Limiters** - Scholarly (Peer Reviewed) Journals; Date of Publication: 20120101-20231231 **Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase	View Results (15,242) View Details Edit

☐	S9	AB self-harm* OR AB deliberate selfharm* OR AB self-injur* OR AB self-mutilat* OR AB intentional selfharm* OR AB non-suicidal self-injur*	**Limiters** - Scholarly (Peer Reviewed) Journals; Date of Publication: 20120101-20231231 **Expanders** - Apply equivalent subjects **Narrow by SubjectAge:** - adult: 19-44 years **Search modes** - Boolean/Phrase	View Results (4,058) View Details Edit
	S10	AB self-harm* OR AB deliberate selfharm* OR AB self-injur* OR AB self-mutilat* OR AB intentional selfharm* OR AB non-suicidal self-injur*	**Limiters** - Scholarly (Peer Reviewed) Journals; Date of Publication: 20120101-20231231 **Expanders** - Apply equivalent subjects **Narrow by Language:** - english **Narrow by SubjectAge:** - adult: 19-44 years **Search modes** - Boolean/Phrase	View Results (4,000) View Details Edit

☐	S11	AB adult* mental health patient* OR AB psychiatr* patient* OR AB adult* OR AB patient*	**Limiters** - Scholarly (Peer Reviewed) Journals; Date of Publication: 20120101-20231231 **Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase	View Results (5,635,736) View Details Edit
☐	S12	AB adult* mental health patient* OR AB psychiatr* patient* OR AB adult* OR AB patient*	**Limiters** - Scholarly (Peer Reviewed) Journals; Date of Publication: 20120101-20231231 **Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase	View Results (5,635,736) View Details Edit
☐	S13	AB adult* mental health patient* OR AB psychiatr* patient* OR AB adult* OR AB patient*	**Limiters** - Scholarly (Peer Reviewed) Journals; Date of Publication: 20120101-20231231 **Expanders** - Apply equivalent subjects **Narrow by Language:** - english **Search modes** - Boolean/Phrase	View Results (5,425,968) View Details Edit
☐	S14	AB adult* mental health patient* OR AB psychiatr* patient* OR AB adult* OR AB patient*	**Limiters** - Scholarly (Peer Reviewed) Journals; Date of Publication: 20120101-20231231 **Expanders** - Apply equivalent subjects **Narrow by SubjectAge:** - all adult: 19+ years **Narrow by Language:** - english **Search modes** - Boolean/Phrase	View Results (1,767,584) View Details Edit
☐	S15	(AB S5 AND AB S10 AND AB S14) AND (S5 AND S10 AND S14)	**Expanders** - Apply equivalent subjects **Search modes** - Boolean/Phrase	View Results (203) View Details Edit

	S16	(AB S5 AND AB S10 AND AB S14) AND (S5 AND S10 AND S14)	**Expanders** - Apply equivalent subjects **Narrow by SubjectAge:** - adult: 19-44 years **Search modes** - Boolean/Phrase	View Results (119) View Details Edit
	S17	(AB S5 AND AB S10 AND AB S14) AND (S5 AND S10 AND S14)	**Limiters** - Scholarly (Peer Reviewed) Journals **Expanders** - Apply equivalent subjects	View Results (119) View Details Edit

			Narrow by SubjectAge: - adult: 19-44 years **Search modes** - Boolean/Phrase	
☐	S18	(AB S5 AND AB S10 AND AB S14) AND (S5 AND S10 AND S14)	**Limiters** - Scholarly (Peer Reviewed) Journals **Expanders** - Apply equivalent subjects **Narrow by Language:** - english **Narrow by SubjectAge:** - adult: 19-44 years **Search modes** - Boolean/Phrase	View Results (119) View Details Edit

Appendix 2(Table 3): Critical Appraisal Skills Programme (CASP) Scores

Study	Research design	Sampling	Data Collection	Reflexivity	Ethical Issue	Data Analysis	Findings	Value of Research	Total Scores
Hunter et al. (2013)	2	1	2	1	2	2	1	2	13
Turner et al. (2017)	2	2	2	1	1	2	2	2	14
Wadman et al. (2017)	2	1	2	2	2	2	2	2	15
Trepal et al. (2015)	2	2	1	2	1	2	2	2	14
Jacobson et al. (2015)	2	2	2	2	1	2	2	2	15
Steinhoff et al. (2020)	2	2	2	2	2	2	2	2	16
Turner et al. (2019)	2	2	2	1	1	2	2	2	14
Macrynikola et al.(2018)	2	2	2	2	1	2	2	2	15
Liu(2023)	2	2	2	1	1	2	2	1	13
Lewis et al. (2019)	2	2	2	1	1	2	2	2	14
Kim and Hur (2023)	2	2	2	1	1	2	2	2	14

Devassy et al. (2023)	2	2	2	1	1	2	2	2	14

Application of CASP

To illustrate how researcher applied CASP tool, Turner et al., (2017) in Table 2. above will be used as an example. The CASP score in the study by Turner et al., (2017) shown is derived from the following observations: Thestudyhadclear aim and objective stated as: to examine differences in baseline measures of interpersonal competence and functioning and experiences between young adults with history of NSSI and those without NSSI. In the study, the sample size N=116 was consistent with research method –quantitative analysis. External validity was considered; exclusion and inclusion criteria were used to screen and target sample. Recruitment of participants was via internet advertisement and poster distributions. This gave potential participants room to deicide freely without researcher undue influence therefore eliminating potential researcher bias in recruitment of participants which may affect result. Interviews were conducted by bachelors or master's–level clinical assessors trained for reliability with study investigators. Inter-rated reliability was good with average diagnostic agreement greater or equal to 85%. Informed consent and ethical issues were considered. Intensive micro-longitudinal method as daily diaries was used to clarify the precise nature of interpersonal problems as they occur in daily life.

Appendix3A (Table 2): Characteristics of identified studies

Title/Author(s)/year/Journal	Aim & Purpose	Research method	Sample &research location	Main Findings

Service user perspectives on psychosocial assessment following self-harm and its impact on further help-seeking Hunter et al., (2013) Journal of affective disorders	To explore service user experiences of assessment and examine the shortterm and long-term meanings of assessment for service users	Qualitative Interpretative phenomenological Analysis (IPA)	N=13 United Kingdom	This study demonstrates that service user experiences of services can influence future help-seeking
Characterising interpersonal difficulties among young adults who engage in non-suicidal self-injury Turner et al., (2017) Journal of Behavioural and Cognitive Therapies	To examine the interpersonal competence and experiences of young adults with recent repeated non-suicidal self-injury and those without using a 14-day diary design.	Quantitative Comparative study Intensive microlongitudinal method	N=116 Canada	Participants with .NSSI compared to those without, had significantly less contact with families and friends
An interpretative phenomenological analysis of the experience of selfharm repetition and recovery in young adults Wadman et al., (2017) Journal of health psychology	To explore reasons why young adults repeat or maintain self-harm	Qualitative	N=6 United Kingdom	Young adults does not believe they can completely stop self-harm. Support strategies to focus on coping skills not just to eradicate self-harm
Trepal et al., (2015) A cross-sectional matched sample study of nonsuicidal self-injury among young adults support for interpersonal and intrapersonal factors with implications for coping strategies	To explore the difference in relation to; emotions, coping strategies, interpersonal support and ethnic identity of individuals who currently engage in NSSI and those who engaged in NSSI in the past	Quantitative Cross-sectional study	USA N=282	Individuals who never engaged in NSSI reported significantly higher levels of ethnic belongingness and interpersonal support, lower levels of depression and anxiety than both groups that engaged in NSSI. Young adults who currently engage in NSSI reported higher levels of depression and anxiety and perceived less support.
The association of interpersonal and intrapersonal emotional experiences with non-suicidal selfinjury in young adults	The study sought to explore intrapersonal and interpersonal correlates of NSSI	Quantitative	N=449 USA	Those who have difficulty expressing emotions are at higher risk of NSSI even after controlling depressive symptoms. Expressing emotion to be targeted in treatment for people who engage in NSSI

Jacobson et al., (2015) Archives of suicide research				
Stressful life events in different social contexts are associated with selfinjury from early adolescence to early adulthood Steinhoff et al., (2020)	To examine the stressful life events (SLE) in different social contexts and NSSI among young adults..	Quantitative Comparative study	N= 1,480 Switzerland	Reducing risk of SLE in different social contexts and improving young people's coping skills could help reduce their risk of self-injury
Experiencing and resisting nonsuicidal self-injury thoughts and urges in everyday life Turner et al., (2019) Suicide and life threatening behaviour	To use daily diary to examine the experience of NSSI	Qualitative	N=60 USA	Persistent thoughts predicted less frequent NSSI, whereas intense urges predicted more frequent NSSI
Social connectedness, stressful life events, self-injurious thoughts and behaviours among young adults Macrynikolaet al.,(2018) Comprehensive Psychiatry	Examined the relationship between SLEs and risk for different forms of SITBs and buffering roles of social connectedness in young adults	Quantitative Cross sectional survey	N=1712 USA	Lower level of social connectedness and higher amount of SLEs were associated with SITBs. Social connectedness however did not buffer the effect of SLEs on SITBs
The epidemiology of non-suicidal selfinjury: lifetime prevalence, sociodemographic, and clinical correlates, and treatment use in a nationally representative sample of adults in England Liu, 2023 Journal of Psychological medicine	To estimate the lifetime prevalence of NSSI in adults and its association with sociodemographic characteristics, psychiatric disorders and lifetime treatment for NSSI	Qualitative study Face-to-face survey	N=7192 United Kingdom	NSSI lifetime prevalence rate was estimated to be 4.86%. Absence of biological parents in household, poor parenting, being unmarried, poor background and younger age were associated with NSSI. About 63.82% of respondents with lifetime NSSI had at least one psychiatric disorder of which about 30.92% had engaged in severe self-harm requiring treatment

Understanding selfinjury recovery: Views of individuals with lived experience Lewis et al., (2019) Journal of Clinical Psychology	To explore the views of individuals with lived experience of NSSI in order to advance the concept of NSSI recovery	Qualitative study using thematic analysis	N=233 Canada	The concept of NSSI recovery is multifarious, nonlinear and subjective. From the responses the following themes emerged: (a) recovery is complete NSSI cessation; (b) recovery is more than cessation; (c) recovery involves lingering NSSI features; (d) recovery involves developing resilience; (e) recovery is a process; (f) evolution in understanding recovery; and (g) recovery is a subjective experience
What's different about those who have ceased selfharm? Comparison between current and lifetime nonsuicidal self-harm Kim and Hur (2023) Journal of the international academy for suicide research	To investigate the socio-demographic and psychological variables as well as the function of NSSI related to the cessation of NSSI by analysing the difference between those currently engaged in non-suicidal self-injury (NSSI) and those who have stopped NSSI behaviours. This is to understand the factors that stop as well as those that continue NSSI behaviours	Qualitative study	N=490 Asia	There were no significant group differences in socioeconomic status. Individuals with current NSSI were slightly younger than those who had ceased NSSI behaviour. The current NSSI group endorsed more intrapersonal functions. The participants who had ceased NSSI behaviour reported significantly less perceived stress, dysfunctional attitudes, alexithymia, emotion reactivity, and suicidal ideation. The lifetime NSSI group showed greater psychological resources such as self-esteem, distress tolerance, and resilience
Vulnerabilities and life stressors of people presented to emergency departments with deliberate selfharm: consolidating the experience to develop a continuum of care using mixed method framework Devassy et al., 2023 Frontiers in Public health	To explore the interactions between bio psychosocial vulnerabilities and stressors leading to deliberate self-harm behaviour among people who presented to emergency departments with suicidal attempts with the purpose of developing continuity of care	Mixed-methods study Qualitative analyses were performed using thematic analysis and quantitative descriptive and inferential statistics were performed using STATA software.	N=44 Asia	The bio-psychosocial vulnerabilities remain dormant until it is disturbed or activated by life stressors (family related stressors, and social support-related vulnerabilities) resulting in severe self-harm behaviours. Mental health teamdriven assertive engagement, positive coping, and social support interventions would help prevent reattempts in people with self-harm behaviours

Appendix 3B (Table 4): Meta –Synthesis of Literature

Key themes, phrases and quotes first iterations	Key themes, final iterations	Core concept, first iteration (second order constructs)	Core concept, final iteration (third order constructs)	Contributing papers to theme
Intense emotion Emotional regulation and coping Relational skills Unmarried relationship Separation Self-esteem Self-disgust Dysfunctional attitude Distress tolerance Self-awareness Hopelessness Situational stress Shame and stigma Self-harm provides relief to mounting pressure Social anxiety Social connection Chronic stressors Overwhelmed Psychological strain Stressful life events	Emotional regulation Coping with difficult emotions Emotional stress	Manage difficult emotions Psychological distress	Psycho-social factors	Kim and Hur (2023); Lewis et al (2019);Devassy et al (2023); Liu et al (2023); Trepal et al (2015);Turner et al(2017); Stienhoff et al (2020);Hunter et al (2015); Jacbson et al(2015); Macrynikola et al (2018)

Unemployment and divorce Economic status Socio-economic adversity Impoverished Self-harm as habit for relief of distress Consequences of self-harm	Economic factor Consequences of self-harm	Economic and social related stress	Socio-economic factors	Liu (2023);Devassy et al. (2023) ; Kim and Hur (2023); Wadman et al. (2017)
Ethnic identity and belonging Religion, and spiritual form of coping	Religion, spirituality and ethnicity Alternative coping strategies	Ethnic belongingness and coping Religion, spirituality, ethnicity and sociocultural strategies	Religion and cultural belongingness	Trepal et al.(2015); Turner et al. (2017); Wadman et al.(2017); Devassy et al.(2023)

Positive factor and supportive relationship Peer support Coping and support Developing alternative coping Acceptance and humour strategies Support seeking	Positive supportive relationship Interpersonal support and relationship	Social connections Interpersonal relationships	Social connection and belongingness	Macrynikola, Miranda and Soffer, 2018; Wadman et al., 2017; Liu, 2023; Devassy, 2023; Turner et al., 2017; Jackobson et al., 2015; Kim and Hur, 2023).

Appendix 4 (Table 5): IPA Final Themes & Participants' Emergent Themes

Final (Master)themes	Participants' emergent themes
Thought of the consequences	P1-Fear of losing limb. P2-Consequence of self-sabotage P3-Effect of self-harm on family and friends P4-Knowledge of the consequences P5-Thought of the consequences
Responding to stressful life events	P1-Stressful life events and way of relief P2-Stressful relationship P3-Stressful life events P4-Overwhelmed and out of control P5- Abusive relationships and low self-esteem P6-Psycho-social stress

Relationship with family and others Seeking support of peers	P1-Support from family and peers P2-Interpersonal relationship P3-Connecting with family and friends. P4-Connecting with people. P5-Having people around you. P6-Social connectedness
Understanding my illness and resilience journey Seeking professional support	P1-Healthcare professionals' attitude P2-Healthcare specialist support P3-Dealing with health problem. P4-Understanding my illness. P5-Right diagnosis and specialist support P6-Healthcare specialist intervention

P1=Jacob

P2=Joel

P3=Jude

P4=Medlin

P5=Maria

P6=Daniel

Appendix 5 (Table 6): Higher-Order Themes & Emerging Examples-Extract

Participant	Super ordinate themes and emerging themes examples	Example of quotes	Line reference

Joel	**Interpersonal relationship**		
	Family connection and support	"…., the only thing that really stopped me…saw a picture of my kids and that stopped me from jumping in"	00:11:36-00:11:53
		"…but what's changed my life is the support I get from my children, the support I get from my wife, and…"	00:23:19
	Social relationship	*"I'm in a new relationship and the person my wife is really supportive and…"*	
		"…You know there we don't judge each other we just understand and that sense of companionship and support"	00:12:21
	Companionship	*"…that sense of you doesn't have to be perfect. You know you can just get by"*	00:18:39-00:18:48

	Social acceptance		
		"…gave me a sense of purpose, but also the people. It's lovely to be around people who understand because for the simple reason they've had their own experience and…"	00:13:31
	Peer support of those with lived experience of self-harm	*"…the struggle with the poor self-esteem and the confidence, that's a daily struggle*".	00:15:25-00:15:30
	Stressful relationships Struggle with self-esteem and confidence	*"You know, I would never amount to anything I didn't have any purpose in my life, I mean.* *I never felt good enough".*	
			00:12:23
	Lack of purpose Breakdown in relationship	"My first marriage kind of broke up after 20 years. She accused me of all these horrible things…and that was when my world really fell apart"	
			00:08:44-00:08:47
	Stress at work	"I did a lot of work with trafficked people and people who had gone through lots of abuse and things, and I didn't get any supervision…….So I was doing his job and my job and I just fell apart. I just couldn't handle this anymore"	
		"…if you are told enough times that you're useless…especially from a very early age, that becomes your mantra for life, you will never be anything you know"	00:08:55-00:09:04
	Beliefs, culture and spirituality	*"…. and that support you've given is how people see their lives in a different way… and knowing that you made a difference, it makes you proud."*	00:10:23-

	Belief and spirituality of the spoken (negative) word.		00:10:27

	Self-fulfilment Fulfilment in supporting people Ability to access support Masking Consequence of deliberate selfsabotaging of life **Healthcare specialist support** Support from health care professionals	"…the support that you surround yourself with is a huge factor, but also..." "I used alcohol a lot to mask a lot of anxiety and things..." *"...the psychological or the kind of deliberate sabotaging of your life, you know, has a consequence"* "…for a while after that, our mental health was really poor…got referred to a lady psychologist…….felt the support from the psychologist, the support of…have been amazing"	00:27:25-00:27:43 00:34:18-00:35:12 00:31:25-00:31:38 00:04:23-00:04:28 00:26:10-00:26:14 00:14:44-00:16:32

Appendix 6: Initial Coding Examples

Questions	P1(responses)	Condensed sentences/initial descriptions
How long has it been since you self harmed	And I would say officially last night …. I tend to deprive. 00:03:04P1 Myself, the food and that. 00:03:05P1 To me, is a safer way of self harming than cutting myself.	
Before you self harmed, what were your support and coping strategies to self-harm that is? 00:03:38Researcher How were you? 00:03:40P1 Coping	…I went to the doctors to get. 00:04:02P1 Support and all they. 00:04:03P1 Did was push antidepressants towards us. … I didn't think was very. 00:04:17P1 Helpful and I've got this in no support, just pushed tablets So really no support at all, and all the doctor said is if I keep cutting myself, I'm. 00:04:55P1 Going to end up losing a limb. 00:04:58P1 I don't think. 00:04:58P1 That we're really any support. 00:04:59P1 Services back in the day for that	Went to the doctors who prescribed antidepressant medication which were not helpful.
Apart from going to the doctor or seeking a sort of support from. 00:05:12Researcher	The support meant a lot of family members did not hold the window up with this, so they just used to kind of block me out, which I kind of	Did not get family support due family being against his alcohol habit.

The professionals, I mean like doctor nurses and all health care workers. 00:05:19Researcher Is there any other thing you have tried? Any other sort of support that you have tried?	understand why they did that. But I had a major alcohol.00:05:38P1 Problem as well	
What do you feel led to your self harm? 00:08:07Research	I was being sexually abused by one of our dad's best mate and I tried to take my own life and that was when I started self harm and cutting myself because I thought it was a a good mechanism and a work relief and stress and I managed to stop cutting myself and then I used to I still control. 00:03:02P1 But I'm doing better. 00:03:02P1 At that now. …00:08:55P1 It was a genuine suicide attempt, but as soon as I cut myself, cutting. 00:08:58P1 My wrest that night. 00:09:00P1 It was like all that pressure had. 00:09:01P1 Lifted off and. 00:09:03P1 That was what I used to cope.	Psychological trauma of sexual abuse then self-rejection resulting in suicidal attempt. Self-harm by cutting helped me release pressure to cope.

00:09:45Researcher What do you what? 00:09:45Researcher feel 00:09:47Researcher could have prevented your self-harm?	the first thing that would prevent me from self harm is being able to pay some of those being sexually abused back in the day, if something like that was happening. 00:10:07P1 You don't like to talk about it? It was. 00:10:09P1 All petrol(control) the hush hush in the family. ….the recovery College in Newcastle where I work. It's a peer support service and everybody that works there	The prevention of the sexual abuse.Family support, peer support for people with lived experience of selfharm
	and all the volunteers, the staff and all the	

What is your own? I mean, what is your own view? 00:11:51Researcher On the effectiveness of your support. 00:11:55Researcher And coping strategies. How effective do you think they were or they are?	I do know about a. 00:12:02P1 Lot of corporate strategies. 00:12:03P1 And that I've learned over the years. But they weren't around when I was self-harming. I mean the stuff like. 00:12:09P1 And making some ice cubes with some red food colouring in, keeping them your freeze on them when you feel the need to cut yourself, you take the ice cubes out the the. 00:12:17P1 Freezer. You squeeze them. 00:12:19P1 And the coldness of the ice cube gives you. 00:12:21P1 The same feeling as if you cut yourself. 00:12:24P1 And of course, the ice cubes melt with the red food colouring in, and then it looks like you're bleeding as well. Can be very effective. 00:12:30P1 …., I open that box and I've gotta go. 00:13:34P1 Through me good. 00:13:34P1 Memories before I get to work, stuff to harm myself. 00:13:38P1 And I've heard that that's very effective, but you can use that in all walks of life, not just for self harm, stuff like that. 00:13:44P1 But I think the key thing for me. 00:13:45P1	Psychotherapy of learned techniques such as use of red coloured-ice cubes tosimulate the effect of cutting by pressing the ice cubes against the wrest to melt leaving the red mark on the wrest which will appear to be bleeding. The psychology of distraction technique by going through good memory records kept in a self-harm tool box. Distraction is achieved before getting to the tools to self-harm which were kept intentionally at the bottom of the box. Key thing is peer support from people with lived experience of self-harm who would share their coping strategies.

	Would have beensitting down with somebody that. 00:13:47P1 cut themselves as well, and how they coped with it.	
How have you? 00:14:04Researcher Been to the hospital because youself harm.	Yes, I mean I. … I would end up in casualty either getting my stomach pumped because of an overdose of tablets or overdose of alcohol or drugs or getting stitches in my arm or other parts of my body … one. 00:14:42P1 Night got put in. 00:14:42P1 The hospital and they just left me in. 00:14:44P1 an empty room all night. 00:14:45P1 And to me, that wasn't. 00:14:46P1 Very supportive at all. And then of course, for the nurse to turn around. 00:14:49P1 and she said, you know,you're wasting our time. That was like the 00:14:52P1 the final blow for me. 00:14:54P1 And Ilost all trust in hospitals. … And I'll answer the phone little bit, but if you told the doctor, it was just more medication, more medication, more medication which wasn't solving the problem all it. 00:15:09P1 Was doing was covering it up.	Reason for going to the hospital: -overdose -cutting Hospital experience not supportive. Professionals were judgemental and felt that their times were being wasted by people who self-harmed.

Why did you choose to go to the hospital?	Because I was fearful of actually losing the limb. I got an infection or something and it was the only place I	Severe cut needing stitching
00:15:21P1	could get treatment for the wounds because some of them. 00:15:33P1 Are quite severe and we did need stitch.	Fear of infection

What support did you receive? 00:15:56Researcher In the hospital to help you cope with self harm.	00:16:00P1 Absolutely nothing. It would just be right, we'll stitch. 00:16:03P1 You up where? 00:16:04P1 You go dissolvable stitches, go at your doctors just to get checked. And that was the process. And that went on for quite a. 00:16:11P1 Number of years. And then of course, when I was getting that attitude from the hospital and the doctor, I would just dress my own wounds. 00:16:20P1 And I mean, I've got some sore in here and some of the sores are like an inch wide because. 00:16:25P1 They didn't get treated. …00:16:48P1 I just felt there was no care. …Then there was an off duty social worker who took us to one side, made some inquiries, got me into supported housing and that was when I was introduced the the likes of RECO the Recovery College where I was meeting other people that sell pound(selfharmed) and I've got a boss now Alistair and he's been really supportive overthe years He's not, he's not in the face (place) 00:18:05P1 All the time. But he's always there for us, always looking out for us. And when I was talking to. 00:18:10P1 Alistair about I.	Stitch up the wound/dressing Psychological intervention from social worker to meet social need such as assisted with supported accommodation -referral to appropriate services for support eg to recovery college

	00:18:11P1 Mean he's seeing me arms? There was no judgement. 00:18:14P1 There, it was accepted. 00:18:15P1 And I've never had. 00:18:15P1 That before in my life.	

Before you self-harmed, what were your supportand coping strategiesto self-harm? 00:02:52 Speaker 2	Well, I do use a certain coping strategies such as a red pen when I'm feel like to self-harm, I'll use a red pen and go on the old scars on the arms. 00:03:05 Speaker 1 And that tells me brains for a split second that I've already done it. So it does help sometimes. The only problem with that is that I don't get any pain with it, so I'll often use it. 00:03:16 Speaker 1 Bubble and when I flick it off my wrist, it can bring us back in me my like into the hearing now cause obviously when you say when you want yourself harm you like hitting your head sort of things so that will help bring us back to the hall now and sometimes use candle wax because that gives us the warm feeling. 00:03:37 Speaker 1 Yeah, which is what you get when youself harm when you, when the blood's releasing. Sometimes that doesn't work, cause the blood's not coming out. So I would use, like, a pen. I mean, a pen and just. 00:03:48 Speaker 1 Just like do little pinpricks on my hand and that brings the blood to the surface. That could also work and support wise. I've got a massive like a really good family. My partner who I'm with, he doesn't live with us, but he's was playing on and off for the	Psychological factor=psychotherapy=distraction technique= Well, I do use a certain coping strategies such as a red pen when I'm feeling like to self-harm, I'll use a red pen and go on the old scars on the armsand that tells me brains for a split second that I've already done it. So it does help sometimes. The only problem with that is that I don't get any pain with it, so I'll often use… … and sometimes use candle wax because that gives us the warm feeling. Psychological factor=distraction technique Yeah, which is what you get when you selfharm , when the blood's releasing. Sometimes that doesn't work, because the blood's not coming out so I would use, like, a pin. I mean, a pin and…

	last eight years and.00:04:05 Speaker 1 He's very, very supportive. 00:04:08 Speaker 1 If it wasn't for him, I don't think I'll be this well with my mental health to be on. 00:04:13 Speaker 1 And my daughter, she's like a best friend. So I have most support from her, so I tend. 00:04:17 Speaker 1 To think distraction is a massive case, so if you've got family that's there, use them to try and distract yourself if you feel like you will selfharm.	Just like do little pinpricks on my hand and that brings the blood to the surface. That could also work and Distraction=psychological factors= To think distraction is a massive case, so if you've got family that's there, use them to try and distract yourself if you feel like you will selfharm. Interpersonal factor=family support=psychosocial factors=Support wise I've got a massive like a really good family. My partner who I'm withhe doesn't live with us…he's very, very supportive.If it wasn't for him, I don't think I'll be this well with my mental health…andmy daughter she is like a best friend. So I have most support from her.
00:04:30 Speaker 2 what do you think or what do you feel led to your self-harm?	Well, when I was four years old, I suffered sexual abuse from my granddad. So pretty much all my childhood. I was growing up with that. I was very vulnerable and lack of social care and things. And when I got in, I mean secondary school. 00:04:59 Speaker 1 I start getting bullied and things and that's just obviously. 00:05:03 Speaker 1 That's where it more or less stemmed. And then when I met my first partner, he started to like abusing us as well. So like. 00:05:12 Speaker 1 Seven years spent in that kind of abuse and then when I left him, I was in another 10 year abuse relationship which uncovered a lot of rapes and beatings and stuff. So I think I self harmedall them years because of how them relationships made us fail, if that makes sense.	Psychosocial factor=sexual abuse=dealing with emotional trauma= Well, when I was four years old, I suffered sexual abuse from my granddad. So pretty much all my childhood. I was growing up with that Got bullied at secondary school= I start getting bullied and things and that's just obviouslywhere it more or less stemmed. And then when I met my first partner, he started to like abusing us as well. So like… Abusive relationship=psychosocial factor= ..like seven years spent in that kind of abuse and then when I left him, I was in another 10 year abuse relationship which uncovered a lot of rapes and beatings and stuff. So I think I selfharmed all them years because of how them relationships made us feel..

What do you feel could have prevented your self-harm? 00:06:03 Speaker 1	Well, not getting abused for starters, but because I was abused at such a young age, I don't think anything could have prevented my self-harm, to be honest, because I grew up with a lot of lack of self-worth and me parent like me, Mom suffered with mental health difficulties and she was like.	Well, not getting abused for starters, Building on self-worth=Well, not getting abused for starters, but because I was abused at such a young age, I don't think anything could have prevented my self-harm, to be honest, because I grew up with a lot of lack of self-worth and me parent (hereditary)like me, Mom suffered with mental health difficulties and she was like.

	00:06:20 Speaker 1 And I'll look for a while and I don't think any of my life could have changed. So I don't think anything at all would have prevented us from self harming because I would have always carried this. 00:06:30 Speaker 1 Even like myself, not liking myself like because it was such a young age, I don't know what I was like before the abuse happened. 00:06:40 Speaker 2OK. 00:06:41 Speaker 2 Do you feel anything like uh, self worth could mean anything different. 00:06:49 Speaker 2 To you self harming yourself, what at that time? 00:06:56 Speaker 1 I'm not really sure, to be honest. I mean, maybe if I didn't meet the two abusive partners that are hot when I left school, I think maybe they might have all different path if that makes sense or I might not. 00:07:09 Speaker 1 Have carried on self harming from school. I'll start self harm. 00:07:14 Speaker 1When I was at.00:07:14 Speaker 1 school, but I think I might have grown out of it if I hadn't have met them people all my life. So. 00:07:21 Speaker 2 OK.	And I'll look for a while and I don't think any of my life could have changed. So I don't think anything at all would have prevented us from self-harming because I would have always carried this.Even like myself, not liking myself like because it was such a young age, I don't know what I was like before the abuse happened.
What is your view on the effectiveness of your support and coping strategies? How effective do you think this your coping strategies and supports are? 00:07:36 Speaker 1	I mean, I think they're really effective that I have now, I mean this this is a year that I've gone and it's the longest I've ever gone from selfharming in the in the whole life since. 00:07:47 Speaker 1 Normally, the longest I've been is like 3 months. That's how long	I mean, I think they're really effective that I have now, I mean this this is a year that I've gone and it's the longest I've ever gone from selfharming . Normally the longest I have gone is like 3 months.

	because I have tried to get myself better. I do everything that I've been asked. It didn't help that I had a misdiagnosis for a long time, so I wasn't diagnosed with the right illness until 2020. And I think getting that diagnosis helped us. 00:08:06 Speaker 1 Realise who I was as a person and realised that a lot of the things a lot of the behaviours weren't me. It was me, illness, if that makes sense. 00:08:16 Speaker 1 And I've got a massive support, a really good support network with staff of community mental health team like our treatment team has been there now for the last five years. 00:08:28 Speaker 1 And I've got a Cpl that I'm with now, who helped us, got, who helped us get me right diagnosis, and she's very supportive at the minute and I'm currently waiting EM for AMD R, which is weird. List is quite. 00:08:41 Speaker 1Long to be there. 00:08:43 Speaker 1 But once I've have passed, I'm hoping. 00:08:45 Speaker 1 That I'll be. 00:08:45 Speaker 1 In a much better place with me, flashbacks and things. 00:08:50 Speaker 2 Can you clarify what MDR is? 00:08:54 Speaker 1 …Yeah. So this is sort of psychology. 00:10:03 Speaker 1 Yeah, yeah, there's, yeah.	Understanding the nature of illness = getting the right diagnosis =professional support= I wasn't diagnosed with the right illness until 2020. And I think getting that diagnosis helped us realise who I was as a person and realised that a lot of the things a lot of the behaviours weren't me. It was me, illness, if that makes sense Professional support And I've got a massive support, a really good support network with staff of community mental health team like our treatment team has been there now for the last five years. Specialist professional care And I've got a CPN (Community Psychiatrist Nurse)that I'm with now, who helped us get me right diagnosis, and she's very supportive at the minute and…

Have you been to the hospital because you self-harm?	00:10:12 Speaker 1 Yes, I've had a couple of operations over and over hard one, I think it was 2007 where I'd cut my arm, but I'd	(Method used to self-harm=cutting which was severe)= Yes, I've had a couple of operations over and over hard one, I think it was 2007 when I had

	gone right to the bone. So I'd gone through. 00:10:27 Speaker 1 And fans and nerves. So unwell. I had an operation and I was in hospital for a few days. The operation was of 5 1/2 hours long. I've also punched a mirror and like I took the top end of my hand off. 00:10:46 Speaker 1 So I was in hospital for three days. Then I haven't been sectioned. Mental health wise, but I have been hospitalised for self-harm incidents that's gone not to plan if that makes sense. 00:11:01 Speaker 2UM. 00:11:04 Speaker 2 If I could just ask, why did you? 00:11:07 Speaker 2Go to the hospital. 00:11:09 Speaker 1 Because the few times I did go to hospital, I had to have stitches and to be fair, I have had a few incidents where I should have had stitches but didn't go. 00:11:22 Speaker 1 And when I had my first part self harm incident.00:11:26 Speaker 1That I had to have. 00:11:28 Speaker 1 The operation, the really bad operation for the hospital, didn't make it feel like a very nice person, more or less made us feel like I was wasting their time. So after then I just.00:11:39 Speaker 1 Every cell comments and I try to keep from going to hospital so I would use. 00:11:46 Speaker 1 And story strips and things and dominion stitches. If I felt like they needed them because I didn't want to go.	cut my arm, but it had gone right to the bone. So unwell. I had an operation and I was in hospital for a few days. The operation was of 5 1/2 hours long. (Mtd of self-harm=punching)I've also punched a mirror and like I took the top end of my hand off. Reason for going to the hospital=for intervention=stitches= Because the few times I did go to hospital, I had to have stitches and to be fair, I have had a few incidents where I should have had stitches but didn't go.

		Attitude of staff at the hospital= The operation for the hospital…more or less made us feel like I was wasting their time. So after then I just…try to keep from going to hospital so I would usestory strips and things

	00:11:52 Speaker 1 To hospital also I have children as well, so that's sort of like. 00:11:59 Speaker 1 Deterred us from going because I didn't want to lose them, even though I didn't lose them for a short while because of myself harming, but I got them back. 00:12:07 Speaker 1 Just felt like I couldn't go to the hospital and then a couple of times I did go was because I didn't have much choice because I needed an operation, really. 00:12:16 Speaker 2 OK. So would it be correct to say that you went to the hospital the time you did because you found the cut was such in such a state that it needed to be stitched? OK, good. Thank you. What support did you receive in the hospital? So help you cope with this? 00:12:29 Speaker 1Yeah, yeah. 00:12:38 Speaker 1 Well, I am the first time I was in. I was obviously referred to the Mental Health Service, which got us the CPN. Even though after that I didn't really engage well with the service afterwards or obviously it didn't. I didn't get better.00:12:58 Speaker 1The second time. 00:13:01 Speaker 1 I was at the ward They wouldn't even refer us to the mental health. I had to beg them to. Week for years. 00:15:25 Speaker 1 Started to get the last. 00:15:27 Speaker 1 Few years since I've been in treatment for the last five years, like extensively, I've been there, every meeting I've been, every weekly appointment for the last five years and I've engaged with the service	and dominion stitches. If I felt like they needed them because I didn't want to go They aren't very nice. And they're like I've said, like each time I've been hospitalised for self harm, that just don't make youfeel you were supposed to be there. They don't. They just say you are wasting their time because they could be saving a life. But they knock stitching me up because of something I've done myself… Apart from staff attitude another reason for not wanting to go to the hospital after self-harm= I have children as well, so that's sort of likedeterred us from going because I didn't want to lose them, even though I did lose them for a short while because of myself harming, but I got them back. Support received from the hospital apart from stitching the wound= I was obviously referred to the Mental Health Service, which got us the CPN. Everything after that I didn't really engage well with the service afterwards or obviously I didn't get better. Referral to the mental health services was helpful as right diagnosis was made. Patient able to understand thenature of her illness and how to cope= And then I was diagnosed with PTSD and 28, but that wasn't the right diagnosis. I didn't get diagnosed with a EUPD until 2020 and then complex PTSD, which is slightly worse. So it takes a little bit more time to treat. 00:14:02 Speaker 1 But ever since I've got them diagnosis, I'm in a much better place that I can handle life a lot better than I.00:14:07 Speaker 1 Have been over the years.

	this time. So like it made things a lot easier. Compare the. 00:16:00 Speaker 2 Help you got from the hospital and the help you normally. 00:16:07 Speaker 2 Have to stop you from self harm, support. 00:16:14 Speaker 1 I mean it does. It does help having the support I've had now and like the last five years, I only started like self harm and had gone from two to three times a week down once a week and then once a month and it's just progressed like that really and havingthe treatment that I'm in now. 00:16:34 Speaker 1 It really helped because like I say, you're getting realising that it's me illness and not me as a person. But I mean you can't. You can't help the illness. It's just learning to accept the fact that you've got the illness and trying to take the necessary steps to. 00:16:50 Speaker 1 Make things easier on yourself, really. The support you, you you got from the hospital. 00:17:07 Speaker 2 And the support you are having now. 00:17:11 Speaker 2 Which one do you think is more effective? 00:17:15 Speaker 1 The one I'm in now, so the actual community mental health team is what's doing it for me. I didn't get any support from the. 00:17:22 Speaker 1 Hospital at all.	

	00:17:25 Speaker 2 OK, the support for mental health thing, can you be can you give an example of the type of support you're talking about that is better than the one you said that the hospital didn't help you with? 00:17:39 Speaker 1 Well, the mental health team give us the mental health assessment. When I first got into the service, cause at first I was only diagnosed with depression and anxiety, which is what I have been on pretty much all my life. 00:17:53 Speaker 1 But in 20/20/28 I got diagnosed with PTSD, so having that assessment sort of goes into psychology. So they referred us to psychology. So I had a psychology assessment there and I started doing trauma work, which was weekly sessions, basically just learninghow how what trauma is and. 00:18:14 Speaker 1 How it's affected the brain and stuff like that. And while I was in that treatment, that's when the CPN and I have now realised that I didn't just have PTSD. I have also EUPD. So once I got that diagnosis, I did the work for the EUPD, which. 00:18:30 Speaker 1 Is dialectical behavioural therapy, which is what learn is, how to cope with the self harm so that treatment was sorely built, cause self-harm is one of the main symptoms of my illness or when I start doing the proper treatment it made us realise that it was an illness and not just me. 00:18:50 Speaker 1 And and DBT dialectical behavioural therapy. I've just finished treatment now. It took me 3 months, so I think that's why I'm in a position where I'm not self harming anymore.	

		Effectiveness of received support= I was still self-harming 2-3 times aweek for years.Few years since I've been in treatment for the last five years, like extensively, I've …engaged with the service this time. So like it made things a lot easier.

		The one I'm in now, so the actual community mental health team is what's doing it for me. I didn't get any support from thehospital at all. And DBT dialectical behavioural therapy. I've just finished treatment now. It took me 3 months, so I think that's why I'm in a position where I'm not self harming anymore.

What doyou feel helps you reduce or resist how often you self harm or the severity of your self-harm? 00:19:23 Speaker 1	I think it's just, it's just it depends on you as a person because I don't think it depends. 00:19:29 Speaker 1 On your environment as well. 00:19:33 Speaker 1 If things is going alright at home, then you tend not to need to self harm if that makes sense. 00:19:39 Speaker 2 Can I stop you there? You save things. 00:19:43 Speaker 2 Are going on well at home? Is that what you said? Did you say if things are going on well at home, it helps you not to self harm. 00:19:53 Speaker 1 It's like it. I do think a lot of it depends on your environment. It really does and if you've got people around you that's making you feel low, then you're always going to feel low if that makes sense and. 00:20:07 Speaker 1 If I've got, I'm looking because I've got a good support system. Not everyone has that for me. I think destruction is a massive OK for me, like I've got to keep myself busy. I can't just sit and dwell on things because then that's when it makes us want to self harm. If I'm left to just be with me. 00:20:28 Speaker 1 So it's constantly all day, every day. So even if I'm feeling low in the morning and I'll still force myself to get up, get dressed, get washed, and I'll force myself to take me down to school and stuff like that rather than just lying in bed. 00:20:44 Speaker 1 And wishing you weren't here because it doesn't achieve anything. It just makes you feel worse. So I think destruction has been the main key for me, plus a really good support system, which I am, which obviously I do get that not everyone has got, but thathas much been for me. 00:21:02 Speaker 2	Low stressful life events (SLEs)=psychosocial factors= If things are going alright at home, then you tend not to need to self-harm if that makes sense. Interpersonal factor= It's like it. I do think a lot of it depends on your environment. It really does and if you've got people around you that's making you feel low, then you're always going to feel low if that makes sense. Distraction technique=psychological factors=for me, like I've got to keep myself busy. I can't just sit and dwell on things because then that's

		when it makes us want to self harm. If I'm left to just be with me 00:20:28 Speaker 1 So it's constantly all day, every day. So even if I'm feeling low in the morning and I'll still force

	If you talk about support system, are you talking in terms of like people around you or something else? 00:21:10 Speaker 1 Both like people around us, like a good family and also the support of the mental health service like.00:21:18 Speaker 1 But like having professionals involved can actually really help, but you have got engaged with the service for the treatment to work, otherwise it won't work. I've tried that for years, like just gone and not done what they've lost. It doesn't work. You have todo the work. You have to want to get better before you can start getting better if that makes sense. 00:21:41 Speaker 2 Thank you.	myself to get up, get dressed, get washed, and I'll force myself to take me down to school and stuff like that rather than just lying in bed. 00:20:44 Speaker 1 And wishing you weren't here because it doesn't achieve anything. It just makes you feel worse. So I think destruction has been the main key for me, plus a really good support system, which I am, which obviously I do get that not everyone has got, but thathas much been for me. 00:21:10 Speaker 1 Both like people around us, like a good family and also the support of the mental health service like. Support of professionals= 00:21:18 Speaker 1 But like having professionals involved can actually really help, but you have got engaged with the service for the treatment to work, otherwise it won't work. I've tried that for years, like just gone and not done what they've lost. It doesn't work. You have to do the work. You have to want to get better before you can start getting better if that makes sense.

00:21:44 Speaker 2 Which ways do you feel are effective and and what or which way do you feel is the most effective one about all this support you're getting? Which one do you think is more effective for instance?	00:22:03 Speaker 2 If you compare the support around you like people with good family and all that and other things, you getting other support you're getting from the Community team, which one do you feel is more effective and why? 00:22:20 Speaker 1	Effectiveness of professionals compared to other supports=00:22:20 Speaker 1 I think the supportI've heard from.the CPN has been more effective than my family, I think, because my family don't really understand me illness and for all they are there for is don't understand what I'm going through and they don't know the symptoms or anything like that.Even though they still love us for who I am, but the mental health team, having a good CPN

	I think the support. 00:22:25 Speaker 1 I've heard from. 00:22:27 Speaker 1 The CPN has been more effective than my family, I think, because my family don't really understand me illness and for all they are there for is don't understand what I'm going through and they don't know the symptoms or anything like that. 00:22:43 Speaker 1 Even though they still love us for who I am, but the mental health team, having a good CPN has made is like if I'm struggling and I'm like say for instance, I'll say things say things differently than the average person because of my illness or if I'm struggling with the situation, my CPN couldn't explain it to me.00:23:04 Speaker 1 In the right way for me to understand. So then I don't really. 00:23:09 Speaker 1 The hold on the things as much. Now I know that it isn't' just me. Thoughts and me feelings rather than the situation being a problem. It's just more or less. Maybe that's the problem. I know that doesn't sound very healthy. 00:23:20 Speaker 1 But because I know a lot of it is me and how I think.00:23:24 Speaker 1And feel I. 00:23:25 Speaker 1 Can take a step back from that situation now and realise that I could say things differently. Learning to see things from other people's perspectives is really helped rather than just seeing them from me on that makes sense. 00:23:39 Speaker 2	has made is like if I'm struggling and I'm like say for instance, I'll say things say things differently than the average person because of my illness or if I'm struggling with the situation, my CPN couldn't explain it to me. Interpersonal and intrapersonal factors=peer support=00:24:30 Speaker 1 And I I'm very empathetic. I'm very resilient, and I've got being resilient to have getting through all the abuse I have and I think.You're talking to someone as well that's also experienced. What you have really helps, because then if you, I think that's what gives us the incentive to get better, because if people can look up to me and think, well, if you have gone through all of that and you are still where you are now, because I've come through addictions, both drug and alcohol. I'm not using them as strategies anymore, like I've literally came out a better person because of the abuse I've suffered. Culture and spirituality=religious factor=00:26:10 Speaker 1 *I don't really have any beliefs. I'm not really religious as such, I'm more of a spiritual person, so I believe in life after death andstuff like that.* *But I don't. I don't think that my religious beliefs has had any impact whatsoever on my self harm or how I feel about myself, if that makes sense.*

Appendix 7: UoS Ethical Review Approval

Downloaded: 23/03/2023
Approved: 23/03/2023

Hilbert Abie
School of Nursing and Health Sciences
Programme: Research degree

Dear Hilbert

PROJECT TITLE: Self-harm and resilience factors in young adult mental health patients
APPLICATION: Reference Number 015728

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 23/03/2023 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 015728 (form submission date: 22/03/2023); (expected project end date: 01/11/2023).
- Participant information sheet 1023295 version 1 (08/12/2022).
- Participant information sheet 1024735 version 1 (22/03/2023).
- Participant consent form 1023296 version 2 (22/03/2023).

If during the course of the project you need to deviate significantly from the above-approved documentation please email ethics.review@sunderland.ac.uk

For more information please visit: https://www.sunderland.ac.uk/research/governance/researchethics/

Yours sincerely

Mrs Andrea Howell
Ethics Administrator
University of Sunderland

Appendix 8: Health Research Authority Approval

Email: approvals@hra.nhs.uk

Dr Sarah Lonbay
University of Sunderland
University of Sunderland
Edinburgh Building, City Campus
Chester Road, Sunderland
SR13SD

21 March 2023

Dear Dr Lonbay

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Self-harm and resilience factors in young adult mental health patients**
IRAS project ID:	**300717**
Protocol number:	**N/A**
REC reference:	**23/WS/0005**
Sponsor	**Organization not set**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Appendix 9: Distress Protocol

Study Title: Self-harm and resilience factors in young adult mental health patients.
IRAS Project ID: 300717

Distress Protocol for qualitative data collection

Distress Protocol 1: The protocol for managing distress in the context of a research interview (Adapted from : Draucker C B, Martsolf D S and Poole C (2009) Developing Distress Protocols for research on Sensitive Topics. Archives of Psychiatric Nursing 23 (5) pp 343-350)

Distress
Participant indicates experiencing a high level of stress or emotional distress OR exhibit behaviours suggestive that the discussion/interview is too stressful such as uncontrolled crying, shaking etc

Stage 1 Response
•Stop the discussion/interview.
•Researcher (who is a health professional) will offer immediate support
•Assess mental status: Tell me what thoughts you are having? Tell me what you are feeling right now? Do you feel you are able to go on about your day? Do you feel safe?

Review
•If participant feels able to carry on; resume interview/discussion
•If participant is unable to carry on; go to stage 2

Stage 2 Response
•Discontinue interview
•Encourage the participant to contact their GP or mental health provider OR
•Offer, with participant consent, to do so OR
•With participant consent contact participant's care coordinator (Key worker) or a member of the health care team treating him/her for further advice/support

Follow up
•Follow participant up with courtesy call (if participant consents) OR
•Encourage the participant to call his/her GP or care team if he/she experiences increased distress in the hours/days following the interview

Confidentiality
Confidentiality would be broken if participants disclose that they or someone else is at risk of significant harm

Version: DP/27/01/23
IRAS project ID: 300717

Appendix 10: Consent Form

Consent Form

Study Title: Self-harm and resilience factors in young adult mental health patients.
IRAS Project ID: 300717

*Resilience means beingable to withstand or recover quickly from difficult conditions

Please initial box

1. I confirm that I am over 18yrs and have read the information sheet (version: **PIS/27/01/23** for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2 I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. This should be within 6 weeks of participation as it would not be possible to remove data after data analysis started. ☐

3 I understand that the information collected about me may be shared anonymised in quotes in publications and with other researchers ☐

4 I understand that confidentiality would be broken if I disclose intention to harm self or others ☐

5 I understand that my initial here in the box indicates that I would like the results of the study to be made available to me ☐

6 I agree to my General Practitioner being informed of my participation in the study ☐

7 I confirm that original copy of the participant information sheet and completed copy of consent Forms have been given to me and I understand that copies are also filed in the Investigator's file. and patient's note ☐

8 I understand that the interview will be recorded and transcribed ☐

9 I agree to participate in the above study ☐

PARTICIPANT INFORMATIONSHEET

Study Title: Self-harm and resilience factors in young adult mental health patients
IRAS Project ID: 300717

*Resilience means being able to withstand or recover quickly from difficult conditions

What is the purpose of the study?

This is a PhD study to explore, factors that makes young adult mental health patients able to withstand self-harm and how these work to support the prevention of self-harm and promote mental well-being. It is anticipated that this research will help to inform and contribute to effective management of self-harm in young adult mental health patients.

Who can take part in the study?
Any mental health patient (18-64years) under the adult mental health service with history of self-harm. This will include mental health patients with mental capacity to give informed consent and are not acutely unwell. You are being invited to take part because you were recently discharged from the hospital and have the experience that is relevant to this study. If you do not wish to take part, then please disregard this information and you will not be contacted again.

Do I have to take part?

Participation is entirely voluntary. Your decision about whether to take part in the study will have no impact on the care and support that you currently receive. If you change your mind about taking part in the study, you can withdraw at anytime during the study. You can also withdraw in retrospect after fully participating in the study. This should be done within 6 weeks of participation; after this time it will not be possible to remove your data from the study once data analysis has taken place. Participants who lose capacity after they have given informed consent will be withdrawn from the study. However, data obtained before losing capacity will be retained and used in the study.

What will happen to me if I take part?
You will be interviewed over the phone or via a virtual platform (e.g. Microsoft Teams or Zoom) or face to face to hear your experience of self-harm and the factors you consider helped to prevent and reduce self-harm behaviours. The interviews will be audio recorded and transcribed, with your consent.

You will be asked questions such as: What have you experienced in terms of self-harm? What situations or contexts have typically influenced your experiences of self-harm? Other open-ended questions may be asked.

- You will be interviewed one-to-one over the phone or via an agreed virtual platform (e.g. Microsoft-Teams or Zoom) or face to face, with date and time agreed.

Appendix 11: Participant Information Sheet
Appendix 12: Interview Guide

Interview Guide

The following are examples of questions that might be asked in the interview. Other questions might also be asked. Any question that you are either not able to answer or not comfortable with, will be left out. Apart from the questions asked during the interview, if you feel there is something important you want to talk about, you should feel free to do so. During the interview you might wish to take short break.

Introduction

- Brief chat
- Background information

Sample questions

- How long has it been since you self-harmed?

Before you self-harmed

- What were your support and coping strategies to self-harm?
- What do you feel led to your self-harm? What do you feel could have prevented your self-harm? What is your view on the effectiveness of your support and coping strategies?

Hospital experience

Have you been to the hospital because you self-harmed? Why/why not?

- What support did you receive in the hospital to help you cope with self-harm?
- How did you experience the support that you received? Was it helpful? Why/why not?
- In your own view, did the support help you not to self-harm in hospital or did it help you reduce how often you self-harmed or the severity of your self-harm? Why/Why not?