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Understanding Student Self-Harming Behaviours and The Spectrum of Care Within a University Context: A Mixed-Methods Approach

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Understanding Student Self-Harming Behaviours and The Spectrum of Care Within a University Context:

A Mixed-Methods Approach

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(NEÉ CULSHAW)

A thesis submitted in partial fulfilment of the requirements of the University of Westminster for the degree of Doctor of Philosophy

School of Social Sciences, Unit of Psychology

July 2023

Abstract

Young people present a high-risk group for engagement in self-harming behaviours, commonly associated with mental health difficulties and increased risk of suicide. University is a key period of transition for students, offering opportunities for personal and academic growth. However, managing the demands and responsibilities of university life can be overwhelming (Taliaferro & Muehlenkamp, 2015). Psychological distress may lead to engagement in self-harm as a means of coping (Stallman, 2020). Poorer outcomes in academic achievement, employability, and relationships have been reported among students who fail to receive support for their mental health. Resultantly, university has been highlighted as a crucial time point for psychological support (Holm-Hadulla & Koutsoukou-Argyraki, 2015). Despite this, research exploring self-harm within a UK university setting is lacking.

Study one consisted of two online questionnaires measuring self-harm alongside a series of psychosocial outcomes amongst current university students reporting lifetime self-harm, as well as those providing support to student self-harmers. Increased rates of alexithymia, emotional inhibition, and rumination, and reduced social contacts for students reporting lifetime self-harm were detected. Stigma and uncertainty regarding available support were common barriers to help-seeking at university. Further, the majority of those offering support to students who self-harm felt out of their depth and in need of their own support. Study two expanded on these findings with an in-depth qualitative exploration of student self-harm. Interviews revealed three key themes regarding the influence of university-specific factors on motivating, maintaining, and preventing self-harm. Whilst some reported difficulties with academic stressors, others felt that university was an opportunity for developing their identity and new relationships. Finally, study three presents the voice of those providing support for university students engaging in self-harm.

A broad spectrum of care in a university setting emerged, from professionals to friends and family members, including students with personal experiences of self-harm. Across all studies, the variation in supportive resources across UK universities was highlighted, with limited sessions and availability resulting in increased pressures on supporters and many students not accessing the care they need.

This body of research is unique in its understanding of self-harm from multiple perspectives and offers reflections from students who self-harm and those offering support. Novel insight into support provisions and help-seeking, as well as key triggers and maintenance factors of self-harm within a university context, is timely due to rising rates of poor mental health among students and demands on university support systems.

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List of Abbreviations

ACT	Acceptance and Commitment Therapy
A&E	Accident and Emergency
ANOVA	Analysis of Variance
APA	American Psychiatric Association
APMS	Adult Psychiatric Morbidity Survey
BPD	Borderline Personality Disorder
BPS	British Psychological Society
CBT	Cognitive Behavioural Therapy
CR	Critical Realist
DBT	Dialectical Behavioural Therapy
DSH	Deliberate Self-Harm
DSM	Diagnostic and Statistical Manual of Mental Disorders
EAM	Experiential Avoidance Model
EI	Emotional Inhibition
GP	General Practitioner

HE	Higher Education
HEPI	Higher Education Policy Institute
IMV	Integrated Motivational-Volitional
I-RS	Inhibition-Rumination Scale
ISAS	Inventory of Statements About Self-Injury
MDT	Multi-Disciplinary Team
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NSSI	Non-Suicidal Self-Injury
ONS	Office of National Statistics
RCT	Randomised Control Trial
SAS-FI	Social Adjustment Scale Friendship Index
SH	Self-Harm
SIB	Self-Injurious Behaviour
SI	Self-Injury
SU	Student Union

TA	Thematic Analysis
TAS	Toronto Alexithymia Scale
UK	United Kingdom
UREC	University of Westminster Research Ethics Committee
VAS	Visual Analogue Scale

Overview of Publications and Presentations

Publications

Edwards-Bailey, L., Cartwright, T., Smyth, N., & Mackenzie, J. M. (2022). A qualitative exploration of student self-harm and experiences of support-seeking within a UK university setting. *Counselling Psychology Quarterly*, 1-25. https://doi.org/10.1080/09515070.2022.2146054

Edwards-Bailey, L., Smyth, N., Cartwright, T., & Mackenzie, J. M. (2023). The spectrum of care within a university context: the differing roles of carers in supporting students who self-harm. *International Journal of Care and Caring*, *7*(4), 708-734. https://doi.org/10.1332/239788221X16890865425257

Presentations and Media

Culshaw, L., Mackenzie, J.M., Cartwright, T., & Smyth, N. (2021). University Students who Self-Harm: A qualitative exploration of supporters' experiences (The CHERISH Study). Oral presentation at the Suicide & Self-Harm Early and Mid-Career Researchers' Forum, June 17th 2021.

Culshaw, L., Mackenzie, J.M., Cartwright, T., & Smyth, N. (2021). University Students who Self-Harm: A qualitative exploration of supporters' experiences (The CHERISH Study). Oral presentation at the University of Westminster, Health Innovation and Well-being Research Community Event: Caring for University Students' Mental Health and Well-Being, June 6th 2021.

Culshaw, L., Cartwright, T., Smyth, N., & Mackenzie, J.M. (2020). Helping Understand Student Self-Harm: The Lived Experience of Students and their Supporters'. Invited guest speaker at Alder Hey Children's Hospital, Clinical Health Psychology CPD Event, November 2020.

Culshaw, L. Invited to a radio interview with Vanessa Feltz on BBC Radio London to discuss findings from my PhD research, October 9th 2020.

Culshaw, L., Cartwright, T., Smyth, N., & Mackenzie, J.M. (2019). University students who Self-Harm: A Qualitative Exploration of Supporters' Experiences. Poster presentation at the International Association of Suicide Prevention (IASP) Conference: "Breaking down walls and building bridges", Derry, Londonderry, Northern Ireland. September, 2019.

Culshaw, L., Cartwright, T., Smyth, N., & Mackenzie, J.M. (2019). University students' perceptions of self-harm and experiences of support-seeking: a qualitative approach. Oral poster presentation at the Suicide & Self-Harm Early and Mid-Career Researchers' Forum, Glasgow UK, June 17th 2019.

Culshaw, L., Cartwright, T., Smyth, N., & Mackenzie, J.M. (2019). Helping Understand Student Self-Harm (The HUSSH Study): A mixed-methods approach. Interactive poster presented at the BPS Annual Conference, Harrogate UK. May, 2019.

Culshaw, L., Cartwright, T., Smyth, N., & Mackenzie, J.M. (2019). University students' perceptions of self-harm and experiences of support-seeking: a qualitative approach. Interactive poster presented at the BPS Annual Conference, Harrogate, UK. May, 2019.

Culshaw, L. (2018). Individual Differences in Suicide. Invited guest lecture at the University of Westminster, Health Psychology MSc, February 20th.

Culshaw, L. (2018). Individual Differences in Self-Harm. Invited guest lecture at the University of Westminster, Health Psychology MSc, February 13th.

Culshaw, L., Cartwright, T., Smyth, N., & Mackenzie, J.M. (2017). Poster presentation at Westminster University, Department of Psychology Research Forum.

Culshaw, L., Mackenzie, J.M., Borrill, J., Cartwright, T. (2017). University Students who Self-Harm: What can we do to Help? Poster presentation at the University of Westminster, Faculty of Science and Technology Doctoral Conference.

Prizes

Winner of Best Poster Award, Suicide & Self-Harm Early and Mid-Career Researchers' Forum (2019).

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In loving memory of my granny, Elizabeth Agnes.

Whilst you haven't been able to share this journey with me, your heart and fondness for learning and education have been with me every step of the way.

Wow…what a journey! Never in my wildest dreams did I think I'd undertake a PhD. I remember attending my BSc graduation ceremony and seeing the select few individuals in red caps and gowns. As much as I had a passion for academia, I cannot deny the doubt I had regarding my own ability of ever being able to reach that level. So as you can imagine, writing this as I finalise my thesis is extremely emotional. I've always believed in the mantra that your support system is everything. And so, there are several key people whom I would not have made it to this day without their love, support and dedication to my success and getting me over that finish line.

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To my family, I love you. Thank you for your continued support, love, and care. To my mum and dad, for always being there at the end of the phone when I needed those gentle words of encouragement and never doubting me. To my brother (Paul) – for your proofreading skills and empathy whilst both doing our PhDs alongside each other. To Liam (my little brother) – for never failing to make me laugh and always being there to chat to me about football when I needed a 'happy place' and a connection with home. And to my in-laws – Sharon, Adrian, Lily & Paul - your support throughout my journey in academia has been incomparable, thank you.

To my friends - thank you for always being available for the laughs, glasses of wine, nights of dancing (yes, I mean Oslo & Popworld) and tubs of ice cream! You've given me the break I needed from my PhD at the times when I needed it most and helped me with the 'guilt' of feeling as though I should be constantly working. Thank you for saving my well-being & sanity!

And last, but definitely not least, my participants. This project would not have been possible without your bravery and openness, as well as your desire to improve the future and lives of those attending university, offering support, and/or engaging in self-harm. Whenever I felt like

giving up, I always had you in the back of my mind cheering me on as I know how important it is to share your stories. This is for you.

Author’s Declaration

I declare that all of the material presented in this thesis is my own work and has not been submitted at any other University.

Signed: *Laura Edwards-Bailey* (July 2023)

1. Chapter One: Introduction

This chapter introduces the current thesis, with particular emphasis on existing policies and initiatives specific to university settings and self-harm. The purpose of this chapter is to introduce the reader to key strategies and statistics foundational to this research, with a more in-depth exploration provided in subsequent chapters (chapters two and three), as well as setting the scene for the research carried out and presented later.

1.1 Mentally Healthy Universities

The mental health of university students has received worldwide attention within the last decade due to increasing difficulties relating to well-being and psychological distress amongst this group (Bantjes et al., 2022; Browne et al., 2017; Holm-Hadulla & Koutsoukou-Argyraki, 2015; Thorley, 2017). The majority of those attending university fall within a critical time point for the development of mental illness, with over 60% of individuals experiencing symptoms by their mid-20s on a global scale (Solmi et al., 2022). This was acknowledged in the National Health Service (NHS) Long-Term Plan (NHS, 2019), with a specific pledge to improve student mental health. In line with this increasing recognition of student distress, it appears that rates of individuals disclosing mental health difficulties are also rising (Thorley, 2017) (see Figure 1). Unsurprisingly, the demands on university support services are also increasing (Thorley, 2017) (see Figure 2).

Figure 1

The Number of Students Disclosing Mental Health Conditions to Universities between 2007-2017 (Thorley, 2017, adapted for visualisation in Suicide Safer Universities, University UK, 2018b, p.12)

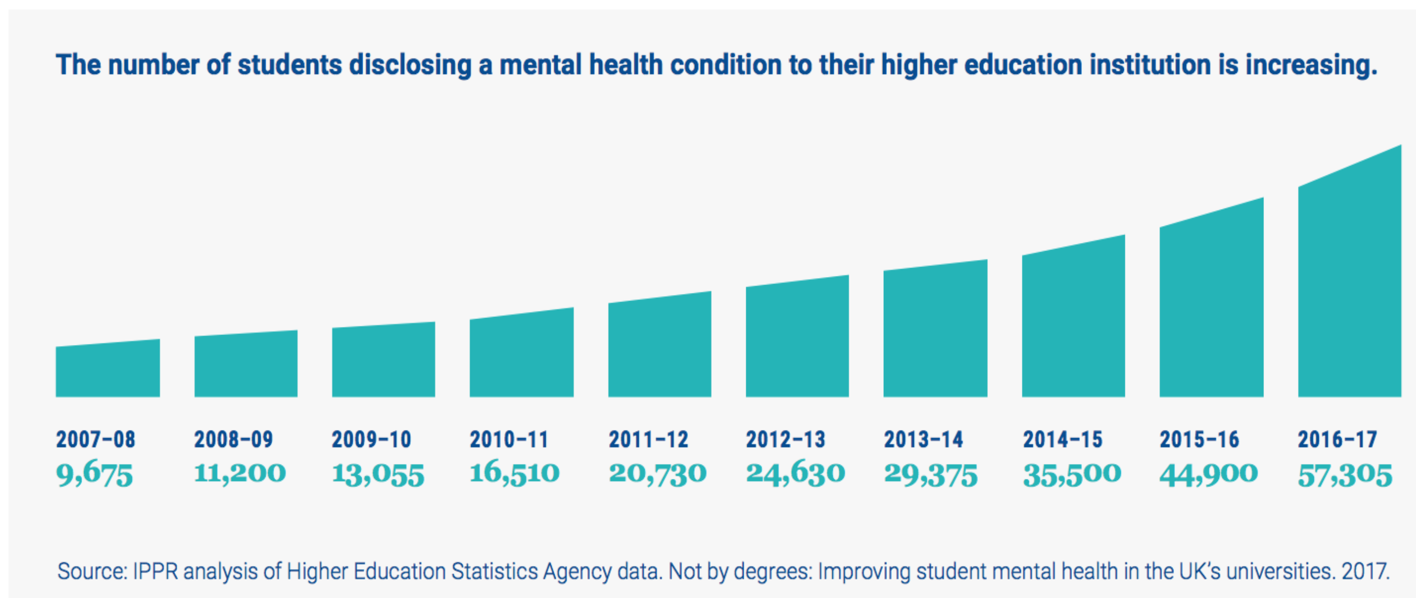
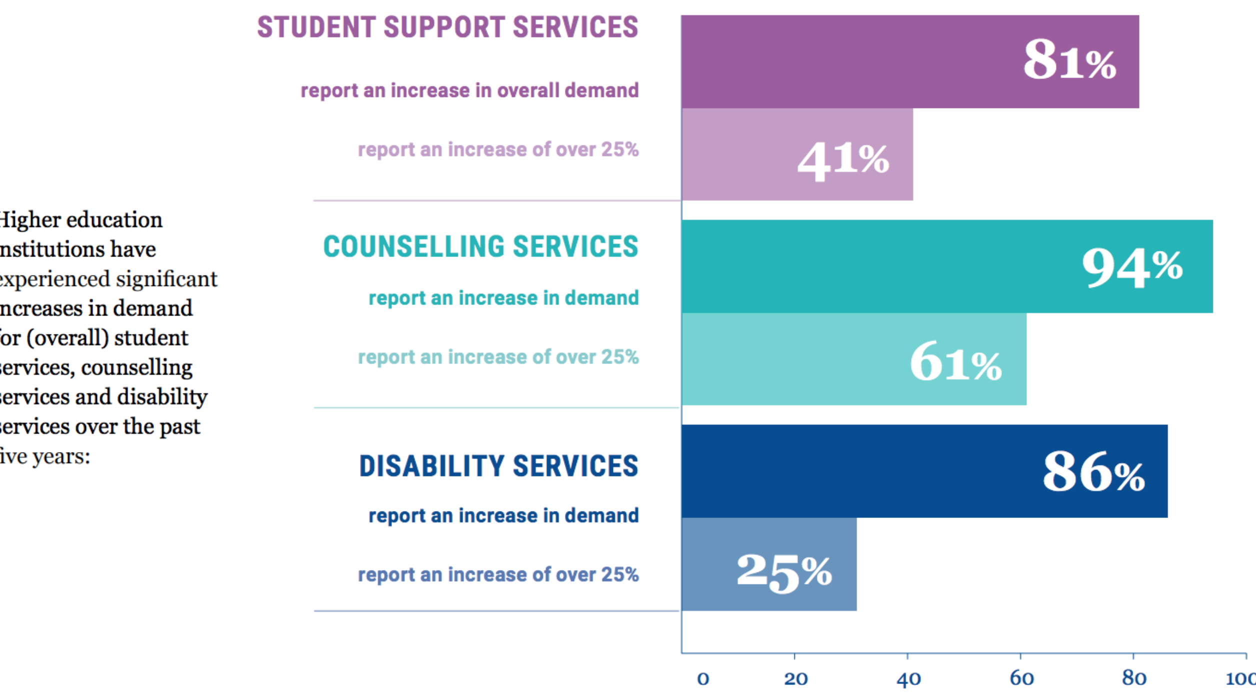


Figure 2

Overall demand for all student, counselling, and disability services in the last five years (Thorley, 2017, adapted for visualisation in Suicide Safer Universities, University UK, 2018b, p.13)



An indication that these demands are exceeding capacity, resulting in students failing to access support, is evident in the literature (Brown, 2016). To promote psychological safety within universities, Universities UK launched the 'Stepchange' initiative highlighting the need for a united approach to student mental health (De Pury & Dicks, 2023). This shares similarities with the 'Minding Our Future' policy (Universities UK, 2018a), aiming to improve mental health support between universities and NHS services. A drive for universities to prioritise student

mental health was also proposed in the 'charter framework' (Hughes & Spanner, 2019), directed at connecting university mental health services to collaborate and share ideas relating to their practice. The most recent strategic framework entitled 'Stepchange: Mentally Healthy Universities' (De Pury & Dicks, 2023) presents an updated call for action, asking universities to *"adopt mental health as a strategic priority, to see it as foundational to all aspects of university life, for all students and all staff".* Within this framework, five key domains are proposed (De Pury & Dicks, 2023, p.5):

1. Aligned - the need for collaboration, sharing and celebrating resources and approaches.
2. Adaptable - recognising differences in cultures and contexts and adapting as required for the student population/specific university.
3. Strategic - the need for long-term commitment across sectors and organisations.
4. Share - recognising a shared vision for "mentally healthy universities".
5. Evolving - building on the existing evidence base and responding to new research and policies.

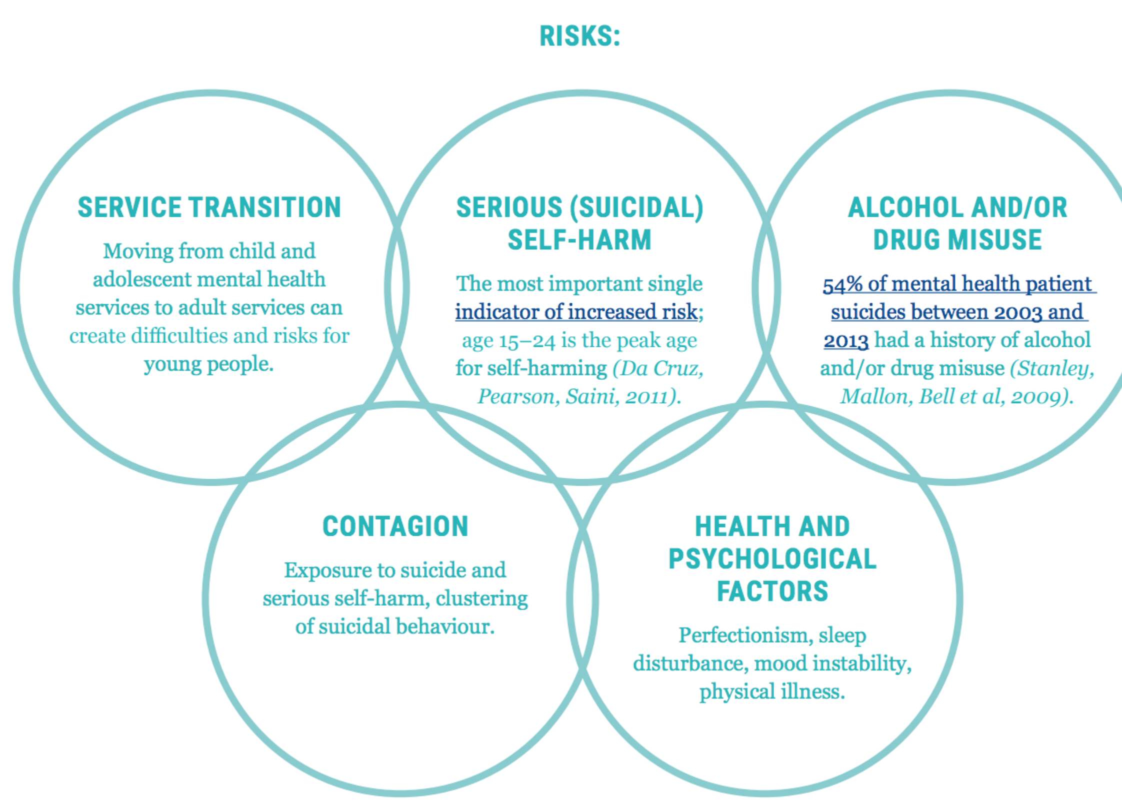
Whilst mental health more broadly has been a core focus within healthcare and educational guidelines (e.g., NHS Long-Term Plan (NHS, 2019) and 'Stepchange' (De Pury & Dicks, 2023)), recognition to groups of students that may be at higher risk of experiencing increased distress during university is less common. In 2014, the Adult Psychiatric Morbidity Survey (APMS) showed an increase in rates of lifetime self-harm amongst those aged 16-24, from 2.4% in 2000 to 6.4% in 2014 across males and females (McManus et al., 2016). Similarly, suicidal thoughts and attempts also increased, and the highest rates were observed in women aged 16-24 years and men aged 25-34 years. Over 25% of females between the ages of 16-24 reported

lifetime self-harm, compared to 9.7% for males. For females aged 25-34 years, 13.2% were currently engaging in self-harm. Further statistics were published for 2021 by the Office of National Statistics (ONS) (ONS, 2022b), revealing a significant increase since the initial records started in 1981 in suicide rates amongst females aged 24 and under. Given the increased risk of suicide for those with a history of self-harm (Joiner Jr et al., 2005; Mars et al., 2019; Wilkinson et al., 2011), alongside difficulties with disclosure and the private nature of these behaviours (Rowe et al., 2014), research focusing on the needs of this specific group within a university context is warranted.

In the UK specifically, at least 95 university students died by suicide between 2016 - 2017 (ONS, 2018), with only 12% known to student support services (De Pury & Dicks, 2023). This led to the publication of 'Suicide Safer Universities' (Universities UK, 2018b), resulting from a collaboration between Universities UK and PAPYRUS, a charity aimed at preventing suicides in young people. Within these guidelines, a need for research studies collating data and providing further in-depth exploration amongst students who self-harm was suggested (Universities UK, 2018b, p. 10), given the identification of self-harm as the single greatest risk factor for suicide in young adults (Da Cruz et al., 2011) (see Figure 3). This proposal for future research highlights the importance of a joint collective to prioritise student mental health between universities, the National Health Service (NHS) and the UK government (Brown, 2016).

Figure 3

Risk Factors for Student Suicide (taken from Suicide Safer Universities, University UK, 2018b, p.10).



Recent publications of guidelines and initiatives from universities and related organisations (e.g., Student Minds and Universities UK) evidence the increasing responsibility of universities themselves to provide well-being support for students. However, it is widely established that other support systems (e.g., family and friends) play a crucial role in supporting loved ones experiencing poor mental health, self-harm and/or suicidal ideations. In 2013, the Carers Trust

conducted research specifically focusing on the experiences of young adult carers attending a UK college or university (N=101) (Sempik & Becker, 2014). Findings highlighted challenges in managing academic demands alongside caring roles, with almost half (45%) reporting difficulties with their own mental health. Resultantly, recommendations emphasised the need for universities to acknowledge and support the specific needs of young adult carers (Sempik & Becker, 2014). Whilst more formal caring roles have been researched, considering the university context and that many students may live or move away from home, additional opportunities for more 'informal' means of support from fellow students are plausible.

Research has highlighted the specific need to focus attention on young adult caregivers due to the many changes that accompany this life stage (e.g., studying and career development) (Boumans & Dorant, 2018). Further, specifically for self-harm, we know from literature including adolescent samples that individuals are most likely to seek support from friends and family in comparison to professionals (Rowe et al., 2014). However, our understanding of informal care-giving for self-harm in a university setting, and the impact of these ever-growing demands on university support services, is limited.

Considering the impact of informal caring roles on the mental health of supporters, increasing demands on universities to prioritise student support, alongside the rising rates of mental health difficulties and suicide among students, there is a clear need to understand the experiences of individuals delivering support to students and working within these systems. In addition, recognition of where students may go as a result of not being able to access professional support, or due to fear of disclosure, requires exploration. In response, the current thesis devised three studies to address gaps within the existing evidence base regarding student self-harm, help-seeking, and care-giving.

1.2 An Overview of the Current Thesis

The research presented in this thesis aimed to understand and explore self-harming behaviours amongst university students, including help-seeking and the experiences of those providing formal and informal support for this group. Chapters two and three present an overview of the existing literature in the areas of self-harm, university students, and supporters/carers, providing rationale for the aims of the current research. Chapter four includes a detailed description of the methods adopted to collate and analyse the data across this thesis. Chapters five, six and seven present the findings of the three studies conducted amongst university students and supporters utilising quantitative and qualitative methodologies (see Figure 4). Finally, chapter eight offers a general discussion of all the research findings, acknowledging strengths and limitations, as well as implications and suggestions for existing practice and future research.

Figure 4

Overview of Thesis Studies, Samples, and Applied Methodologies

Study 1
(Chapter 5)

Two online surveys exploring self-harm amongst university students, help-seeking, and experiences of supporters.
(n=399)

Statistical, Descriptive and Thematic Analysis

Study 2
(Chapter 6)

One-to-one interviews with 16 individuals with lived experience of self-harm in a university setting.

Thematic Analysis

Study 3
(Chapter 7)

One-to-one interviews with 24 individuals with lived experience of offering professional and/or informal support and care for university student/s engaging in self-harm.

Thematic Analysis

2. Chapter Two: Literature Review - Self-Harm

To provide context, this chapter will provide an overview of the self-harm literature, including various definitions, theories, and prevalence rates of self-harm reported in existing research. Factors thought to increase the risk and maintenance of self-harm will be discussed, with reference to interventions commonly drawn on when working with individuals who engage in self-harming behaviours.

2.1 Background

Definitions and individual perceptions (e.g., professionals, researchers, people who self-harm, and the general population) of self-harm have adapted and evolved dramatically over time. Resultantly, various terminology describing self-harm exists across the literature, including: Self-Injury (SI), Nonsuicidal Self-Injury (NSSI), Deliberate Self-Harm (DSH) and Self-Injurious Behaviour (SIB). Many other terms have also been suggested, aiming to classify behaviours in which injury has been self-inflicted. The presence of suicidal intent, or lack of, has provoked further controversy when defining self-harm. NSSI refers to the direct and deliberate destruction of one's own body tissue, without suicidal intent (Nock et al., 2006). Whereas, Hawton et al. (2003) defines self-harm as "the intention to self-injure or self-poison, regardless of motivation or suicidal intent". Despite varieties in definitions, the self-harm literature is extensive. Due to increasing rates of self-harm reported across the general population, the main focus has shifted to prevention and development of effective interventions and methods of support (ONS, 2022a). To do this, it is crucial to identify specific groups and contexts in which self-harm may be heightened.

2.2 Defining Self-Harm in Britain: An Historical Overview

Responses and treatment of self-harm from healthcare systems have altered drastically over the last 100 years (Dale, 2015). These changes have been attributed to the varying ways of defining self-harm discussed above, influenced by both individual and societal attitudes. In the early 1900s, self-cutting was seen to be an attempt to murder oneself, with some believing individuals enacting it should be criminally charged by the police (Millard, 2013). In late-Victorian times, self-harm as a concept was characterised differently. For example, behaviours such as cutting, biting, inserting needs, and self-castration were all categorised within the bracket of 'self-mutilation', a term which is seldom used in today's literature due to its negative historical associations (Chaney, 2011). It is within this same period that an interesting distinction between self-harm and suicide existed. Those that presented at hospitals due to self-harming behaviours were not assessed, and the intent of the act was not considered despite the majority of self-harm being medically treated during this time. However, some reports suggest that hospitals refused to treat these individuals due to their view of this behaviour as one of a criminal description (Millard, 2013). Much debate over who was responsible for taking care of the individual existed, including arguments that local authorities should take responsibility for conducting observations, and healthcare staff resenting police officers for bringing these individuals to hospital (Millard, 2012). Many hospital workers viewed presentations involving self-harm as a considerable hindrance to their funding, given that the National Health Service (NHS) did not exist at that time, instead relying on donations from wealthy members of the community to keep services running (Rose & Keigher, 1996). This dispute regarding responsibility relates to two main factors– 'renewal' (more commonly known as 'repetition' in modern literature) and 'violence'. The concept of 'renewal' relates to the concern that the

individual may repeat the presenting behaviours, due to their initial attempt having failed, reflecting the association of self-harm and suicidal intent at that time. ‘Violence’ represented the confusion of professionals as to whether the act was mainly directed at themselves, or at another individual. Therefore, if it was felt that the individual was likely to repeat the behaviour or use methods of violence as a form of communication, responsibility for observation fell to the local authorities (Dale, 2015).

During the 1920s, cases deemed to be emergencies would either be treated in workhouses or voluntary hospitals. At this point, individual intentions began to gain traction as an important factor to consider in deciding the most appropriate location for them to be treated. Those thought to have attempted suicide would be taken to the workhouses, based on the view that these cases were ‘different in character’ to those seen at the voluntary hospitals. Furthermore, workhouses were more equipped in managing these cases due to the presence of ‘qualified professionals’ within these institutions (Mohan & Gorsky, 2001). However, decisions as to whether the individual’s behaviour was one of attempted suicide were based upon the violence of the act, driving high levels of stigma within society. Further, issues in relation to how effective the concept of ‘violence’ was as a means of distinguishing between attempted suicide and self-harm were noted. After the mid-1900s, the concept of ‘violence’ as a measure of attempted suicide became irrelevant as self-poisoning was reported as the most common method of attempted suicide until the 1980s, a method in which violence plays little part. Therefore, the need to shift the way in which hospitals and health professionals distinguished between self-harm and suicide became apparent (Dale, 2015).

The notion of mental illness and what may contribute to the development of self-harm and suicidal ideation began to advance in the 1960s. Genetics and anatomy had been the main

considerations to date, however the significance of social factors, relationships and attachment began to emerge. At this point, self-harming behaviours as a means of communicating psychological distress (Kessel & McCulloch, 1966), and the use of overdose as a method of self-harm, rather than an attempt to end one's life, became apparent. Doctors noted most overdoses did not involve taking amounts that would lead to death, and the terminology of 'self-poisoning' and 'parasuicide' were introduced. This attempted to prevent confusion with 'attempted suicide' by classifying these behaviours based on intent rather than the behaviour itself (Millard, 2016). Similarly, in the 1970s and 1980s, the terms 'self-harm' and 'DSH' were used for categorising behaviours such as self-cutting. Self-harm was viewed differently to attempted suicide in that individuals were not communicating or help-seeking, but instead using self-harm as a coping mechanism to release and regulate emotional distress, resulting in a sense of control for the individual (Kahan & Pattison, 1984), a theory that is still well regarded today.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013) introduced 'self-harm' as its own discrete category for the first time, having previously featured in the DSM as a symptom of other diagnoses. Recent advancements in the self-harm literature likely account for this, providing a greater understanding of triggers, risk factors, and maintenance factors, allowing for the theoretical underpinnings of self-harm to progress.

2.3 Theories of Self-Harm

Theories of self-harm share commonalities with that of suicide, however they also have distinct differences, highlighting the variance between these behaviours (Jacobson & Batejan, 2014). Biological theories suggest that NSSI occurs as a means of improving mood. When an individual engages in self-harm, this provokes the release of endorphins, including an opioid

released in response to pain which causes a temporary state of elation, which may induce the mood-regulating effects that many individuals who self-harm report after carrying out this behaviour (Favazza, 1998; Richardson & Zaleski, 1986). However, several studies have failed to support the opioid hypothesis, questioning its ability to explain and understand the complexity of self-harm (Thürauf & Washeim, 2000).

Animal models propose the dopamine system as key in NSSI (Groschwitz & Plener, 2012). The dopamine pathway is associated with addiction due to the way in which many drugs alter its activity (Volkow, 2005). It has been suggested that a similar process may occur during self-harm, offering explanation as why the behaviour is often repeated – i.e., the individual forms an 'addiction' (Blasco-Fontecilla et al., 2016). Support for this analogy is provided by animal studies which have found that when monoamine reuptake inhibitors (which prevent the reuptake of dopamine by blocking the receptor) are administered to animals (such as rats and mice), self-harming behaviours are often observed (Winchel & Stanley, 1991). However, further research has suggested other explanations as to why SIBs are detected in these studies, including the notion of neuroplasticity, which describes the brain's capacity to alter and modify in response to new experiences (e.g., learning new skills) (Chang, 2014). One study reported that when individuals with SIBs were administered medication linked to enhancing neuroplasticity (e.g., topiramate), SIB reduced (Blake et al., 2007; Muehlmann et al., 2008). Therefore, individuals who self-harm may repeat this behaviour due to inadequate or limited plasticity preventing development of other coping strategies, questioning the extent to which the dopamine system is solely involved in maintaining self-harm (Muehlmann & Devine, 2008).

Overall, biological theories highlight potentially predisposing factors which may result in later self-harm. Individuals with altered and dysregulated levels of neurotransmitters are at a

greater risk of engaging in both self-harm and suicidal behaviours (Mann & Currier, 2007; Van Heeringen et al., 2003). By applying this theory, there is potential to identify those at risk and allow for preventative measures to be put in place. However, these theories are limited, and research has yet to identify specific biological mechanisms which when altered result in observable behavioural changes (Devine, 2012; Muehlmann & Devine, 2008).

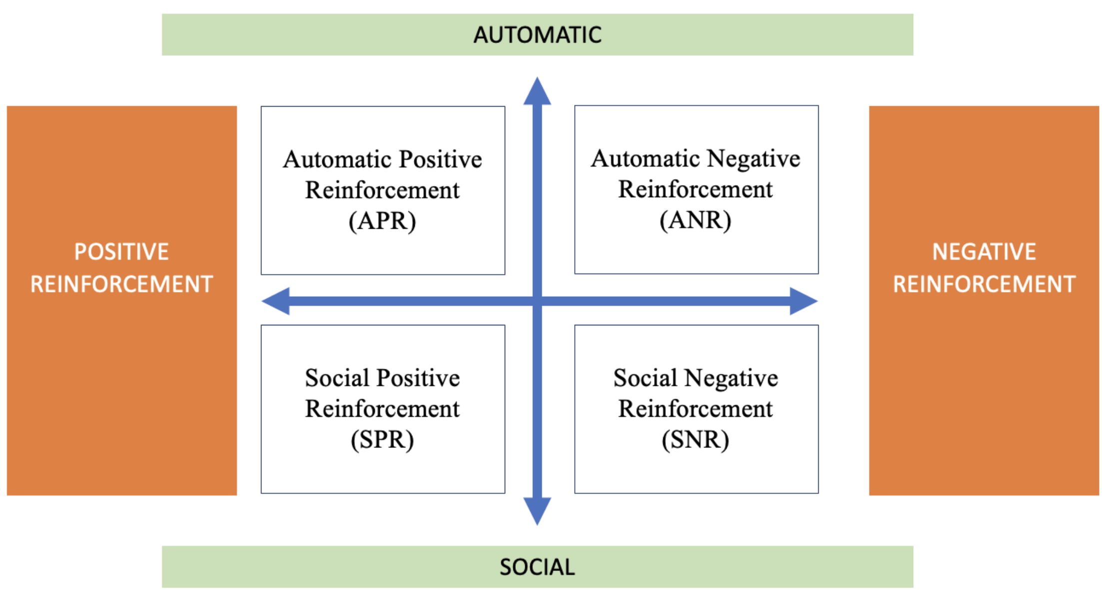
NSSI has also been explained by social theorists. Earlier social theories understood self-harm as a manipulating behaviour, suggesting individuals engage in self-harm to influence and manipulate those around them (Chowanec et al., 1991). However, these views have been criticised for their stigmatising language and connotations, and social theorists instead recommend viewing NSSI is a means of communicating emotional pain. This pain may occur as a result of poor family relationships, especially those who receive high levels of criticism from close family members (Linehan, 1993).

Nock and Prinstein (2004) investigated the functions of self-harm amongst an adolescent population, leading to the development of the four-factor model (FFM) of NSSI. Their results propose that the functions of self-harm can be categorised by two groups of: a) variables, and b) reinforcement. They propose that the variable can be either automatic (i.e., intrapersonal) or social (i.e., interpersonal). Intrapersonal describes private internal factors such as emotions and cognitions, whereas interpersonal variables are experiences and interactions with the external environment. Reinforcement can either be positive or negative. Positive reinforcement is experienced when a new stimulus is added, whereas negative reinforcement is the removal of an existing stimuli (Skinner, 1974). By combining the categories of variables and reinforcement, four unique functions of NSSI were put forward in the FFM: Automatic Positive Reinforcement

(APR), Automatic Negative Reinforcement (ANR), Social Positive Reinforcement (SPR) and Social Negative Reinforcement (SNR) (Nock & Prinstein, 2004) (see Figure 5).

Figure 5

Nock and Prinstein's (2004) Four Factor Model of NSSI

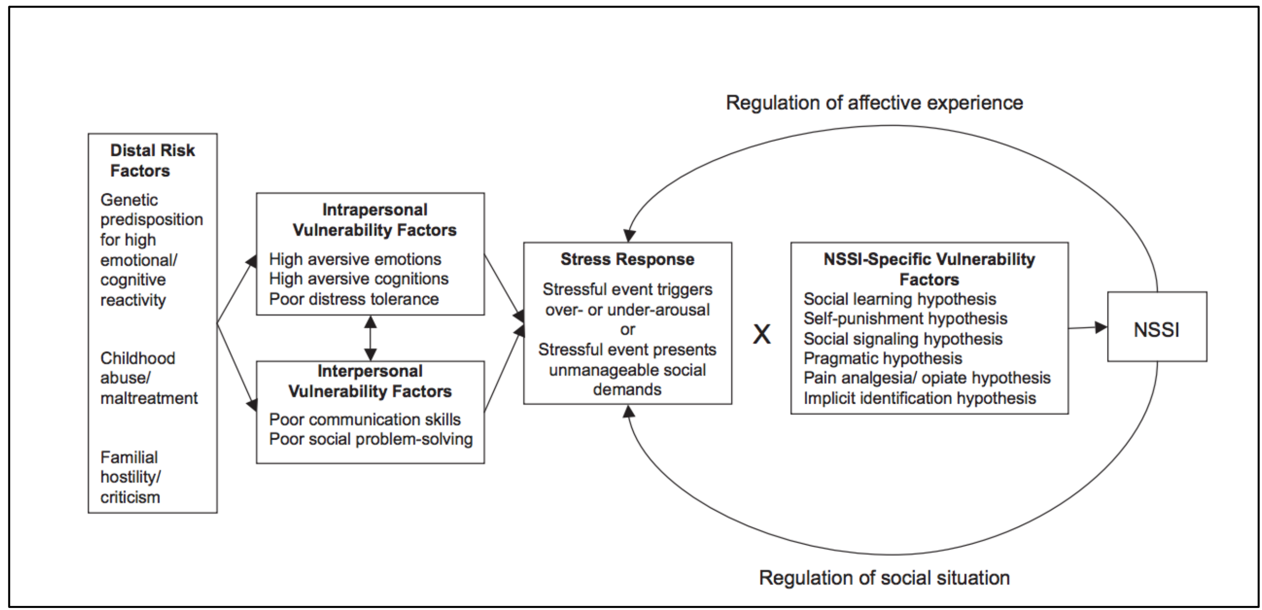


Within the FFM, ANR describes self-harming to reduce unwanted emotions or thoughts; APR is self-harming to promote positive feelings; SNR is the function of self-harm to aid management of interpersonal demands, and SPR is self-harming to draw attention and increase access to support (Nock, 2009, 2010). Empirical research has supported the FFM when investigating motivations for engagement in self-harm (e.g., Rolston & Lloyd-Richardson, 2017), however the model has been critiqued for its failure to explain what factors may influence initial engagement in self-harming behaviours (Bentley et al., 2014). Resultantly, Nock (2009) proposed the

Integrated Theoretical Model (ITM) for the Development and Maintenance of NSSI, bringing together research and literature surrounding risk and vulnerability factors for self-harm, including distal factors (e.g., genetic predispositions), childhood trauma (e.g., abuse) and family adversity (e.g., poor parental mental health) (Hawton et al., 2012b). Within the model, these variables are recognised as increasing vulnerability for factors such as poor emotion regulation skills (i.e., intrapersonal factors), and social and communication skills (i.e., interpersonal factors), influencing the way in which the individual is likely to respond to events/stimuli that would be expected to instigate a stress response (i.e., numbness/shutting down, or increased anxiety/adrenaline). As a way of managing this, the individual may engage in NSSI, usually to overcome the sense of 'numbness' or to release unwanted negative emotions, identified as functions of self-harm in the literature (e.g., Klonsky, 2007; Norman et al., 2020) (see Figure 6).

Figure 6

Nock's (2009) Integrated Theoretical Model of the Development and Maintenance of NSSI



As mentioned previously, whilst theories of self-harm and suicide have clear distinctions, they also share many similarities. Interestingly, social theories are the most contrasting in their understanding of self-harm and suicide. Whilst NSSI is seen as a manipulative behaviour, suicide is explained in the context of an intolerable social environment, often accompanied by social isolation and disconnection from their surroundings (Joiner Jr et al., 2005). Although they suggest that suicide attempts and ideations can act as a form of manipulation, it is also noted that for those experiencing more severe suicidal ideation, and as this ideation increases, individuals often withdraw. This manifests in a lack of communication within their social environments, including avoidance of socialising with friends and family, a behaviour which they believe is not observed amongst individuals who self-harm (Van Orden & Joiner Jr, 2006). In comparison, evidence suggests that some individuals engaging in self-harm discuss their behaviours openly, for example using online forums for NSSI in which individuals normalise self-harm (Whitlock et al., 2006). Whilst differences in the underlying functions between suicide and self-harm are important to recognise, the distinction between self-harm and suicide made by social theorists has been criticised due to its minimalistic stance. The stigma attached to the view of self-harm as a form of manipulation, and the fact that research has shown that individuals who self-harm are often socially isolated and commonly withdraw from family and friends, have argued that social theories do not acknowledge the complexity and negative impacts of this behaviour (Hawton et al., 2003).

From a psychodynamic perspective, self-harm is frequently referred to as 'self-mutilation'. Within these theories, the sexual model explores self-harm as a means of avoiding sexual emotions, considering these behaviours an attempt at sexual fulfilment or deprivation (Suyemoto, 1998). Self-harm is therefore suggested as an enjoyable experience for some, or

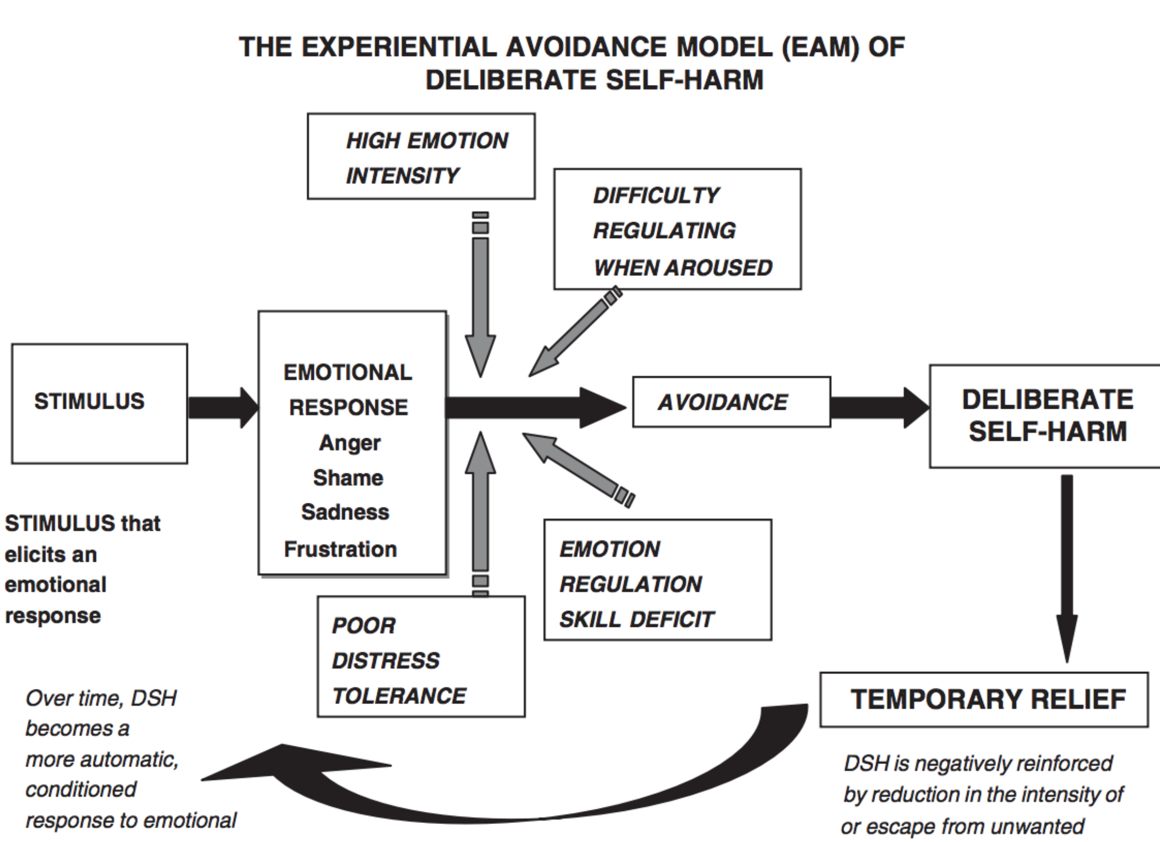
contrastingly, one of pain that acts as a form of punishment for the individuals' sexual needs. This phenomenon has been particularly applied when considering acts of self-harm involving the genitals (Daldin, 1988). Others have suggested similar explanations but shift the focus from sexual desires to levels of criticism from those around them. Therefore, one may harm themselves due to persistent negative comments that lead them to feel they deserve to be punished (Linehan, 1993). Alternatively, this notion of consistent criticism may lead to the individual needing to release anger onto themselves (Bennun, 1984; Soloff et al., 1994), allowing them to externalise unwanted emotional distress (Kafka, 1969). According to these theories, during the act of self-harm, the individual does not view their skin as their own, enabling them to carry out this behaviour as they do not see it as a direct act of harm to themselves, a notion that has been further developed by psychodynamic theorists. Pao (1969) suggests that during self-harm the individual enters an 'altered ego state', experiencing 'depersonalisation' through a dissociative state. It is this level of dissociation that explains how the individual comes to harm themselves, again by not seeing the act as a form of harm to themselves. The Antidissociation Model of NSSI' builds on this, indicating that dissociation may occur due to emotional distress, resulting in a state of numbness (Klonsky, 2007). The Antidissociation model provides an explanation for the commonly reported idea that self-harm is a way of allowing the individual to feel again, proposing that the physical sight of blood can inhibit dissociation (Gunderson, 2009). Support for this model and its ability to explain the occurrence of self-harm is mixed. Whilst studies have indicated a positive correlation between dissociation and self-harm (e.g., Černis et al., 2019), others have evidenced that dissociation does not directly predict self-harm (Ohmann et al., 2008). A recent systematic review by Rossi et al. (2019) offers further insight into these findings, suggesting dissociation is a mediating factor between historical trauma and self-harm.

Therefore, whilst psychodynamic theories offer an explanation as to why and how self-harm may come about, they are limited in their ability to explain why such a severe method of harm is used as a means of coping with emotional distress (McAllister, 2003). Furthermore, the evidence to support many of these theories is mixed and consistent findings have yet to be reported. The reasons why some people engage in self-harm and others do not cannot be fully understood when considering the psychodynamic perspective alone.

More recently, behaviour theorists introduced the Experiential Avoidance Model (EAM) of DSH as a means of explaining factors that may contribute to the repetition of self-harm (Chapman et al., 2006). The main motivational and maintaining factor within DSH is suggested as 'unmanageable emotional arousal', i.e., self-harm is maintained as a method of avoidance, proposing that those who regularly engage in self-harm may develop a conditioned behavioural response which further encourages the use of self-harm in similar situations in the future. For example, circumstances in which negative thoughts or feelings are experienced will result in the individual feeling unable to manage these sensations, leaving them feeling overwhelmed (Chapman et al., 2006). Therefore, the individual uses avoidance (i.e., self-harm) as a way of coping, subsequently reducing unwanted thoughts and feelings. In doing so, this method of avoidance is negatively reinforced, increasing the likelihood of the avoidant behaviour (self-harm) being repeated in the future due to the association of this behaviour with a reduction in these negative sensations (see Figure 7).

Figure 7

The Experiential Avoidance Model (EAM) of DSH (Chapman et al., 2006)



Whilst the majority of previous theories have evolved from research amongst specific groups, i.e., those with a mental health diagnosis (e.g., Borderline Personality Disorder (BPD), Psychosis etc), the EAM is unique in that it has been devised based on a variety of different groups of individuals who self-harm, offering greater generalisability. However, the EAM is specific to self-harm in the absence of 'any intent to die' (Chapman et al., 2006), suggesting a clear distinction in the functions of self-harm vs suicide attempts. Despite this, recent findings have

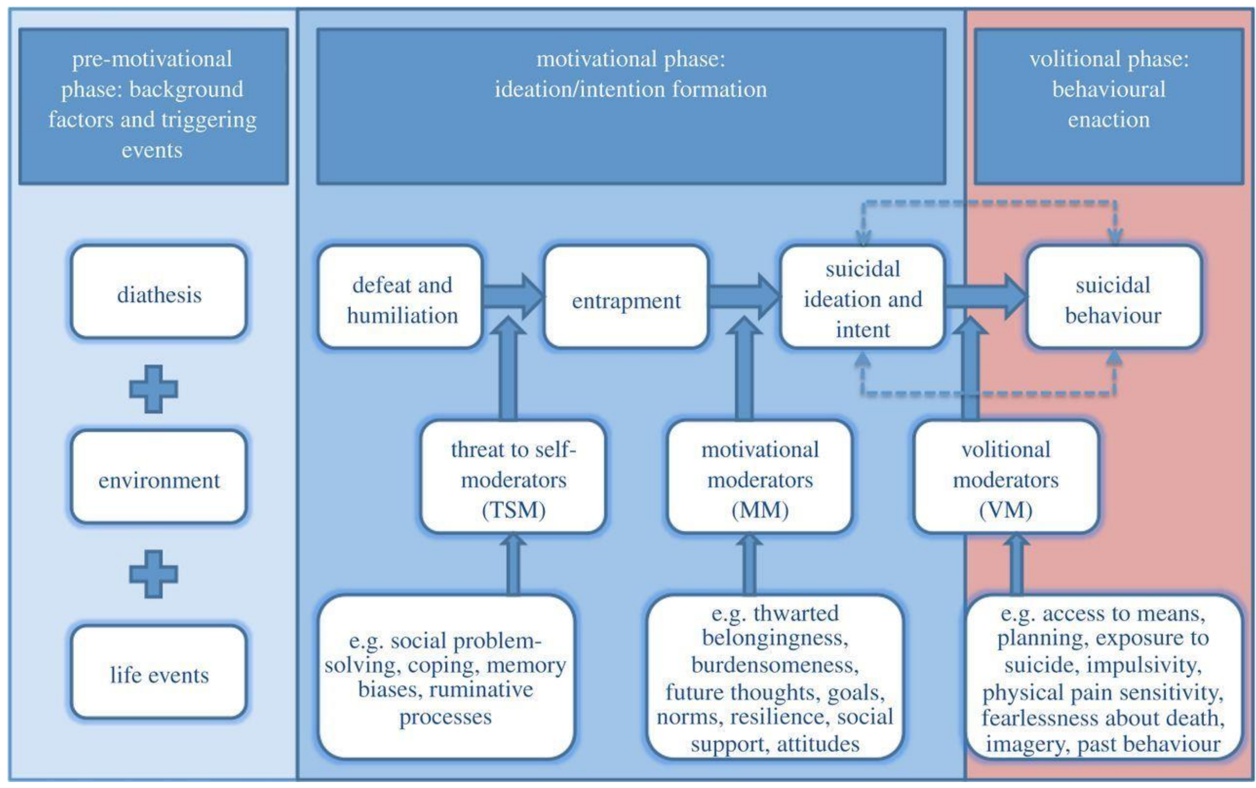
demonstrated that experiential avoidance is influential in the occurrence of self-harm regardless of suicidal intent, which is not currently accounted for by the EAM, or existing models of self-harm (Nielsen et al., 2018).

The theories discussed here offer different perspectives and views on the reasons why self-harming behaviours may emerge, as well as what may contribute to these behaviours being repeated and maintained. Many of these theories have been supported within the literature, however when considered in isolation, are not able to offer a full explanation for the complexity of self-harm. The introduction of the EAM has developed our understanding of NSSI further and provided a more comprehensive model that considers the influence of many different environmental factors (see Figure 7). It is important to note that whilst theories differ, they also share an important commonality. All theories and models consistently recognise that NSSI acts as a means of escape and a way in which the individual can avoid and/or manage unwanted emotions and sensations. Whilst this is consistent and a commonly recognised reason for self-harm across reviews and meta-analyses (e.g., Gillies et al., 2018; Taylor et al., 2018), further consideration to the fact that many individuals experience high levels of unwanted emotional arousal but do not engage in self-harm is needed. Identifying other factors that may influence these negative emotions becoming unmanageable is important to gain a greater understanding of the reasons for engaging in self-harm, as well as factors that may accentuate this behaviour (Chapman et al., 2006). Most existing theories also exclude self-harm that occurs in the presence of suicidal intent, despite emerging evidence for similarities with regards to functions and motivations (i.e., avoidance of unwanted emotional distress) (Nielsen et al., 2018). The integrated motivational-volitional (IMV) model of suicidal behaviour (O'Connor & Kirtley, 2018) has recently been acknowledged for its applicability to self-harm, with a biopsychosocial

stance that explores why some individuals may self-harm, and why others may not (O'Connor & Kirtley, 2018). The IMV model comprises three parts, including the pre-motivational phase (i.e., biopsychosocial factors that may influence the development of suicidal behaviours), the motivational phase (i.e., factors causing suicidal ideations/intent) and the volitional phase (i.e., the enaction of suicidal behaviour influenced by volitional moderators (VMs) such as access to means) (see Figure 8). In this context, self-harm or suicide attempts are classified as VMs. Interestingly, evidence suggests that other VMs, such as impulsivity and having a friend or family member with a history of self-harm, may differentiate between those with thoughts of self-harm (i.e., ideators) vs those who have carried out self-harming behaviours (i.e., enactors) (O'Connor et al., 2012). Therefore, there is a need within the existing literature to conduct research with a broader stance regarding the ways in which self-harm is defined, given the possibility to exclude people who self-harm in the presence of suicidal ideations. In doing so, there is opportunity to understand self-harm in greater depth and ensure a more comprehensive understanding of all forms of self-harm, including triggers, motivators, and vulnerability factors, are established.

Figure 8

The Integrated Motivational-Volitional (IMV) Model of Suicidal Behaviour (O'Connor & Kirtley, 2018)



2.4 Risk Factors Associated with Self-Harm

Focus on predictive factors and potential underlying mechanisms of self-harm are common in existing theories and models of self-harm. However, consideration of vulnerability factors is also vital to provide context and a deeper understanding of the reasons many individuals may engage in self-harm. The following sections will discuss several risk factors linked with self-harm, with emphasis on those that are particularly heightened in young people.

2.4.1 Psychiatric Illness

It is widely reported that the onset of self-harming behaviours occurs most commonly during adolescents/early adulthood, with those aged between 12-25 reporting the highest rates of NSSI in comparison to all other age groups (De Leo & Heller, 2004; Hawton et al., 2003; Moran et al., 2012; Nock, 2010). Adolescence and young adulthood have also been associated with high rates of poor mental health, with over 80% of adults and young persons who engage in self-harm reporting psychiatric disorders, most frequently anxiety and depression (Hawton et al., 2013). Worldwide, approximately 14% of children and adolescents between 10-19 years old encounter mental health problems (World Health Organisation (WHO), 2021). Of these individuals, more than half will show symptoms of these disorders before the age of 14, reaching 75% by mid-20s (Kessler et al., 2005). Disability-adjusted life years (DALYs) is a measure used to indicate the number of life years lost as a result of specific diseases and ill-health, i.e., the overall burden of the disease (Murray, 1994). For those aged between 10-19 years old, early death and ill-health (i.e., DALYs) is most commonly attributed to mental health problems, specifically depression and anxiety (WHO, 2021). Mental health disorders are more prevalent in teenagers who have attempted suicide and/or engaged in self-harm in comparison to adolescence with no previous history of NSSI or suicidal ideations (Hawton et al., 2012b). A recent survey conducted amongst a large sample of university students, including over 37,500 students across 140 universities, found that on average, 8 out of 10 students reported distress and anxiety during their studies. Furthermore, 45% had encountered episodes of depression, with an alarming 19% indicating that they had experienced suicidal ideations (The Insight Network, 2019).

In the context of psychiatric diagnoses, self-harm and suicidal behaviour are commonly observed amongst those with borderline personality disorder (BPD) (Reichl & Kaess, 2021),

with the presence of either or both forming part of the BPD diagnostic criteria (APA, 2013). BPD is characterised by difficulties with emotion regulation, interpersonal relationships across several contexts (e.g., work and home), low self-esteem, impulsivity, and engagement in risky behaviours (e.g., self-harm) (APA, 2013). Across the general population, the prevalence of BPD is estimated at 1%, rising to 10-12% for community mental health patients, and 20-22% for inpatient settings (Ellison et al., 2018). A systematic review specifically exploring lifetime prevalence amongst university students reported rates of 9.7%, however consistency in measures used to confirm BPD diagnoses were mixed (Meaney et al., 2016).

Symptoms of BPD most commonly initiate during adolescence and share similarities with those of other mental health diagnoses (e.g., depression), making BPD difficult to diagnose (Biskin & Paris, 2012). Self-harm has been identified as an early marker for the risk of developing BPD, with one retrospective study reporting a history of NSSI for approximately 90% of BPD adults, which most often started before the age of 18 years (Zanarini et al., 2006). Goodman et al. (2017) described similar prevalence rates amongst inpatients with BPD, with NSSI reported in 95% of adolescents and 90% of adults. NSSI is thought to be maintained by affective instability, identity difficulties and relationship problems for those with BPD (Reichl & Kaess, 2021), offering a form of emotion regulation to promote positive states (Taylor et al., 2018). Due to the common occurrence of self-harm in BPD, therapeutic approaches have been designed to specifically target self-harm for this group (e.g., Dialectical Behaviour Therapy (DBT)), which are explored further below (see section 2.6.3).

Whilst self-harm is more prevalent amongst those with a mental health condition, not all individuals engaging in self-harm have a psychiatric diagnosis. Most self-harm that presents to hospitals and services is often due to more severe episodes of self-harm as a result of other

comorbidities that become overwhelming for the individual (i.e., low mood) (Klonsky et al., 2003). These experiences are important to consider when identifying risk factors and treatment for self-harm, nonetheless it is vital to recognise that many individuals who self-harm do not present to services, potentially due to their self-harm being more ‘manageable’ or less severe and not in the presence of other symptoms that would meet criteria for a mental health diagnosis (Hawton et al., 2002; Meltzer et al., 2001). Despite this, the majority of treatments available for self-harm are focused on self-harm as a symptom of other diagnoses, rather than viewing it as a distinct category. More recently, the DSM-V includes a distinct section for self-harm, with guidelines suggesting that further self-harm research is needed to advance the field and allow for targeted interventions to be developed (APA, 2013).

2.4.2 Gender

Higher rates of self-harm amongst females compared to males are reported across adolescents and young adults (Hawton & Harriss, 2008; Moran et al., 2012), whilst figures show that suicide rates are at least two times greater for males than females in western countries. In the UK, nearly three-quarters of those who die by suicide are male (ONS, 2022b). Suggestions that this may relate due to the role of masculinity within society have been proposed, with males feeling less able to express their emotions and seek support in comparison to females (Möller-Leimkühler, 2003). Differences in methods of self-harm between males and females are also reported. Gratz and Chapman (2007) found that female psychology students were more likely to use cutting and scratching as methods of self-harm, whereas males were more likely to use cutting and burning.

Whilst evidence is limited, provisional findings have also indicated a potential gender difference in the effects of bullying on self-harm. Hay and Meldrum (2010) found that cyber-

bullying increased the risk of engaging in self-harm and experiencing suicidal ideation at a higher rate for males in comparison to females, with male risk being approximately 70% higher than females for both outcomes. Although surprising, this finding may highlight differences between genders when considering risk and motivational factors for self-harm.

2.4.3 Bullying and Victimisation

High prevalence of self-harm amongst the adolescent population has led researchers to investigate which factors may elevate an individual's risk of self-harm. One factor that appears consistent in the literature is the link between bullying and self-harm, specifically for this age group. A study conducted amongst a sample of adolescents in New Zealand (N = 3,265) found that 32% of adolescence had given thought to self-harm and 19% had carried it out. Furthermore, 27% of the sample reported that they had been subjected to intense bullying during their education (Coggan et al., 2003). Fisher et al. (2012) investigated self-harm amongst 12-year-old children. Of those engaging in self-harm, over half (56%) had experienced frequent episodes of victimisation and bullying. When emotional and behavioural difficulties, level of IQ and environmental risk factors were controlled for, experience of bullying was still a significant predictor of higher rates of NSSI. Bullying during this key period can lead to long-lasting effects, with individuals indicating continual difficulties into adulthood, such as low mood and anxiety (Copeland et al., 2013; Evans-Lacko, 2017; Takizawa et al., 2014).

Historically, bullying was considered to take place face-to-face, however, with recent developments in technology, research has highlighted the impact of internet-use and cyberbullying (Durkee et al., 2011). Since 2000, worldwide internet usage has increased by 1,392% (Internet World Stats, 2022). The internet provides a widely accessible platform that is

often unmonitored, allowing bullying and victimisation to go undetected. The effects of cyberbullying have been found to be as significant, with some suggesting a greater impact, in influencing self-harming behaviours in comparison to physical bullying. Cyber-bullying has been found to affect both the victim and perpetrator, with rates of attempted suicide rising by approximately 1.5 – 1.9 times (Hinduja & Patchin, 2010). However, many children and adolescence are exposed to bullying but do not engage in self-harm. Therefore, there is a need to consider other factors that may contribute to the development of self-harm within this population. Bullying is a significant predictor of self-harm, and particularly common amongst those under the age of 20 who die by suicide (Healthcare Quality Improvement Partnership (HQIP), 2017). However, the accompaniment of mental health difficulties, family history of suicide (ideation/attempt/completed) and physical abuse from an adult, have been found to be significant in distinguishing between children who experience bullying and those who go on to engage in self-harm as a result (Fisher et al., 2012).

2.5 Maintenance factors

Factors influencing initial engagement in self-harming behaviours have been established, whilst also recognising that self-harm varies greatly in severity and regularity. Several variables have been identified as influential with regards to what may cause an individual to continue to self-harm, i.e., maintaining the behaviours. These factors will be explored further within this section.

2.5.1 Social Influences

Many social factors within an individual's environment are related to an increased risk and impact on maintaining self-harming behaviours. Having friends and social groups, as well as family members, who engage in self-harm increases an individual's likelihood of self-harming themselves (De Leo & Heller, 2004; Hawton et al., 2002; O'Connor et al., 2009). This may be attributed to those who are more vulnerable being more likely to group together, encouraging these individuals to share their distress, with self-harm being their way of dealing and managing difficult situations and feelings (Hall & Melia, 2022; Joiner Jr et al., 2005). Furthermore, findings have suggested that those individuals who use online forums for self-harm are more likely to maintain the behaviour due to reinforcement from others (Mitchell & Ybarra, 2007). Usage of these websites may be encouraged by offering a sense of belonging for individuals who are socially isolated. However, Prasad and Owens (2001) found that individuals who reported having friends who engaged in NSSI were not at a significantly higher risk of self-harm compared to peers. Instead, these findings suggested that the use of websites for self-harm were protective and linked with a reduction in repeated NSSI. Fortune et al. (2008) reported similar findings, with participants reporting the positive impact of these forums due to providing a space in which they felt understood. In 2019, the health and social care secretary of state (Matt Hancock) shared an open letter to social media outlets (e.g., Snapchat, Instagram, and Facebook), alluding that online self-harm material *"leads to self-harm and promotes suicide"* (Lumley, 2019). However, Lavis and Winter (2020) noted online peer-support can have both positive and negative connotations in the context of self-harm, highlighting that viewing these two variables in isolation is unhelpful with regard to how online safety should be applied in the context of self-harm. Greater risks will occur for some, however, this may also offer a form of

protection for others, and is therefore likely to act as a mediating rather than a predictive factor for engagement in self-harm. Given that most of the research in this area has focused on online forums, further research exploring why some individuals may be more likely to engage in self-harm when surrounded by others who also self-harm, and why others may be more likely to reduce the behaviour, is warranted. Understanding individual differences around the impact of peer groups would allow for those at risk to be identified, as well as those who may benefit from online support to be directed to resources and online peer support groups.

Isolation and lack of support from family members and partners have also been found to maintain self-harm (Hawton et al., 2003). Research within this area accentuates the role of those supporting individuals who self-harm, for example, family, friends and peers. The importance of their knowledge and ability to understand self-harm, including their response to disclosure, may influence maintenance, as well as future treatment and recovery, of self-harm. Despite this, research suggests that the general population do not adequately understand the concept of self-harm (Klineberg, 2013). Evans et al. (2005) found that those who engage in DSH often feel as though they need support from family members, however they do not feel able to ask for it. Furthermore, they reported difficulty in speaking with family and teachers in comparison to their peers. Those reporting DSH were also most likely to seek help from friends compared to other means. Therefore, without understanding self-harm, the question must be asked as to how effective the majority of the general population would be in managing disclosures of self-harm, and supporting repeated occurrences of these behaviours.

Poor social support and relationships have been found to increase the risk of NSSI being repeated, whilst positive social support acts as a protective factor. Research has found that those with receptive and understanding families who are actively engaged in the individual's well-

being and treatment are less likely to repeat the behaviour and show significant improvement on outcomes when compared to those with poor social relations (Ferrey et al., 2016). Exploration around the impact of social support on self-harm, and the potential to integrate this into interventions would be beneficial. Understanding factors that promote a sound understanding of self-harm, as well as those preventing an individual feeling able to speak with family and peers are important to identify. In doing so, opportunity to prevent feelings of isolation and being unsupported, with the potential to reduce rates of repeated self-harm, are offered (Plener et al., 2015).

2.5.2 Individual Factors: Coping Styles, Alexithymia, and Rumination

Coping mechanisms are the process in which both behavioural and cognitive processes are adopted to manage stressful events and situations (Evans et al., 2005). The coping strategies selected are thought to be influenced by the level of threat that the individual experiences from the situation, in addition to the availability of resources to help deal with and manage the scenario (Lazarus & Folkman, 1984). It has been proposed that there are two main methods of coping, the first being problem-focused, in which the individual attempts to change the situation (e.g., they may discuss the problem with someone). The second, emotion-focused, differs in that the individual withdraws from the stressful trigger and instead uses avoidance to deal with the situation. The second process has been associated with an increased level of distress (Carver et al., 1989; Guerreiro et al., 2013).

Individuals who frequently engage in NSSI have poorer coping mechanisms. Evans et al. (2005) concluded that adolescents who engage in DSH are less inclined to focus on their issues and are more likely to display avoidant behaviours. A study conducted amongst a sample of

Australian adolescents found that individuals who self-harm show higher levels of self-criticism and blame when experiencing distressing situations in comparison to their peers (De Leo & Heller, 2004). Further research provides evidence to suggest that emotional intelligence (EI) and coping strategies may interact. EI is defined as an individual's capacity to recognise and understand their own, and others, thoughts and feelings. Mahajan et al. (2014) detected lower EI scores amongst a sample of adolescents engaging in DSH. Furthermore, poor coping strategies were reported, and findings suggested that these strategies influence low EI and self-harm. Studies have attempted to explain reasons for poor coping mechanisms seen in those that self-harm. It has been suggested that perceived parental attachment impacts on an individual's problem-solving skills which has been shown to affect coping strategies. Those reporting secure attachments are more likely to use problem-solving skills as a way of coping. These skills are less evident amongst individuals who self-harm, with greater utility of emotion-focused skills, the presence of which are seen at a higher rate amongst those with poorer attachment (Glazebrook et al., 2016). Therefore, individuals with non-secure attachment styles may be more likely to self-harm due to ineffective coping, resulting in unmanageable levels of distress.

Alexithymia is defined as the limited ability to recognise and identify one's own emotions, with individuals experiencing difficulty in explaining and distinguishing between emotional states (Cerutti et al., 2014; Sifneos, 1996). Research has consistently detected higher scores of alexithymia amongst individuals engaging in self-harming behaviours (Evren & Evren, 2005; Paivio & McCulloch, 2004), further supported by a recent systematic review reporting a significant positive correlation with a medium effect size ($g = 0.57$, 95% CI 0.46-0.69) (Norman et al., 2020). Similarly, amongst university students, Borrill et al. (2009) found significantly higher alexithymia scores for those engaging in self-harm when compared to students who did

not report self-harm. Based on the well-established link between self-harm and emotion dysregulation, these findings help to explain why some individuals may engage in, and repeat, self-harm. Due to their inability to regulate emotions, and for some this may be experienced as numbness, self-harm is a way of releasing these unmanageable feelings, alleviating their sense of numbness for a short period (Chapman & Dixon-Gordon, 2007; Norman et al., 2020). It is these experiences and feelings which help to explain why alexithymia may maintain self-harming behaviours. This dysregulation leads the individual to release through self-harm and the sensation and temporary relief experienced is what encourages the individual to self-harm again in the future when they feel their emotions are unmanageable (Kealy et al., 2018).

Studies investigating alexithymia and self-harm also highlight the importance of rumination in maintaining this behaviour (Hoff & Muehlenkamp, 2009). Rumination is the notion of persistent negative emotions and thoughts, which are often linked with depressive and suicidal ideations (Smith et al., 2006; Roelofs et al., 2007). Borrill et al. (2009) found that rumination, as well as alexithymia, were the two most predominant factors in predicting self-harming behaviour amongst university students. The effects of rumination and the reasons as to why this process may contribute to the maintenance of self-harm is further linked with the notion of emotion dysregulation. This common tendency amongst those that self-harm to experience intense negative emotions on a regular basis may be amplified by rumination, therefore increasing the need to release and regulate through self-harm (Selby et al., 2013). Due to further support for the association of rumination with engagement and frequency in NSSI, the need for further research to understand how therapies and interventions for self-harm may benefit from adaptations around rumination and emotion regulation strategies have been proposed (Nicolai, 2015).

2.6 Interventions for Self-Harm

Based on the risk factors discussed above, many of the current interventions for treating self-harm have been devised in accordance with this literature e.g., Dialectical Behavioural Therapy (DBT) for BPD. As mentioned previously, most interventions have been targeted at various mental health difficulties, with adaptations to treat self-harm as a symptom of these diagnoses. Limited interventions have been devised to directly target self-harm behaviours. Several key therapies used in treating self-harm will be discussed, as guided by the National Institute for Health and Care Excellence (NICE) recommendations (NICE, 2022).

2.6.1 Pharmacological Interventions

Whilst drug treatment is often not the first line of treatment for self-harm, it is commonplace for many mental health diagnoses, and therefore, its effects on reducing self-harming behaviours require consideration. As noted, theories of self-harm have focused on the role of opioids. A systematic review in which 10 Randomised Control Trials (RCTs) aimed at investigating the effects of opioid antagonists were considered concluded that eight of these trials found significant support for the use of this treatment in reducing self-harm, specifically for individuals with Intellectual Disability (ID). However, results highlighted that whilst this treatment has strong support, identifying individuals who are more likely to respond to this intervention is limited and not yet understood (Roy et al., 2015).

The effectiveness of antidepressants in treating self-harm creates divide. Existing studies have provided support for the effectiveness of antidepressants, with others concluding no benefits in comparison to controls. For example, Martinez et al. (2005) concluded that the effectiveness of

antidepressants may be dose-dependent, suggesting different doses have varying effects, which is also impacted by the age of the individual. Miller et al. (2014) used population-based data on a sample of 162,625 individuals aged between 10 – 64 years who had a diagnosis of depression. All were taking a known dosage of antidepressants and rates of DSH were considered. Results showed that for individuals >24 years, levels of DSH were twice as high for those taking the higher dose of antidepressants compared to matched participants who were taking a modal dose. For individuals aged 25 – 65 years, there was no significant difference in effectiveness between high and modal dosage, and risk for suicidal behaviour was significantly reduced since starting drug treatment. A recent Cochrane review in which pharmacological and psychological treatments for self-harm were considered concluded that there are limited drug-based interventions that show significant effectiveness in treating self-harm specifically. The use of Flupenthixol was highlighted as being effective, however this finding was based on one trial that had several limitations (Hawton et al., 2016a).

For children and adolescents, close monitoring of dosage is vital. For mild to moderate depression amongst this age group, NICE guidelines suggest the use of a therapeutic intervention as the first line of treatment, with CBT, Dialectical Behavioural Therapy (DBT), and Family Therapy most recommended (NICE, 2022). For severe depression, drug treatment is also proposed and so close monitoring of dosage and rates of DSH is required (NICE, 2019). For adults, drug therapy is shown to be effective in reducing DSH, as well as suicidal ideation and depression. However, not all patients show improvement and therefore therapeutic models may offer an alternative method of intervention for reducing rates of self-harm.

2.6.2 Cognitive Behavioural Therapy (CBT)

CBT is recognised as one of the most effective, and therefore gold-standard, treatments for self-harm (NICE, 2022). CBT is based on the concept that your thoughts, feelings, and behaviours are strongly interlinked, aiming to alter individual thinking styles, feelings, and reactions towards a certain situation by focusing on the meaning assigned to specific stimuli (Beck, 2011). When treating self-harm, CBT focuses on identifying individual warning signs, e.g., making the individual more aware of potential stresses and heightened anxiety, and triggers. Once discovered, strategies to manage these situations are addressed, tested, and adapted to suit the individual, aiming to reduce and prevent self-harm in future situations that cause distress (Slee et al., 2007).

Many trials have provided significant support for the effectiveness of CBT in reducing self-harm (Comtois & Linehan, 2006; Daigle et al., 2011; Robinson et al., 2011; Tarrier et al., 2008). A meta-analysis comparing psychosocial interventions for self-harm amongst adults found a significant effect for the use of CBT when compared to treatment-as-usual (TAU), with a statistically significant reduction in self-harm behaviours (Hawton et al., 2016b). A systematic review considering CBT in comparison to TAU as a control condition highlighted the importance of close consideration to the TAU groups used within these trials. Results showed that the criteria used to determine TAU control groups vary greatly between studies. Whilst the majority of these studies proved CBT to be more effective than TAU in treating self-harm, those reporting the most significant effectiveness were found to have the poorest descriptions of what procedure was followed by the TAU group (Witt et al., 2018). Whilst sample size was limited, a recent study trialled the integration of compassion-focused approaches with CBT. Findings demonstrated positive changes in beliefs regarding self-harm, alongside increased utility of

emotion regulation strategies, highlighting a potentially effective CBT-informed intervention for self-harm (Rayner et al., 2022).

2.6.3 Dialectical Behavioural Therapy (DBT)

DBT, developed by Marsha Linehan (1993), was specifically designed for adults with BPD. This therapeutic approach involves an intense course of treatment, requiring patients to attend individual therapy sessions on a weekly basis, as well as a family group session lasting two hours. Individuals are also able to directly access support via telephone on a twenty-four-hour basis. Due to the nature of self-harming behaviours, including the unpredictability of the behaviour and fluctuation in environmental and emotional factors, DBT has been designed to effectively meet the needs of those engaging in self-harm.

Research aimed at trialling the effectiveness of DBT showed support for the reduction in self-harm behaviours and suicidal intentions, specifically measured by the number of hospital presentations and a range of psychosocial outcomes (e.g., anxiety) (Carter et al., 2010; Robins & Chapman, 2004; Linehan et al., 1991, 2006; Verheul et al., 2003). These findings were further developed by trials in which DBT was compared to TAU, with research showing DBT to be more effective than TAU in reducing self-harm (Comtois & Linehan, 2006; Daigle et al., 2011; Panos et al., 2014). DBT has also been used in treating the adolescent population (DBT-A) with emerging personality disorder. Miller et al. (2006) adapted DBT to meet the needs of this population, e.g., the length of the intervention was reduced from one year to 3-5 months. Furthermore, DBT-A integrates parents and caregivers into the treatment schedule, with skills to address emotion dysregulation for both the patient and their families discussed in sessions. Findings have shown support for the effectiveness of DBT-A, as well as treatment satisfaction of

both the individual and their family members (Fleischhaker et al., 2011; James et al., 2008; Mehlum et al., 2019). This has been further supported by a recent systematic review, including five RCTs, in which DBT-A indicated small to moderate effect sizes in reducing self-harm (Kothgassner et al., 2021).

2.6.4 Family Therapy

Based on the effectiveness of psychological therapies that integrate family elements, NICE proposed the need for further research testing the effectiveness of family therapy (Cottrell et al., 2018). Given the importance of relationships and social support in maintaining, or preventing, self-harm, suggestion that family therapy may be significant in treating and reducing self-harm have emerged (Brent et al., 2013; Ougrin et al., 2015). A large-scale randomised trial conducted on a sample of 832 adolescence, i.e., the Self-Harm Intervention: Family Therapy (SHIFT) trial, is one of the largest studies conducted within self-harm, specifically amongst this age group. This study compared family therapy to TAU, with six to eight monthly sessions of family therapy offered to those engaging in self-harm and their families (Cottrell et al., 2018). However, analyses revealed that the use of family therapy within this trial was no more effective than TAU in reducing self-harm. The trial monitored the number of hospital attendance for self-harm as well as further secondary outcomes. The use of hospital attendance as the primary measure of effectiveness has been criticised because regular contact with a family therapist may cause an increase in the number of episodes of severe self-harm being discovered due to the family being more aware of the behaviour and warning signs/triggers (Ougrin & Asarnow, 2018). Therefore, considering the secondary outcomes within this study may be more helpful in measuring the true effect of family therapy for self-harm. For example, the SHIFT trial showed promising results

across scores on the Strength and Difficulties Questionnaire (SDQ) (i.e., a screener for behavioural and emotional difficulties), indicating greater improvement for family therapy than TAU. The need for a standardised definition of self-harm was also highlighted by this study, emphasising that this is necessary to truly measure effects within and between interventions for self-harm (Cottrell et al., 2018; Ougrin & Asarnow, 2018).

2.6.5 Mindfulness

Interventions and methods of coping amongst individuals who self-harm have included psychotherapeutic approaches and more recently, Mindfulness-based techniques (Biegel, 2009). Mindfulness is the process by which individuals are able to identify and accept their own thoughts and feelings without judgement (Ryan & Brown, 2003). This method has been used amongst university students to reduce stress levels, with beneficial effects for emotion regulation and reduced rumination amongst students who self-harm, suggesting the need for future research to explore this phenomenon further (Borrill et al., 2009). Studies conducted amongst adult populations have shown support for the use of mindfulness amongst those with substance abuse and mental health difficulties following participation in an eight-week mindfulness-based programme (Williams & Shannon, 2016). Further studies have also found mindfulness to be effective in reducing repeated self-harm (Norman et al., 2021; Williams et al., 2006; Yusainy & Lawrence, 2014). Based on the fact that mindfulness is thought to reduce rumination and avoidance behaviours due to its focus on the present, alongside creating a non-judgemental state of mind, the positive effects observed on reducing self-harm are not surprising (Hayes & Feldman, 2004). An RCT measuring the use of mindfulness amongst a sample of university students in Cambridge, UK showed positive effects on student mental health within the

mindfulness group when compared to TAU (Galante et al., 2018). Whilst this study focused on mental health difficulties more broadly, based on the fact poor mental health is a risk factor for self-harm, mindfulness may be useful as a technique to reduce self-harm amongst the student population. However, Lomas et al. (2015) highlighted that developing the skills required for meditation, which is a form of mindfulness, can be challenging and, in some cases, can also lead to subjects experiencing highly emotive thoughts which can be difficult to regulate and monitor.

2.6.6 Interventions – Future Directions

Given the high rates of self-harm within the general population, as well as the associated adverse outcomes including increased risk of mental health problems, lower self-esteem and poor emotion regulation, many types of interventions have been proposed. Support for several interventions has been found within the literature to date, however given the costly nature of treatment (Carroll et al., 2014; Owens et al., 2002), further consideration to identifying the best treatment option at initial presentation to services is vital. Research measuring the effectiveness of these interventions share a common limitation in that detail around what the specific intervention involved, as well as the presence of a controlled and detailed TAU condition, are limited. Therefore, conclusions from these trials cannot be generalised (Hetrick et al., 2016). Furthermore, the lack of a standardised definition for self-harm, comparing treatments and studies for effectiveness is challenging. To overcome this, a widely recognised and standardised definition of self-harm needs to be agreed upon and used across the board in studies measuring the effectiveness of treatment for self-harm.

2.7 Summary

Self-harm has been the focus of a wide variety of research across many disciplines. Whilst our knowledge and understanding of self-harm continues to develop, there are several key gaps within the research to date. When considering the current prevalence of self-harm, as well as its associations with mental health difficulties and increased risk of suicide, the need for effective and tailored support is crucial. The majority of research on self-harm has focused on adolescent populations, although recent policies and initiatives specifically targeting universities (e.g., 'Mentally Healthy Universities' (De Pury & Dicks, 2023) and 'Suicide-Safer Universities' (Universities UK, 2018b) as discussed in chapter one), highlights the importance of considering specific contexts and groups to provide a more in-depth understanding of self-harm. The following chapter will therefore focus specifically on self-harm and support mechanisms within a university environment.

3. Chapter Three: Self-Harm and Support Networks Amongst University Students

This chapter focuses specifically on self-harm, support-seeking, and carers[1] within a university context. As discussed in chapter one, university students are a recently identified high-risk group for self-harm and suicidal behaviour, therefore an overview of the research which has been conducted amongst this population thus far, including the gaps and developments needed within this area, are discussed. The role of social support in influencing and preventing self-harm will also be explored. Whilst self-harm has been the focus of much research, studies on students who self-harm and the role of supporters is limited, specifically within the UK.

3.1 A University Context and Why it Matters

The mental health of university students has recently been acknowledged as an important worldwide public health issue (Sharp & Theiler, 2018). University is a key transition period for students, presenting unique demands such as increased independence and managing finances, whilst adjusting to new academic surroundings and ways of working (Taliaferro & Muehlenkamp, 2015). Additionally, many students move geographical locations and/or into new accommodation, creating distance from existing support networks (e.g., friends and family) (Taliaferro & Muehlenkamp, 2015). Whilst this presents an exciting time for personal and academic growth, adapting to these changes can be challenging (Parker et al., 2004; Tosevski et al., 2010). For some, this results in homesickness (Thurber & Walton, 2012) and psychological

[1] The use of carers throughout this thesis refers to the range of care provided in a university setting, including 'formal' and professional caregiving, as well as 'informal', unpaid care. Informal care is defined in line with the NHS (2021b) definition – i.e., "care is provided by anyone who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem, or an addition….the care they give is unpaid". Clear distinctions regarding formal vs informal roles are made throughout for clarity and context.

distress, with global estimates of one in four to one in five university students suffering with depression, anxiety, and high levels of stress (Beiter et al., 2015; Duffy et al., 2019; Lewis & Bolton, 2023; Smith, 2016).

Between 2020-2021, a total of 170 higher education (HE) institutions were recorded by the HE Statistics Agency (HESA) (Universities UK, 2023). In 2022, the number of 18-year-olds entering university in the UK was at a record high, with an increase of 20% from 2019 (Department for Education, 2022). By the age of thirty, 49.8% of those living in England have attended HE (Department for Education, 2018). Over the last decade, mental health difficulties amongst UK university students have increased fivefold (Thorley, 2017), with a 450% (N=21,105) rise in the number of students declaring a mental health condition (UCAS, 2021).

Due to a lack of comparison between general population and student population prevalence of mental health conditions, Stallman (2010) surveyed a large sample (n=6,479) of students across two Australian universities. When using a psychological distress measure (i.e., the K10 (Kessler et al., 2003)), which screened for anxiety and mood disorders in the last month, the majority (83.9%) of university students indicated elevated levels of distress. Further, almost 20% reported probable serious mental health, and 64.7% indicated probable mild-moderate mental illness. Given rates of psychological distress reported amongst the Australian general population are approximately 29% (Australian Bureau of Statistics, 2008), these findings indicated much higher distress amongst university students (Stallman, 2010).

Given that those who fail to receive support when experiencing these difficulties show poorer outcomes in academic achievement, employability, and relationships (Eisenberg et al., 2009; Wang et al., 2007), and the number of students accessing university counselling support has increased more than 50% since 2010 in the UK (Mair, 2015), university has been identified as a

critical point for mental health interventions (e.g., through counselling services) (Holm-Hadulla & Koutsoukou-Argyraki, 2015; Mental Health Foundation, 2016).

3.2 Self-Harm Amongst University Students

As explored in chapter two, significant research has been conducted with adolescents who self-harm. Based on the increasing rates of poor mental health amongst the student population, it is important to consider the effects this may also have on the prevalence of self-harm for this group. Research focusing specifically on university students indicates varying rates of self-harm. Lifetime prevalence of NSSI amongst university students has been reported between 19.6% (N=9821) in Norway (Sivertsen et al., 2019) to 37% (N=91) in the US (Gratz, 2006), with almost 60% (N=224) reporting thoughts of self-harm during university in Jordan (Hamdan-Mansour et al., 2021). In contrast, Hawton et al. (2012a) found occurrences of hospital presentations for self-harm were significantly lower amongst UK Oxford university students when compared to other young people over a 30-year period. However, in a non-clinical student sample, 27% (N=166) reported at least one lifetime incident of self-harm, with 9.7% (N=60) engaging in self-harm whilst attending a UK university (Borrill et al., 2009). However, these findings were limited in that only those students studying psychology or computer sciences, and attending one of two London universities, were included. Another study concluded students were twice as likely to engage in self-harm when compared to age-matched non-students (Swannell et al., 2014). Despite the variety in rates of self-harm reported across university studies, given the associated stigma and shame surrounding self-harm, it is likely these reports are an underestimation (McManus & Gunnell, 2020; Sheehy et al., 2019; Walsh, 2012).

Similarly to broader literature, a consistent limitation of research focusing on student self-harm is the lack of a consistent and standardised definition of what constitutes 'self-harm'. Regardless of the focus of the research, this limitation is frequently noted by researchers as impacting on the generalisability of their findings. The need for a standardised and widely recognised definition of self-harm is imperative for the future of research in this area. To achieve this, exploring the meaning and definitions amongst those with lived experience is critical.

3.3 Student Support

As detailed in chapter two, treatment options and supportive interventions for self-harm are varied. The need for the government, universities, and the NHS to share responsibility for the care and support of students has been recognised, resulting in a range of ways that students may access and receive support for their psychological well-being (De Pury & Dicks, 2023; Thorley, 2017). However, these often require involvement of professional services, which only one in five individuals who self-harm are likely to access (Fitzgerald & Curtis, 2017). Therefore, professional pathways may not be representative of the multifaceted ways in which students who self-harm seek and access support, with differing means of student support explored below.

3.3.1 University Support Services

The majority of universities in the UK offer support relating to student well-being and mental health. This usually consists of a variety of free and confidential in-house services including counselling, advice services, and support networks, however availability and types of services vary across individual institutions (NHS UK, 2023). Most university counselling and/or therapy is provided by trained professionals such as counsellors and psychotherapists. For managing the

impact of poor well-being and mental health on university studies, most institutes have mental health advisors who aim to address any barriers that students may be facing regarding their studies. For example, support in establishing helpful adjustments such as extra time for exams or assessments (NHS UK, 2023). Due to variability, university students are encouraged to check support pathways via their university's website. However, studies exploring student experiences of seeking professional support at university, including counselling and well-being services, have highlighted key gaps and limitations in existing provisions (e.g., availability and quality of care) (Baik et al., 2019).

3.3.2 NHS Services

For students who may not wish to access support directly through university, there are a range of external services available, including NHS services and student-led organisations. The types of support available through the NHS for mental health, and more specifically self-harm, are explored elsewhere (e.g., CBT) (see chapter two). However, it is important to note that access to these services may require alternative pathways for students, including referrals from their university counselling services or university general practitioner (GP). As for all individuals in the UK, students are also able to self-refer to local talking therapies, also referred to as the 'NHS talking therapies service' (NHS, 2023).

3.3.3 Voluntary and Student-Led Organisations

In the UK, there are many charitable and voluntary organisations aimed at supporting student mental health. Based on the scope of this review, focus will be centred on the services offered by

the largest organisations that are commonly recommended on university websites and within government and university policy documents (e.g., Brown, 2016 and De Pury & Dicks, 2023).

Student Minds is a UK mental health charity (https://www.studentminds.org.uk/). They offer a range of services, including signposting to support services for both students as well as friends and family who may have concerns for a loved one whilst at university, online training for university staff, online resources for promoting well-being, and the university mental health charter which aims to identify areas of focus for supporting students in HE (Hughes & Spanner, 2019). More recently, student minds have also launched 'student space' (https://studentspace.org.uk/) following funding from the Office for Students and HE Funding Council for Wales (Office for Students, 2020). Student space provides a support service for students as well as aiding identification of the help available to students at their specific university.

The Nightline Association also offers confidential support for those in further and HE. Established in 2006, Nightline is a student-led listening service open in 36 locations across the UK during the term-time hours when university services are shut, and are contactable via telephone, text, instant messenger or face-to-face. The service aims to provide non-judgemental support in a safe and confidential environment (https://nightline.ac.uk/).

3.3.4 Online Support and Apps

As noted in chapter two, the use of online platforms as a means of providing support for those engaging in self-harm is mixed, with recognition that these can have both positive and negative effects (i.e., social connection vs triggering harmful behaviours) (Lavis & Winter, 2020). In the context of university specifically, more attention has been given to the utilisation of apps as a

form of support. A scoping review of mobile health (mHealth) interventions that were aimed at self-harm specifically, or had an indirect effect as measured by outcomes, showed promising results for the reduction of self-harm and suicidality (Cliffe et al., 2021). However, research quality was mixed, and only five apps were widely available (i.e., free to use). Based on the increased incidents of self-harm among university students, and low rates of support-seeking, further research has sought to develop a smartphone app specifically for university self-harm – ‘BlueIce’ (Cliffe et al., 2023). Initial qualitative data has indicated a positive response to its utility as a form of distress tolerance, however some students felt it would be most useful alongside other means of support (i.e., face-to-face). Given the limited understanding of student views on the use of apps and internet-based means of support, as well as how these can be delivered and accessed in the most helpful way, further exploration is warranted.

3.3.5 Friends and Family

Previous findings indicate that forming quality friendships at the start of university has a positive impact on a student’s ability to adjust to a new environment (Buote et al., 2007; Pittman & Richmond, 2008), as well as reductions in stress levels (Hazell et al., 2020). The role of friendship and social connectedness has also been highlighted as an important factor in self-harm and suicidality, with those who report poorer friendships and peer support being more at risk of engaging in self-harming behaviours (Berry et al., 2021; Plener et al., 2015). This may be explained by an earlier study which concluded that the majority of those who engage in self-harm have a preference to seek support from friends (Evans et al., 2005). Despite criticism for online forums due to links with increasing self-harming behaviour (Mitchell & Ybarra, 2007), research has also shown support for the use of these websites (Prasad & Owens, 2001). Based on

the importance of social support, this may highlight the significance of these online platforms, with individuals reporting that they provide a sense of belonging and an environment in which they feel understood (Fortune et al., 2008). Individuals who fail to form friendships when starting university may lack validation and connectedness with others, potentially increasing the likelihood of self-harm. Despite the clear importance of friendships within a university context, and their relationship with self-harm, research has yet to explore how the two may be linked. If peer support is a significant protective factor for students, further exploration may be crucial to enable development of tailored and effective interventions for this specific group.

3.4 The Impact of Supporting Student Self-Harm

Carers often play a crucial role in an individual's treatment plan and emotional support, including advocacy, encouraging help-seeking, and maintaining engagement with services (Olasoji et al., 2017; Carlsen & Lundberg, 2018; Carers UK, 2019; MacDonald et al., 2021). Many researchers have explored the experiences of those providing informal care for individuals with mental health conditions (Olasoji et al., 2017; Liberati et al., 2021; MacDonald et al., 2021), including depression (Scerri et al., 2019), bipolar disorder (Wasley & Eden, 2018), psychosis (Sin et al., 2021) and eating disorders (Yim et al., 2021). Additional challenges for those providing care to people with mental health conditions are the comorbid behaviours that may occur, including self-harm and suicidal behaviours (McLaughlin et al., 2014; O'Keeffe et al., 2021). The existing research in this field suggests that individuals providing informal and formal care to people who carry out self-harm and/or enact suicidal behaviours could be at an increased risk of experiencing poor well-being, unhealthy stress levels, and burnout (Byrne et al., 2008; Simpson et al., 2019; Hazell et al., 2021; Lascelles, 2021). Additionally, unpaid carers frequently

worry about saying or doing the ‘wrong thing’ which may increase the self-harming behaviour (Reichardt, 2016; Ribeiro Coimbra & Noakes, 2022). As the supporter’s role is thought to be imperative in the prevention and disclosure of self-harm, further research exploring the experiences and needs of those providing support is needed (Klineberg, 2013).

Many individuals providing informal care do not identify with the label ‘carer’ and instead view caring as part of being a parent, partner, or peer (Knowles et al., 2016). As a group of ‘hidden carers’, quantifying the true number of people providing care is challenging (Smyth et al., 2011; Waters, 2019). Despite making significant contributions to the individual they are caring for, and society more widely, hidden carers often struggle to access support for themselves (Khan-Shah, 2020; Onwumere et al., 2018). In particular, young adult unpaid carers, and specifically those studying at university, have been recognised as a unique group requiring greater support at an educational level (Sempik & Becker, 2014). Given increased rates of isolation, loneliness, and poor well-being amongst these individuals (Becker & Sempik, 2019; Greenwood et al., 2018; Sempik & Becker, 2014), identifying contexts in which young carers and unpaid care are under-recognised may allow for increased support provisions to be developed.

In recent years there have been several high-profile cases in the UK when a university student has disclosed suicidal thoughts, mental health difficulties, or self-harm within a university setting, but families were not informed due to Data Protection Laws, and in some instances, these cases involved suicides (Coughlan, 2021; Megraoui, 2021; Murphy, 2019). Initiatives have been introduced to encourage collaboration between service users, professionals, and carers in the UK (e.g., ‘The Triangle of Care’ approach to mental health (Carers Trust, 2013)), with carers being actively involved in the care of their loved ones. However, educational contexts such as

universities may pose more challenges for implementing this approach due to limited understanding of caring in this setting. As a result, those caring for university students are often not involved or entitled to know what care, treatment or support the person they are caring for is receiving. More recently, the essential role of families and carers has been acknowledged in an addition to the Suicide-Safer Universities policy, with some guidance regarding a proactive approach to sharing information with trusted contacts (De Pury & Dicks, 2023).

3.4.1 Theoretical Models

Previous studies have identified key stressors experienced as a carer for those with mental health difficulties, including negative reactions and stigma from family members; carers feeling out of their depth or lacking adequate knowledge about the individual's condition; and experiencing personal distress and social isolation (Greenwood et al., 2018; MacDonald et al., 2021; Sin et al., 2021). Similar findings have also been found amongst professional carers in relation to poorer wellbeing, burnout, compassion fatigue and increased stress (Cavanagh et al., 2020; McCormack et al., 2018). Our understanding of why these negative impacts occur may be explained in the context of effective coping and resilience. Transactional models of caregiver stress highlight differing factors that influence the physical and psychological health of formal and informal carers. Individual characteristics of the carer (e.g., gender), the needs of the individual they are caring for, and the impact of this on employment, relationships, and finances, as well as the availability of social support and coping mechanisms for the caregiver, have been suggested. More recently, the mediating role of compassion on the negative impacts of caring has been proposed by scholars, with the introduction of the caregiver suffering-compassion model (Schulz et al., 2007; 2017). Compassion, defined as "*A deep awareness of the suffering of*

another coupled with the wish to relieve it" (Gilbert, 2009, p.13), involves emotional, cognitive, and motivational processes (Strauss et al., 2016). Meta-analyses support the link between self-compassion and increased psychological well-being (Zessin et al., 2015). However, for those offering a high level of compassion to others, if the individual they are caring for shows limited reduction of suffering, these carers may be more likely to experience negative health impacts. The need for future research to recognise caregiver compassion is crucial for developing our understanding of caring, including ways in which clinical practice and policy can be refined to support the needs of these individuals (Schulz et al., 2007). To do so, exploration of feelings of love, concern and interdependence, negative affect and distress, as well as desire and motivation to help, is required (Murfield et al., 2020). Whilst these compassion-related processes have been explored in a family caring context, recognition of these factors amongst other groups of informal and formal carers is lacking. This highlights the importance of research to better understand the role and experiences of people who provide care and support to people who self-harm, with acknowledgement of wider systemic factors and feelings of the carer that may influence the physical and psychological health of this group. One avenue is to consider context specific care, and context specific self-harm.

3.5 Conclusions and Future Directions

When considering the literature across chapters one-three, there is a clear need for further research to explore and understand self-harm amongst university students, their experiences of support-seeking, alongside the voice of those also offering both formal and informal care for students. Due to the limited research conducted amongst those providing support for university students specifically, consideration to the carers literature, and particularly that of young carers,

has been presented. Whilst this thesis aims to focus on the role of family and friends, this is the only existing body of literature that can be used to contextualise supporting others outside of 'normal' friendship and familial relationships. Despite the need for universities to recognise and support the specific needs of young adult carers (Sempik and Becker, 2014), our understanding of the impact of these ever-growing demands on university support services, as well as informal carers, is limited.

Much of the research aimed at understanding self-harm amongst university students has been conducted using quantitative measures. These studies are crucial in allowing comparisons and causal relationships to be established across populations, however they fail to detect and recognise the nuances of behaviours (Robertson et al., 2018). In contrast, qualitative approaches offer an in-depth and direct exploration of lived experiences (Willig, 2013), presenting a unique understanding of individual perspectives, which is particularly useful when exploring sensitive issues and under-researched areas (Roche, 1991). Qualitative research has provided a greater level of understanding into why adolescents self-harm, including the importance of developmental and environmental factors such as separation, independence, and forming of an identity (Stänicke et al., 2018). Resultingly, exploring self-harm at important time points and in specific contexts may allow for a greater understanding of phenomena that contribute to harming behaviours. Further consideration of how these factors may be relevant to students, with recognition to university as a time of change and transition, is required.

Whilst research has frequently focused on the experiences of professional carers in health and social care, the voice of those working in educational, voluntary, and third-sector settings is lacking, despite playing a pivotal role in patient care (Harrison & Gordon, 2021). For the education sector specifically, the increasing rates of poor mental health amongst students,

including those in informal caring roles, are placing rising demands and pressures on professional carers in university settings (Auerbach et al., 2018; Sempik & Becker, 2014). Further, many university students and family members are providing informal support and care for their friends and loved ones, highlighting the uniqueness of caregiving in a university setting (Byrom, 2019; Edwards-Bailey et al., 2022; Hazell et al., 2021; Laws & Fiedler, 2012). Given the additional stressors of caring for people who self-harm (e.g., Hazell et al., 2021), the increasing demands on university support services (Hubble & Bolton, 2020), as well as students who may be providing care alongside their own difficulties and pressures of university life (e.g., coursework and deadlines) (Sempik & Becker, 2014), further research seeking to understand the impact and attitudes of informal and professional carers specifically within a university setting is warranted. To the researcher's knowledge, there is currently no literature specifically exploring the role and experiences of those providing care to university students who self-harm.

3.6. Aims and Research Questions

The current research has several key aims:

1. To provide an updated understanding of the common methods and functions of self-harm amongst UK university students and compare scores on psychosocial measures of friendship, emotional inhibition, rumination, and alexithymia between students who report lifetime self-harm and those with no experience of personal self-harm.
2. To qualitatively explore experiences of self-harm amongst UK university students, learning about students' own understanding and experience of dealing with self-harm at university, including triggers, maintenance factors, coping strategies, and support-

seeking. It is hoped that these findings will be useful in identifying ways in which universities and student services may need to be developed or adapted to provide effective and tailored support for this vulnerable group.

3. To provide a novel insight into the experiences of people providing care to UK university students who have self-harmed during their time at university by aiming to understand the experiences of the differing groups of carers in universities, what caring means to them, as well as identifying any areas in which they may require further support within their role.

4. Chapter Four: Methodology

This chapter provides a critical account of the methodology used in this thesis, with an overview of the methods applied across each study. Specific methodologies for individual studies are presented in subsequent chapters (chapters five-seven), with this chapter focusing more broadly on the general methodology applied across this thesis. This includes an overview of the i) rationale for using mixed-methods, ii) psychosocial measures used, iii) study designs across the thesis, iv) qualitative analysis, v) ethics and vi) personal reflection.

4.1 Mixed-Methods: Why Use This Approach?

Quantitative research, and more specifically the use of psychological measures and closed questions (i.e., numeric), are applied extensively within psychological research. Recognition has been given to the advantage of applying a mixed-method approach, with the use of both quantitative and qualitative methods adding a unique and meaningful dynamic to data interpretation (Creswell & Creswell, 2005; Hughes, 2016; Teddlie & Tashakkori, 2003). This approach is often adopted when it is felt that neither quantitative nor qualitative methods in isolation are satisfactory, and the use of both methods provides a more in-depth analytical approach (Green et al., 1989; Green & Caracelli, 1997). This is particularly important given that the target population are an under-researched group, specifically in relation to self-harm. When designing a mixed-methods study, there are three main approaches: 1) Sequential, in which either quantitative or qualitative data collection occurs first, and then the other method is applied in a later phase of the study; 2) Concurrent, in which both quantitative and qualitative data are collected simultaneously; and 3) Transformative, a theory-driven approach in which sequential or concurrent strategies may be adopted (Creswell et al., 2003).

The combination of both qualitative and quantitative research methods offers a unique opportunity to overcome the limitations of each approach in isolation, and consequently produce firmer conclusions (Bryman, 2006; Greene & Caracelli, 1997). For example, findings produced from quantitative research can be applied and generalised across larger groups, whereas qualitative approaches enable a deeper and more nuanced understanding of data and experiences that cannot be obtained by quantitative methods alone (Clark & Ivankova, 2015). Further, when using both methods simultaneously, comparisons can be made across findings, prompting triangulation between the data. Adopting a sequential mixed-methods approach also enables the development of additional studies based on initial findings (Greene et al., 1989). However, it is important to recognise the challenges and limitations of using mixed-methods.

Attention must be drawn to the time taken to analyse and collate two different forms of data, and the requirement of the researcher to be knowledgeable in both methods (McKim, 2017). Most commonly, researchers are established and comfortable with either quantitative or qualitative methods, and therefore to use mixed methods effectively, must dedicate time to familiarising themselves and conducting both forms of research, which is often time-consuming. In addition, determining the focus and weight of the different forms of data can be challenging, and researchers need to be aware of any potential bias that they may have towards one method when interpreting their findings (Creswell et al., 2007). Another difficulty when using mixed methods is choosing the most appropriate terminology and nomenclature when writing up studies and research. Whilst language and terms are established in quantitative and qualitative research, discrepancies between researchers carrying out mixed methods studies are apparent (Teddlie & Tashakkori, 2003). Given that this approach is growing in popularity, this is to be expected and the debate of whether to continue with existing nomenclature from qualitative and quantitative

measures, or to re-determine terminology specifically for mixed methods research, remains open (Armitage, 2007). For the purpose of this thesis, study one used a concurrent mixed-method approach, incorporating both quantitative numeric data (i.e., psychological measures) and qualitative data (i.e., open-ended exploratory questions) within an online survey. Studies two and thre then followed sequentially, with the design influenced by the findings of the subsequent studies. Given that the aim of this thesis was to produce generalisable findings for the student population, as well as gain a greater understanding of student and supporters' experiences in relation to self-harm and university support, a mixed-methods approach was felt to be most appropriate.

4.2 Thesis Study Designs

As visually represented in chapter one, this thesis consisted of three empirical studies employing a range of methodologies and analytical approaches (see Figure 1). Whilst these are detailed further in individual study chapters (i.e., Chapters five – seven), a rationale and overview of these approaches are provided here to provide context to the following chapters.

4.2.1 Online Survey - Psychological Measures

Study one used a series of validated and reliable psychological measures which were selected based upon their frequency and validation within previous research, including:

1. **Inventory of Statements About Self-Injury (ISAS – Section I and II S-F) (Klonsky & Glenn, 2009).** The ISAS is a self-report measure assessing behaviours and functions of

self-harm. Questions are presented in two distinction sections, with Section I focusing on self-harming behaviours and frequency, and Section II addressing functions of self-harm. Section I requires participants to indicate approximate lifetime frequency of 12 NSSI behaviours (e.g., cutting, biting, severe scratching etc). Individuals are informed to only endorse behaviours that they have purposefully carried out in the absence of suicidal intent. Frequency is calculated based on the estimated number of times the behaviour has been carried out (e.g., 0, 5, 10 etc). Participants can endorse as many of the behaviours as they see appropriate. For those who endorse at least one of the behaviours, further questions exploring age at first and most recent self-harm, presence of physical pain, whether the individual is alone when they self-harm, approximate time from thinking about self-harm to acting on it and finally, whether the individual wishes (or did at the time) to stop self-harming. Length of time engaging in self-harm is calculated by the difference in age of initiation and age of last self-harm. For section II (short-form), individuals are asked a range of questions which are used to assess 13 key functions of NSSI: Affect Regulation, Interpersonal Boundaries, Self-Punishment, Self-Care, Anti-Dissociation/Feeling-Generation, Anti-Suicide, Sensation-Seeking, Peer-Bonding, Interpersonal Influence, Toughness, Marking Distress, Revenge and Autonomy). A selection of twenty-six statements are presented and participants are asked to rate the relevance of this in relation to their own self-harm (e.g. "When I self-harm, I am … creating a boundary between myself and others"). Responses to each question are scored on a Likert scale of 0-2 (i.e., 0 = not relevant, 1 = somewhat relevant, 2 = very relevant). Items are then combined into pairs, with scores ranging from 0-4 per function, equating to a final score for the 13 functions (e.g., Affect regulation – items 10 and 17). The higher the score, the more likely that function is to impact upon maintaining and influencing the self-harm. Section I has shown excellent internal consistency

(α= .84), test-retest reliability (.85) and construct validity (Klonsky & Olino, 2008). In section II, both interpersonal and intrapersonal functions have demonstrated strong internal consistency (α = .88 and .80), validity and reliability (Klonsky & Glenn, 2009). A copy of the ISAS is presented in Appendix A.

2. **Toronto Alexithymia Scale (TAS) (Bagby et al., 1994).** The TAS is a 20-item measure requiring individuals to rate how strongly they agree or disagree with a statement (e.g., 'I am often confused about what emotion I am feeling') on a 5-point Likert scale scored from 1 (strongly disagree) to 5 (strongly agree). Five items are reverse scored (4, 5, 10, 18 & 19). All 20 items are used to get a total alexithymia score, using cut-off scoring: equal to or less than 51 = non-alexithymia, equal to or greater than 61 = alexithymia. Scores between 52-60 are indicative of possible alexithymia. The scale can also be split into three subscales, with set items used to produce scores for each:

- Difficulty describing feelings subscale (sum of 5 items - 2, 4, 11, 12, 17). This is used to measure difficulties in describing emotions.
- Difficulty identifying feelings subscale (sum of 7 items - 1, 3, 6, 7, 9, 13, 14). This is used to measure participants' difficulty in their ability to identify emotions.
- Externally-Oriented Thinking subscale (sum of 8 items – 5, 8, 10, 15, 16, 18, 19, 20). This is used to measure the tendency of individuals to focus their attention externally.

The TAS Demonstrates good internal consistency (α = .81) and test-retest reliability (.77, $p<.01$). Research using the TAS-20 demonstrates adequate levels of convergent and concurrent validity (Bagby et al., 1994). The 3-factor structure was found to be theoretically congruent with the

alexithymia construct. In addition, it has indicated stability and replicability across clinical and nonclinical populations (Taylor et al., 2003). A copy of the TAS is presented in Appendix B.

3. **Inhibition-Rumination Scale (I-RS) (Roger & Najarian, 1989)**. The I-RS is a 39-item measure developed from a previous scale (i.e., Emotion Control Questionnaire (ECQ) (Roger & Narjarian, 1989) and is used to measure emotional response style across a variety of settings and populations (Roger et al., 2011). Previous research has highlighted higher scores on both domains of emotional inhibition and rumination for individuals engaging in self-harm, with rumination found to be a significant predictor of self-harming behaviours (Borrill et al., 2009). The I-RS requires participants to answer 'True' or 'False' to a series of statements and is scored based on two factors:

- Emotional Inhibition – A score of 1 for answers "TRUE" on items 3, 4, 7, 8, 10, 13, 16, 17, 19, 23, 32, 33, 38, and 1 point for "FALSE" on items 9, 11, 12, 14, 21, 26, 29, 35.

- Rumination – A score of 1 for answers "TRUE" on items 1, 5, 6, 18, 20, 22, 24, 25, 27, 28, 31, 39, and 1 point for "FALSE" on items 2, 15, 30, 34, 36, 37.

Both components on the I-RS have demonstrated high internal consistency (rumination α =.835 and emotional inhibition α =.855) and have been found to correlate differentially with differing variables, indicating independence between the two factors. Given that they are statistically orthogonal, this allows for each domain to independently measure differing aspects of emotional style (Roger et al., 2011). A copy of the I-RS is presented in Appendix C.

4. **Social Adjustment Scale (SAS) – Self-Report Friendship Index (Marver et al., 2017).**

The SAS – Self Report assesses social functioning within the last two weeks across a 54-item questionnaire (Weissman & Bothwell, 1976; Weissman et al., 2001). It is divided into six subscales aimed at capturing different elements of day-to-day life (e.g., work, family, and parenting). The SAS - Self-Report has high internal consistency (α =.85) and good reliability (.74) (Weismann, 1999). Marver et al. (2017) combined seven items from the SAS to create a friendship index (SAS-FI), measuring frequency and quality of recent interactions with friends (e.g., "Have you been able to talk about your feelings and problems with at least one friend during the last 2 weeks?"). Given previous findings that show social support to be a protective factor for engagement in self-harm (Buote et al., 2007; Pittman & Richmond, 2008), the friendship index was used in study one to gain a greater understanding of social support in relation to self-harm amongst university students.

All items were rated on a 5-or-6-point Likert scale, which are customised for each question (see Appendix D). The measure is scored by summing the value of all the questions, with a higher score indicating greater impairment in quality and frequency of friendships. Questions 20, 23, 24, and 25 had an additional answer choice: "not applicable: I have no friends," which is scored as 6 to highlight greater impairment. The 7-item friendship index has good internal reliability (α = .75). The scale can be broken down into quality (items 20, 23, 24, 25) and quantity (items 19, 21, 26) sub-scores. This enabled the functional (e.g., closeness) and structural elements (e.g., quantity of friends) of friendship on self-harm and related outcomes to be considered. A copy of the SAS – Self-Report Friendship Index is presented in Appendix D.

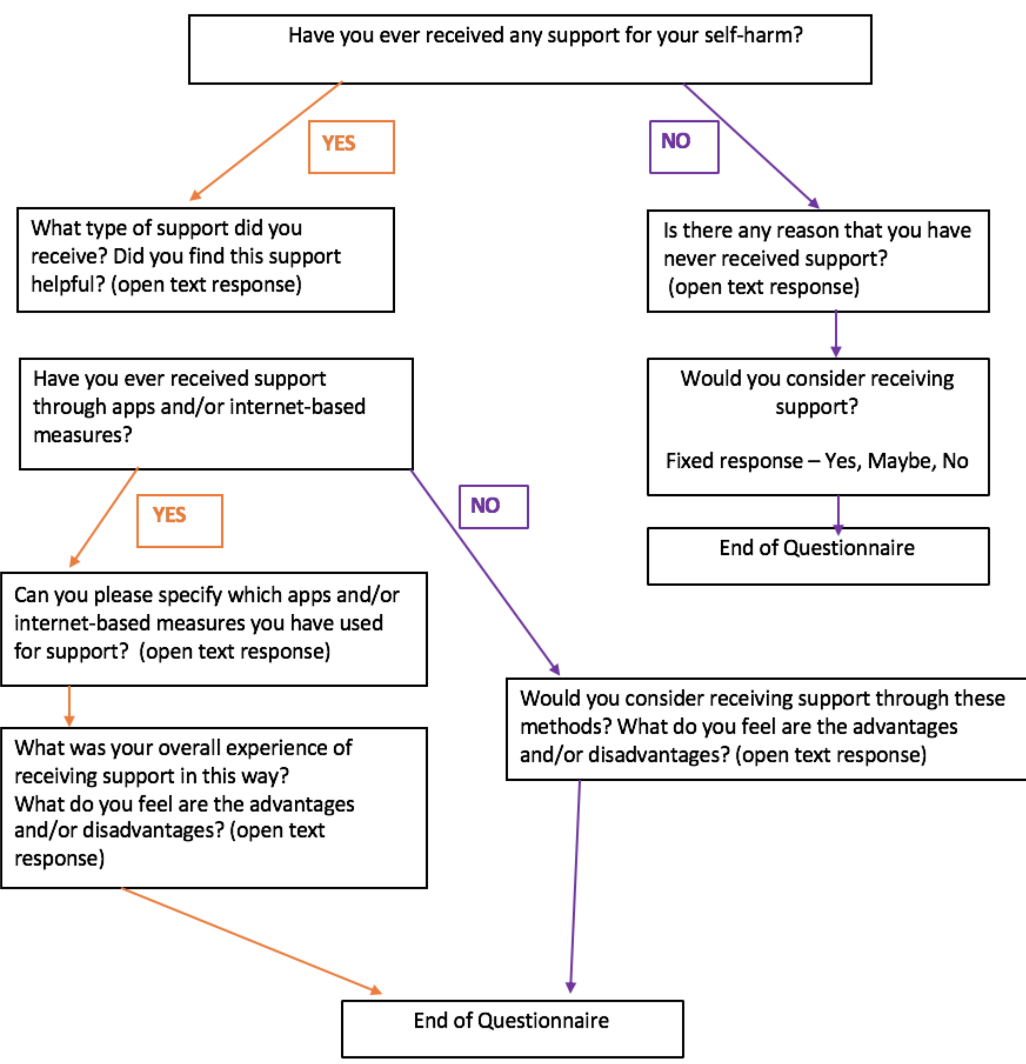
4.2.2 Online Survey – Fixed Response and Open-Ended Questions

A series of open-ended and fixed-response questions devised by the researcher and guided by previous literature were completed by participants in study one. As detailed in the following chapter (chapter five), two questionnaire versions were set up (i.e., version I and version II). Version II aimed to address limitations to the data collated in version I (i.e., lack of a comparison group to compare findings for those with lifetime self-harm vs no self-harm).

For version I, the open-ended and fixed-response questions depended on whether the individual had experiences of engaging in lifetime self-harm, and if they had ever provided support to another individual for self-harm. Those with experiences of self-harm were asked to reflect on their generic support-seeking experiences across their lifetime, as well as specifically during their time at university. Based on certain responses, the questionnaire took different routes to explore individuals' experiences in more depth (see Figure 9). Questions included whether they had ever received support at any time for their self-harm, perceptions of helpfulness around the support for those who had received help, reasons for not receiving support, and whether participants would consider receiving support in the future. Thoughts on the usefulness of apps and internet-based measures were also explored. For those who had provided support for self-harm (see Figure 10), participants were asked to reflect upon the impact of providing support, what they found helpful and/or unhelpful, and whether they had ever sought support themselves.

Figure 9

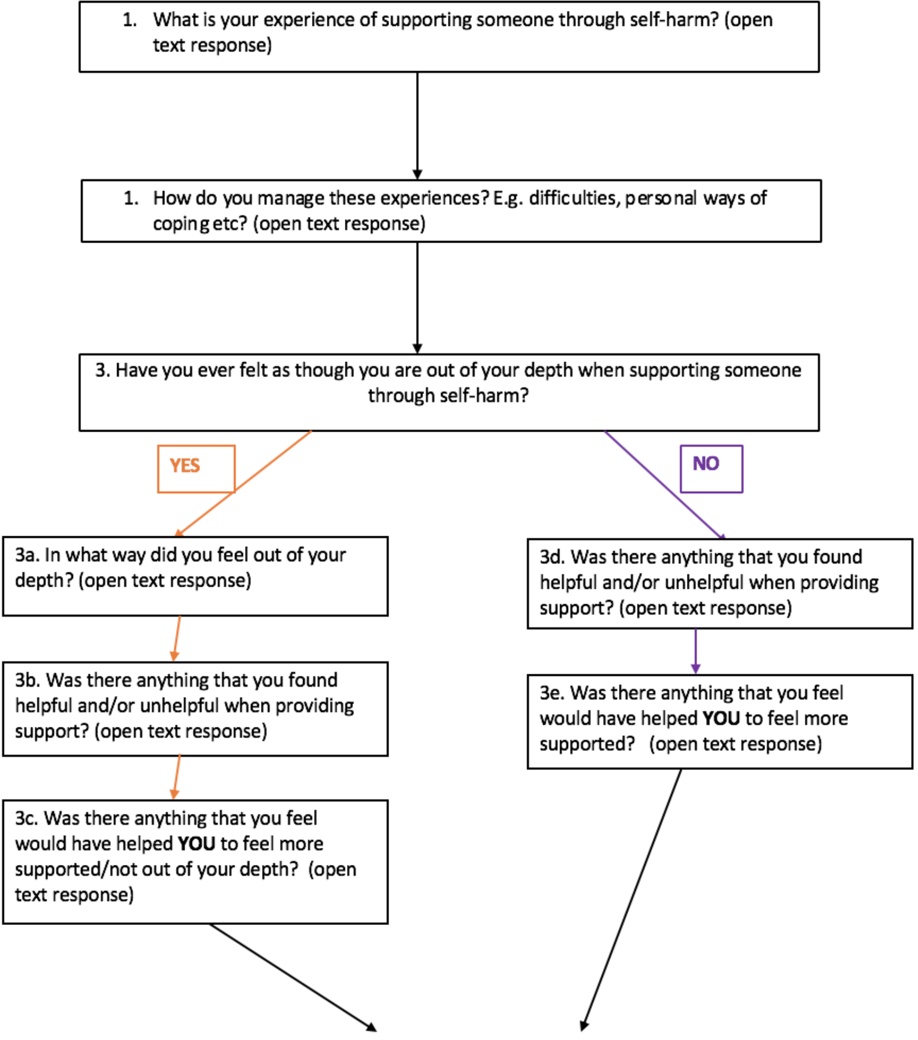
Open Questions for those Engaging in Self-Harming Behaviours used in Study One Questionnaire Version I

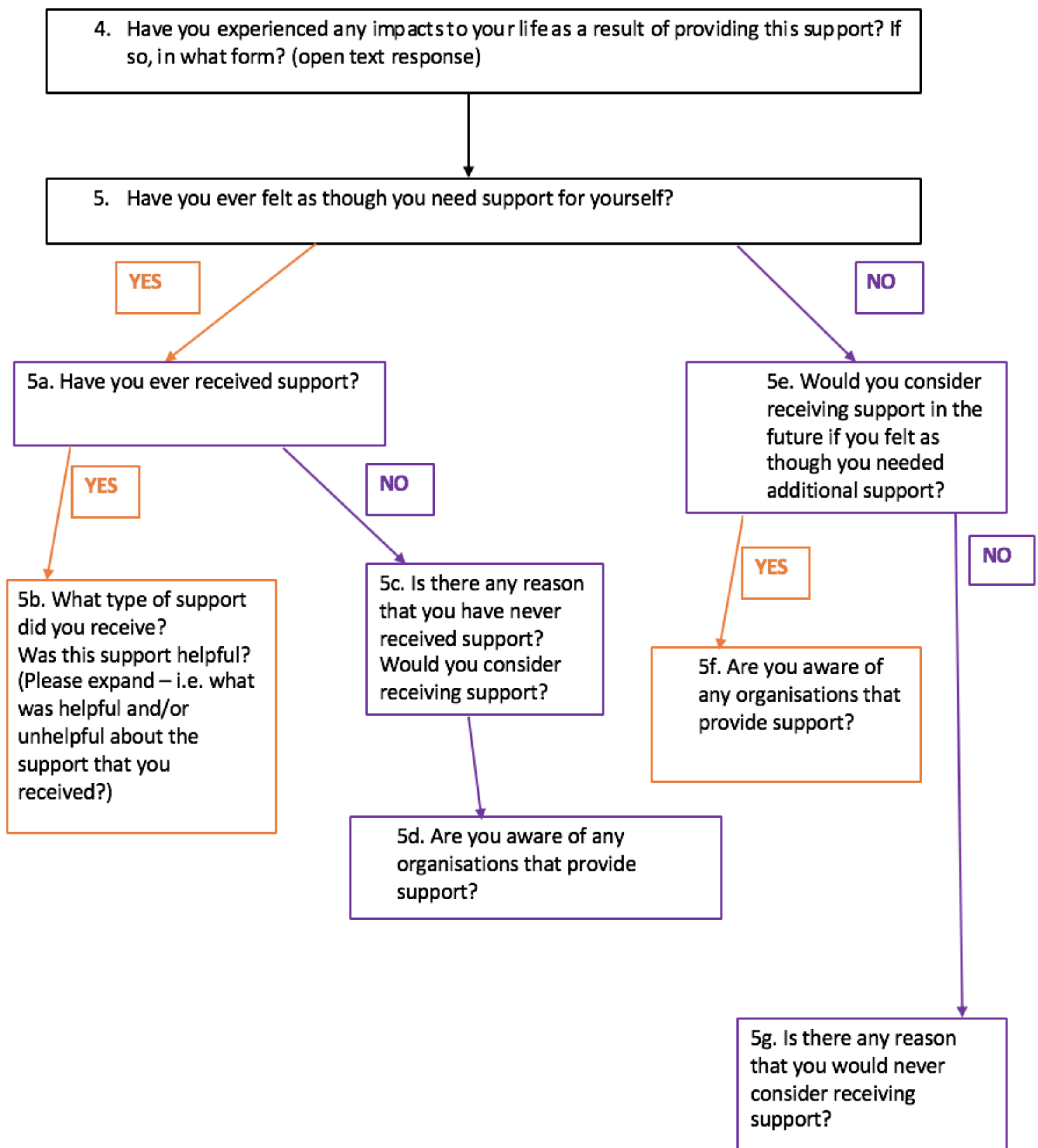


Note. This series of questions were presented to those participants who answered **<u>'Yes'</u>** when asked: *'Have you ever engaged in self-harming behaviours, either currently on in the past?'* following completion of the series of psychological measures detailed above.

Figure 10

Open Questions for those Supporting Individuals who Self-Harm used in Study One Questionnaire Version I



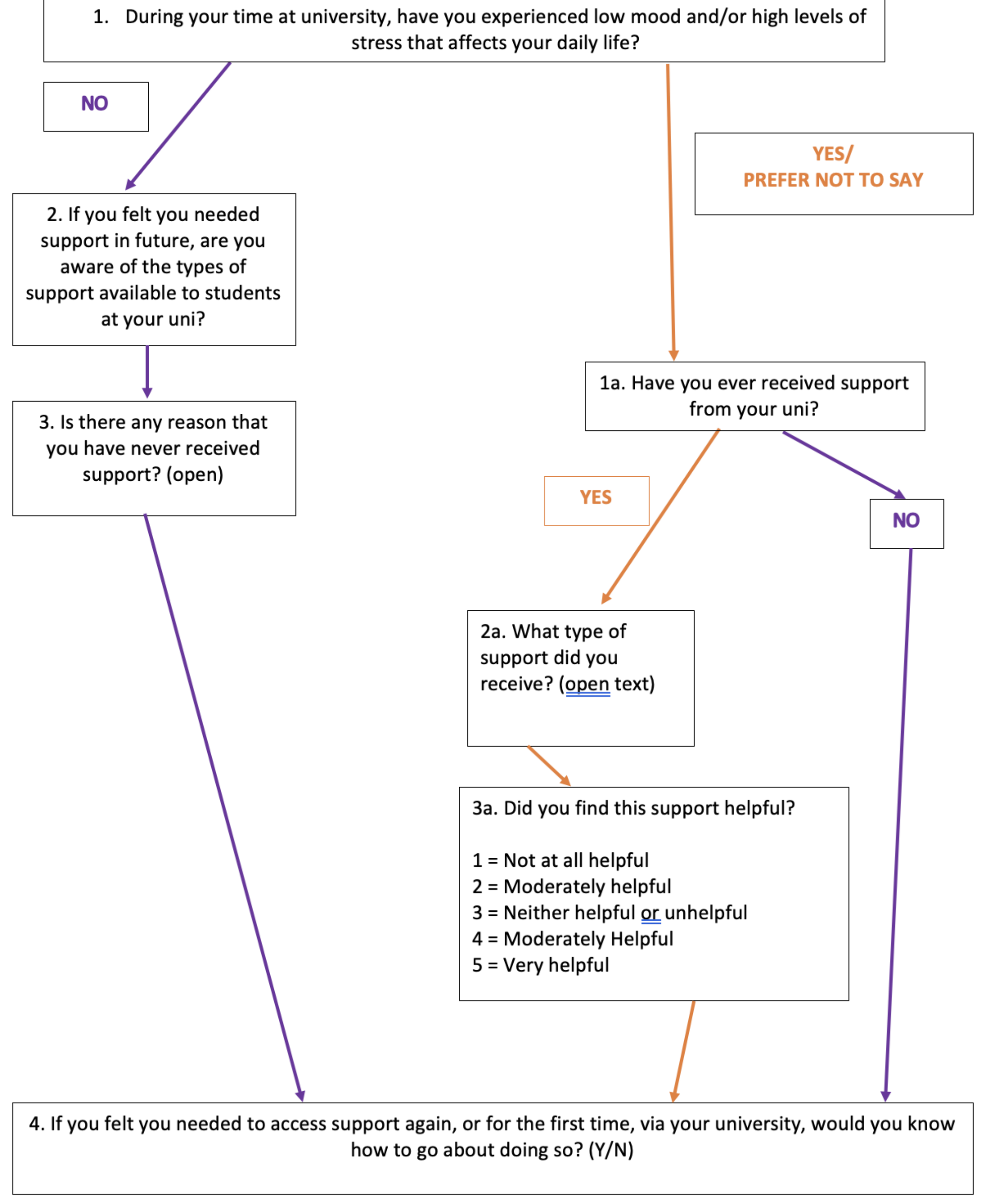


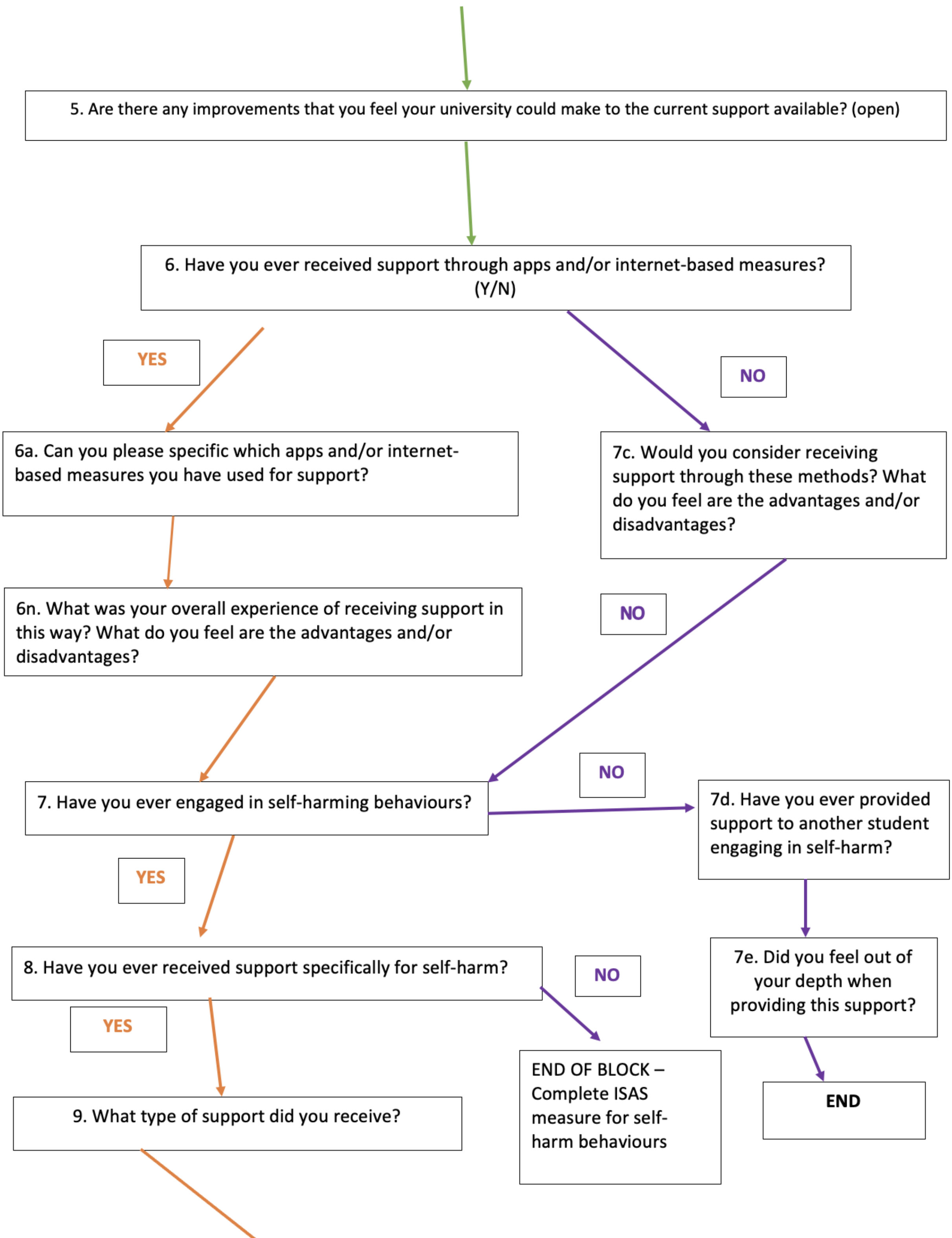
Note. This series of questions were presented to those participants who answered **<u>'No'</u>** when asked: *'Have you ever engaged in self-harming behaviours, either currently on in the past?'* and **<u>'Yes'</u>** when asked: *'Have you ever provided support for someone who was, or is currently, self-harming?*

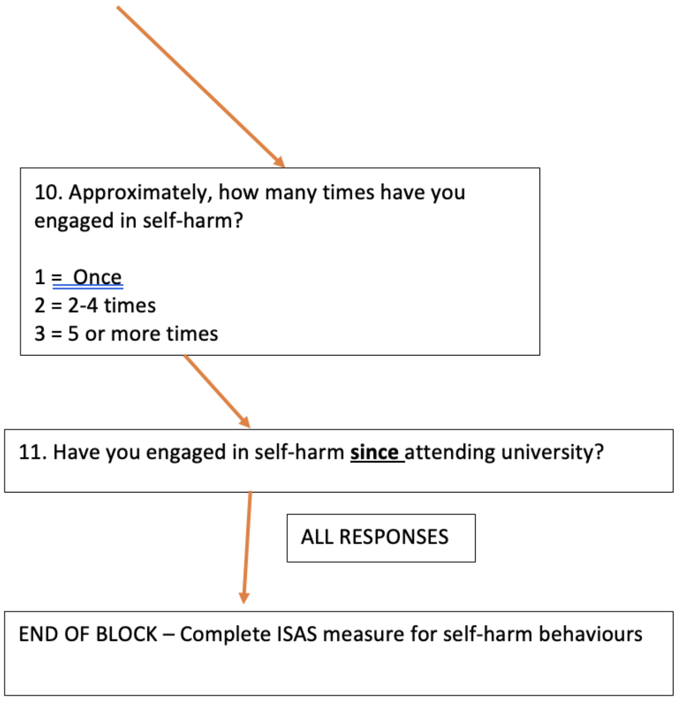
Study one questionnaire version II included a series of open-text and fixed-response questions devised by the researcher to build on version I findings. This included a wider exploration of stress amongst students, and whether students had accessed support for this. Awareness of support available at university and the helpfulness of this support was explored, with participants able to comment on what worked well, as well as improvements and advancements that they would like to see at their university. Similarly to version I, the version II questionnaire branched based upon participant responses, with opinions on app-based measures and more specific questions around self-harm and occurrence at university incorporated (see Figure 11). This is further discussed in chapter five.

Figure 11

Open-Ended Questions Included within Study One Questionnaire Version II




5. Are there any improvements that you feel your university could make to the current support available? (open)
6. Have you ever received support through apps and/or internet-based measures? (Y/N)
YES
NO
6a. Can you please specific which apps and/or internet-based measures you have used for support?
7c. Would you consider receiving support through these methods? What do you feel are the advantages and/or disadvantages?
6n. What was your overall experience of receiving support in this way? What do you feel are the advantages and/or disadvantages?
NO
NO
7. Have you ever engaged in self-harming behaviours?
7d. Have you ever provided support to another student engaging in self-harm?
YES
8. Have you ever received support specifically for self-harm?
NO
7e. Did you feel out of your depth when providing this support?
YES
END OF BLOCK – Complete ISAS measure for self-harm behaviours
END
9. What type of support did you receive?



4.2.3 Qualitative Interviews

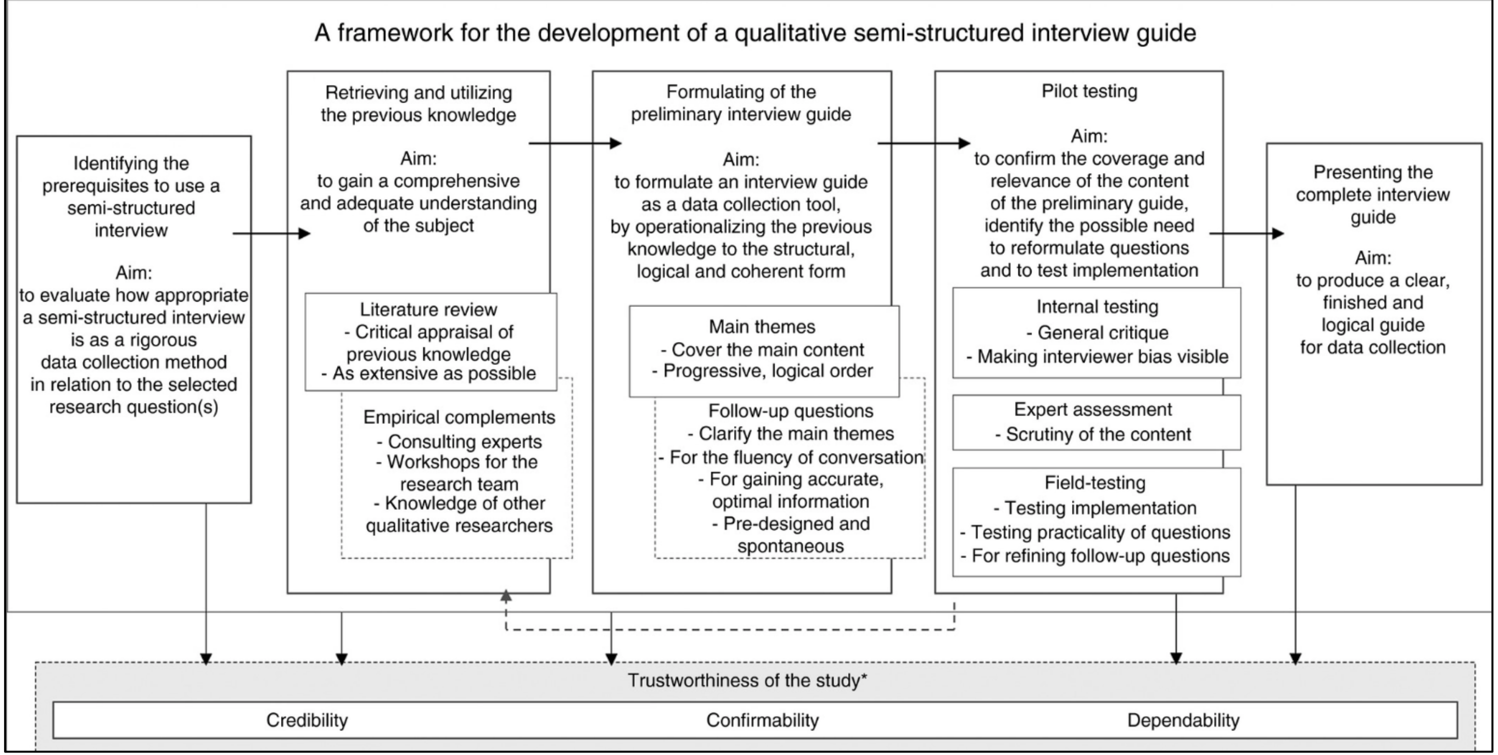
Quantitative studies are crucial in allowing comparisons across populations; however, they fail to detect and recognise the undertones and nuances of behaviours (Robertson et al., 2018). In contrast, qualitative approaches promote an in-depth and direct exploration of lived experiences, highlighting the fundamental motivations and intentions of the behaviour (Willig, 2013). When using semi-structured interviews, both the researcher and the participant are provided with a unique opportunity to expand upon individual experiences, gaining a greater understanding and meaning to a particular phenomenon. Qualitative methods provide insight into the way in which individual experiences are perceived in relation to their own social environment (Harding & Gantley, 1998), and provide a unique opportunity to share ideas and experiences through face-to-face interactions that are challenging to incorporate within quantitative research (Creswell et al.,

2007; Elmir et al., 2011; Kvale, 1996). Due to the sensitive nature of this research, the target population, and the limited research focusing specifically on this group, qualitative interviews were selected (Ritchie et al., 2013). A meta-analysis focusing specifically on qualitative exploration of adolescent self-harm highlighted the importance of this methodology in capturing unique experiences from the individual's viewpoint (Stänicke et al., 2018). Qualitative research to date has provided further insight in relation to the functions of self-harm (i.e., affect regulation), as well as revealing the underlying emotional and personal experiences, adding a unique perspective and level of understanding to adolescent self-harm (Stänicke et al., 2018). Given the high rates of self-harm reported among students, and the call for further research to collate data and provide an in-depth exploration of student self-harm (Universities UK, 2018b, p. 10), further qualitative research is needed amongst this group. Understanding the influence of university life and the journey throughout HE in relation to self-harm will aid awareness of student needs, enabling the development of tailored and supportive resources.

4.2.3.1 Interview Schedules. To address the aims of both studies two and three (see chapter three, section 3.6), the researcher created two semi-structured interview agendas (see Appendix E and F). These were developed following the framework for qualitative interview guide (Kallio et al., 2016), which proposed five key phases for devising a rigorous interview schedule (see Figure 12). Phases were suggested following a systemic literature review of interview studies due to limited research regarding how semi-structured interview guides are developed.

Figure 12

Kallio et al. (2016) Framework for Qualitative Interview Guide



In the current thesis, development of the interview agendas was influenced by previous research, the aims and scope of this project, as well as the provisional data collected in study one. Questions were designed to be open to ensure participant-led findings, enabling understanding and context when exploring participants' lived experiences (Charmaz, 1990). Given the sensitive nature of this research, the interview schedules initially focused on getting to know the participant (e.g., tell me about yourself and your interests), allowing them to settle and feel comfortable with the researcher before exploring more personal and sensitive experiences (e.g. exploring their first experiences and thoughts of self-harm (study two – chapter six), or their

experience of supporting someone engaging in self-harm (study three – chapter seven). Details of specific interview topics and rationale are included in empirical study chapters six and seven.

4.2.3.2 Interview Procedure. Due to similarities in interview proceedings for both studies two and three, an overview is presented here to prevent repetition. Further details specific to individual studies are presented in subsequent result chapters (six and seven). For both studies, interviews took place via a variety of platforms (face-to-face, skype, telephone or instant messenger). This was determined based on participant preference and feasibility. Varying interview methods were used to enable wider recruitment across a diverse geographical setting and encourage those with time and location limitations to participate (Janghorban et al., 2014; Meho, 2006). Further, participants who may not feel comfortable discussing their experiences face-to-face had the opportunity to partake in a less direct and anxiety-provoking setting (Elmir et al., 2011; Mealer & Jones, 2014). Measures were put in place to overcome obstacles when using internet-based methods, such as ensuring a stable internet connection, clarification of answers and topics, attention to pacing, and using quiet environments with limited distractions (Seitz, 2016). Participant experiences when conducting interviews across different platforms remain consistent, with the majority reporting positive encounters regardless of the interface used (Wolgemuth et al., 2015). Pacing and the extent of exploration with participants were determined by the appropriateness and interview flow, with the researcher making judgements as to how best to proceed and gather information based on participants' reflections and comfortableness in exploring certain phenomena.

All verbal interviews were audio-recorded with an Olympus voice recorder. Instant messenger interviews were conducted using 'signal', a secure messaging service recommended by the technical security team at the University of Westminster. Interviews occurred concurrently with

transcription and data analysis, with the number of interviews determined by 'data adequacy'. Whilst the concept of 'saturation' has been commonly discussed in relation to qualitative sample sizes, this has been critiqued for its ambiguity (Vasileiou et al., 2018). Instead, 'data adequacy' suggests that data collection ends when the researcher has enough "meaning-richness" in their data set (Braun & Clarke, 2022), thereby sharing similarities with the concept of theoretical sufficiency (Dey, 1999). Data adequacy was influenced by previous 'saturation' indicators in which limited new codes developed during analysis (Clarke & Braun, 2013; Guest et al., 2006).

4.2.3.3 Challenges and Limitations in Qualitative Interviews. Recruitment for qualitative interviews pose challenges unique to this method of study. Given that interviews often require more time than completing quantitative research, specifically surveys, attracting participants can be challenging. Further, when researching sensitive topics which may involve exploration of difficult and emotional memories, this can deter participants from wanting to partake. There are several strategies and points of reflection from previous research that are important to acknowledge when overcoming recruitment challenges. Ensuring that participants understand the importance and value of them sharing their personal experiences for others to learn and develop from is vital, with a clear description of the need for this research and how it will be applied within the field (Dempsey et al., 2016). Building rapport and displaying empathy are also key to the interview process, recruitment, and in later stages of data collection (Karnieli-Miller et al., 2009). Doing so allows the participant to feel comfortable, enabling the researcher to gain greater insight into their lived experiences (Dickson-Swift et al., 2007). Within this research, initial conversations with participants began via telephone and email when inviting them to take part in an interview and when following up on any questions or queries that they had about the study, allowing the researcher to engage and build rapport prior to the interview taking place. A flexible

approach from the researcher with timing and platforms of interviews was also adopted to encourage participation and reduce participant burden (Dempsey et al., 2016). Participants were offered £15 worth of vouchers for participating in an interview. Whilst it is recognised that using this strategy can present difficulties and considerations concerning ethics, the utilisation of participant vouchers has been found to increase access to 'hard-to-reach' groups, having a positive impact on willingness to participate (Head, 2009). Given that most interviews included university students, and that this is often a time of financial hardship (Taliaferro & Muehlenkamp, 2015), it was felt that offering vouchers specifically for this group would encourage participation.

It is also important to recognise the impact that researching stressful experiences can have on the researcher and the challenges that this form of data collection can pose (Birch & Miller, 2000; Liamputtong & Ezzy, 2005). Morse and Field (1995, p.78) summarised:

> Data collection can be an intense experience, especially if the topic that one has chosen has to do with illness experience or other stressful human experiences. The stories that the qualitative researcher obtains in interviews will be stories of intense suffering, social injustices, or other things that will shock the researcher.

Defining sensitive research and what is considered a stressful life experience can be challenging and open to interpretation. Dickson-Swift et al. (2008) classify sensitive research as any study which may present a risk to participants and any individual involved in the research. Establishing boundaries, having a reflective space, building rapport, and managing emotions arising from sensitive research topics are demands commonly faced by researchers (Dickson-Swift et al., 2006; Kiesinger, 1998; Liamputtong & Ezzy, 2005; Rager, 2005a, 2005b). Therefore, meticulous planning and designing of the research are vital to reduce the threat posed and to encourage

positive research experiences (Ashton, 2014). To achieve this, the essential elements in qualitative interviews framework was adopted (Dempsey et al., 2016) (see Appendix G). Further, reflexivity of the researcher and the use of supervision were encouraged.

4.3 Analytical Approach – Thematic Analysis

Thematic Analysis (TA) is a theoretically flexible approach for analysing qualitative data by offering a methodology that is autonomous of theory, permitting application across multiple epistemological positions (Braun & Clarke, 2006, 2019). TA allows for coding across the data set by recognising patterns, resulting in the establishment of key overarching themes. Whilst it shares similarities with other qualitative strategies including grounded theory (GT) (Strauss & Corbin, 1994) and Interpretive Phenomenological Analysis (IPA) (Smith, 1996; Larkin et al., 2021), TA is unique in its flexibility and has recently been renamed to distinguish this approach – 'Reflexive TA' (Braun & Clarke, 2006, 2019, 2021; Clarke & Braun, 2013). Whilst other qualitative approaches were considered (GT and IPA), reflexive TA is particularly useful when conducting research in areas where there is little existing research, mainly due to its theoretical flexibility (Braun & Clarke, 2006). Given the specific issues and target population of this thesis, the aim was to describe and understand self-harm specifically amongst this group, rather than develop theory. Further, this approach has been used within previous qualitative research exploring experiences of suicide and self-harm (Cheung et al., 2015; Rosenrot & Lewis, 2020; Stubbing & Gibson, 2019).

4.3.1 Epistemology

Paradigms within quantitative and qualitative research have been previously established (e.g., 'positivist' and 'constructivist'), nonetheless determining a philosophical paradigm in mixed methods research is challenging due to differing methodological, ontological, and epistemological positions between qualitative and quantitative approaches (Migiro & Magangi, 2011). Paradigms provide important foundations and beliefs which are used to guide researchers in their decision-making (Tashakkori et al., 1998), specifically influencing ontology, epistemology, and methodology.

To establish rigour when using reflexive TA, and conducting research more broadly, it is important for the researcher to clearly define their epistemological and ontological position (Holloway & Todres, 2003). Epistemology, also referred to as 'theory of knowledge', is the way in which we acquire information (Clarke & Braun, 2013). Ontology is related to existence, and therefore, whilst epistemology and ontology are closely related, epistemology is primarily concerned with what we know and how we know it, whereas ontology focuses on what is actually there (Packer & Goicoechea, 2000; Smith & McGannon, 2018). Therefore, ontology questions whether reality is construed subjectively through individual experiences, meaning and interpretation (i.e., relativist), or is it objective and independent of human knowledge (i.e., realism) (Braun & Clarke, 2013; Guba & Lincoln, 1994). This closely relates to one's epistemological position, with positivist epistemology aligning with objectivism in which the researcher and participants are independent. Therefore, meaning comes purely from participants, with the investigator having minimal influence on research findings (Braun & Clarke, 2013). However, the relativist viewpoint proposes that due to knowledge of reality being subjective,

human bias is always at an interplay and therefore researchers offer their interpretation of reality (Braun & Clarke, 2013).

TA often falls into one of two epistemological categories: essentialist/realist and constructionist (Madill et al., 2000). The essentialist/realist position allows for meaning and experiences to be theorised in a straightforward manner, focusing on the individual's experience and interpretation of a specific event or concept (Widdicombe & Wooffitt, 1995). The realist stance also incorporates the use of triangulation, a method which is applied within qualitative research to assess reliability and consistency, with two or more researchers coding the data and comparing interpretations of the data set (Flick, 2004; Noble & Heale, 2019). On the other hand is constructionist, in which meaning and motivations are theorised from a social perspective, taking a critical view of how we understand and relate to the world and those around us, with less focus on the individual experience (Burr, 2015).

More recently an alternative position, known as ‘critical realism’ (CR), has gained traction in the literature, drawing on both positivist and constructivist approaches to explore both epistemology and ontology (Bhaskar, 1979; Gorski, 2013; Fleetwood et al., 2002). CR sits between realists and relativists, aiming to expand understanding and insight (McEvoy & Richards, 2006) by acknowledging that findings are conditional in nature and may be incorrect (Bhaskar, 1979; Barker et al., 2002). Within research, CR encourages ‘responsible rationality’, in which findings should be viewed critically and considered within their wider context, recognising the influence of societal pressures and structures (Manicas, 2009). By doing so, practical and strategic recommedations can be proposed from the research findings (Fletcher, 2017). Consequently, CR has been praised for its potential to offer insightful and thought-provoking research (Bhaskar, 2014; Karlsson & Ackroyd, 2014). Whilst data can allow for a

greater understanding of one's experiences, it does not necessarily echo reality, and therefore CR recognises that participant accounts may not offer all detail required for analysis (Braun & Clarke, 2013; Harper, 2011). Therefore, some interpretation is required by the researcher as individuals may not have full awareness of their experiences, why they perceive their experiences in a particular way, and the meaning they attach to these experiences (Braun & Clarke, 2013). Acknowledgement of social contexts is particularly important when exploring the experiences of university students, as explored extensively in previous chapters, and therefore the researcher adopted a CR epistemological approach throughout this thesis.

4.3.2 Thematic Analysis in the Current Thesis

Interview data for studies two and three were transcribed verbatim, and all qualitative data cross studies one-three were analysed using TA. As the same analytical procedure was applied across all studies, a summary is presented here. When identifying themes, there are two approaches which can be used in TA; inductive (bottom-up) or deductive (top-down) (Frith & Gleeson, 2004; Hayes, 1997). An inductive approach allows for the coding of the data to be done in isolation of pre-existing theories and coding frameworks, allowing TA to be driven directly by the data. A deductive approach contrasts with this, relying on the researchers' theoretical interest within the area of research, therefore building on existing theories (Braun & Clarke, 2006). Adopting an inductive approach across studies one-three enabled participants' experiences to guide analyses, preventing previous theoretical assumptions from influencing coding and theme development and therefore limiting the impact of the researchers' pre-existing knowledge. Further, two levels of coding, semantic and latent, were used. Semantic coding enables themes to be identified based on the surface meaning, with little exploration beyond exactly what the

participant has stated. In contrast, latent coding develops at the semantic level, searching for the underlying assumptions and meanings (Braun & Clarke, 2006), aligning with the CR epistemological position taken. For all studies, the six stages of TA were applied (Braun & Clarke, 2006):

1. Data Familiarisation
2. Generation of initial codes
3. Searching for Themes
4. Reviewing Themes
5. Defining and Naming Themes
6. Writing up findings

Interviews were conducted, listened to on several occasions, transcribed and initially coded by the doctoral researcher, allowing for data familiarisation. Additionally, following conduction of interviews, the researcher made notes based on topics and thoughts explored, allowing for immersion within each participant account. A semantic and inductive approach to analysis was adopted, enabling coding and themes to be guided by the data (Braun & Clarke, 2006). Initial coding was conducted on a case-by-case basis using sentence-by-sentence coding by the researcher. Following this, the three members of the supervisory team (JM, TC and NS) coded a sample of transcripts (12.5%) to promote authenticity and credibility. Team meetings were held to allow for comparisons and commonalities within interpretation to be explored, enabling a deeper understanding and generation of new and richer codes (Olesen et al., 1994; Saldaña, 2015; Weston et al., 2001). Codes were then collapsed into initial themes that were

representative of the patterns and meanings within the data set (Fereday & Muir-Cochrane, 2006), with the use of a thematic map to facilitate this progress (see Appendix H, I and J). Themes were identified through “careful reading and re-reading of the data” (Rice & Ezzy, 1999), eventually resulting in the establishment of key over-arching themes which aimed to “capture something important about the data in relation to the research question, representing some level of patterned response or meaning within the data set” (Braun & Clarke, 2006, p. 82). These were then named to reflect the meaning of each theme (see Appendix H, K and L). Coding and analysis occurred simultaneously, with consideration to previous steps before further advancement of themes, ensuring any developments were grounded within the data (Fereday & Muir-Cochrane, 2006). The 15-point checklist of TA was followed across studies two and three to ensure a rigours process when conducting TA (Braun & Clarke, 2006) (see Figure 13).

Figure 13

Braun and Clarke's (2006) 15-Point Checklist of Thematic Analysis

Process	No.	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for all each theme have been collated.
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
Analysis	7	Data have been analysed – interpreted, made sense of - rather than just paraphrased or described.
	8	Analysis and data match each other – the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organised story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as *active* in the research process; themes do not just 'emerge'.

4.3.3 Limitations of Thematic Analysis

When initially established, TA was regarded as a poorly utilised strategy that many researchers conducted with little description of the analytical processes followed to reach their conclusions (Tuckett, 2005). Therefore, key steps and criteria for conducting TA have been developed (Braun & Clarke, 2006; Clarke & Braun, 2013). Whilst a strength of TA is its theoretical flexibility, this can present difficulties with the interpretative power of this approach, resulting in inconsistency when analysing the data (Holloway & Todres, 2003). Further, given that TA has been used less extensively within the literature in comparison to other approaches (i.e., GT, IPA), this may lead to early researchers finding it challenging to effectively adopt and use this approach (Nowell et al., 2017). However, more recently, Braun and Clarke (2019) have written to establish clearer and more precise strategies due to growing popularity of the use of TA, providing worked examples and renaming the approach 'Reflexive TA' (Braun et al., 2019).

4.4 Validity and Reliability in Qualitative Research

Validity and reliability are terms often associated with quantitative research, and the ability to establish their meaning and role within qualitative research has been widely debated (Long & Johnson, 2000; Rolfe, 2006). Whilst arguments have been presented for using the same criteria for both qualitative and quantitative research (e.g., Howitt & Cramer, 2010), others feel that qualitative research needs to be recognised as separate and judged according to a specific qualitative criterion (Holloway & Todres, 2007; Yardley, 2008). Development of guidelines in relation to measuring and establishing validity and reliability in qualitative research have emerged, requiring researchers to pay close attention to their method selection and the appropriateness of applying this methodology with certain groups and populations (Noble &

Smith, 2015). However, given the lack of consensus regarding the criteria against which this should be measured, establishing rigour can be difficult, especially for researchers who are new to the field of qualitative research (Rolfe, 2006). Kitto et al. (2008) propose six criteria for assessing validity and reliability in qualitative research: 1) Clarification and justification; 2) Procedural rigour; 3) Representativeness; 4) Interpretative rigour; 5) Reflexivity and evaluative rigour; 6) Transferability. Each criterion will be discussed below and considered in relation to the qualitative research conducted as part of this thesis.

1. *Clarification and Justification*

To provide clarification and justification the researcher must establish several key points: i) the aims of the research, ii) clear research questions, iii) justification for the selection of a qualitative methodology, and iv) justification for the specific qualitative approach. These need to be stated and clearly defined so that the reader can judge the appropriateness of the qualitative methods applied, specifically regarding the theoretical underpinnings of the research. The aims and research questions of each study have been presented in chapter three and individual study chapters (five-seven), with justifications for the use of qualitative interviews provided within this chapter.

2. *Procedural Rigour*

To determine procedural rigour, i.e., clarity of how the research has been carried out, the researcher must precisely document the approach to data collection and analysis. How rapport was developed with participants, the importance of trust, approaches to data recording and analysis, as well as strategies for addressing any difficulties and challenges when collating and analysing the data, should be detailed. Kitto et al. (2008) suggest several questions which are

important to answer to establish procedural rigour: i) How were participants/settings accessed?; ii) which individuals were recruited?; iii) on how many occasions, and for how long, were participants interviewed/observed?; iv) what questions were participants asked during interviews?; v) purpose and scope of the interview; vi) data management. These questions have been used to guide the methodology overview for each study presented in this chapter, and the individual study methods in chapters five-seven.

3. *Representativeness*

This criterion relates to the sampling techniques and strategies adopted within the research and whether they allow for generalisability. For both studies two and three maximum variation sampling was used, with the aim to include individuals from multiple universities, rather than limiting to specific institutions as done in previous studies. To establish sample representativeness, considering findings concerning participant characteristics and acknowledging any similarities and differences across the sample is important (Barbour, 2001). Factors associated with representativeness are detailed in empirical chapters.

4. *Interpretative Rigour*

Interpretative rigour is often discussed in relation to inter-rater reliability which is established through a process of triangulation (Noble & Heale, 2019). This involves the discussion and development of codes and themes between several researchers, allowing for multiple perspectives and interpretations to be considered (Liamputtong & Ezzy, 2005). This can also be established using multiple methods of data collection, as well as using different theoretical frameworks when interpreting the data. Therefore, a concise overview of the analytical approach

in studies 1-3 is provided above, with consideration of any "deviant" accounts in individual chapters (Mays & Pope, 1995). Triangulation was also promoted with supervisors coding a sample of transcripts (12.5%) for both studies 2 and 3.

5. *Reflexivity and Evaluative Rigour*

The process of reflexivity within qualitative research is a crucial process for qualitative researchers, specifically when exploring sensitive research topics. This is also important in relation to reliability and validity, with the need for the researcher to recognise any personal influence that their own experiences may have had on the data collection and interpretation. Therefore, a clear overview of the views of the researcher should be provided. A general personal reflexivity account is provided at the end of this chapter, as well as individual study reflections at the end of each empirical chapter. Evaluative rigour refers to the consideration of ethical issues by the researcher, with the need to obtain ethical approval from the appropriate board. Therefore, the researcher must consider key ethical policies, including informed consent, participant information and debrief. Strategies to ensure minimal participant distress, if/when appropriate, should be established. For the present thesis, all studies were provided with ethical approval from the University of Westminster (see Appendix N). Ethical issues concerning all studies are discussed in the following section.

6. *Transferability*

The final criteria relate to the generalisability of the findings, and how these can be applied to other groups or settings. Further, how the findings can be applied and utilised in relation to current practice should be explored. The implications of both studies one-three on university and

supporter populations have been considered and are presented in detail within the results chapters of each study (chapters five-seven). In summary, this research allows for an under-researched group to be considered, providing insight into the experiences of students and those providing support. Key areas that require improvement and development to effectively support this vulnerable group were highlighted.

In line with these six pointers, the consolidated criteria for reporting qualitative research (COREQ) was adopted throughout this thesis to establish a comprehensive account of the qualitative approach. The COREQ is a 32-item checklist for reporting qualitative research, specifically interviews and focus groups, comprising three overarching domains: 1) Research Team and Reflexivity (e.g., credentials and occupation), 2) Study Design (e.g., theoretical framework and sampling), and 3) Analysis and Findings (e.g., presentation and description of themes) (Tong et al., 2007) (see Appendix M).

4.5 Ethical Considerations

When conducting research exploring self-harm, researchers should be aware of the main ethical considerations specific to this population. Access and recruitment can be challenging due to the emotional nature of this topic. Further, awareness and caution of the possible vulnerabilities of this group need to be acknowledged by implementing key strategies to prevent distress amongst participants. For example, providing individuals with a list of supportive resources and asking participants to complete a safety plan should the researcher have any concerns following participation (Draucker et al., 2009). Whilst this is important to recognise, exploration of delicate topics, and specifically self-harm, are often viewed as a positive and cathartic experience by participants (Biddle et al., 2013).

Due to the sensitivity of this topic, ensuring anonymity and confidentiality is vital. For study one this played little part due to responses being recorded anonymously. However, participants were invited to leave their email addresses should they wish to be entered into a voucher draw, or if they wanted to be kept updated with the outcomes of the study. Further, on completion of the questionnaire, participants had the opportunity to leave their contact details to partake in further research, including one-to-one interviews (studies two and three). Participants were informed at the beginning of the questionnaire that if they left their contact details these would be available to the research team and therefore anonymity of responses within the research team could no longer be guaranteed. For qualitative interviews conducted as part of studies two and three, ensuring confidentiality and anonymity was paramount to allow the participant to feel relaxed and comfortable when sharing potentially vulnerable and sensitive information about their own experiences, and also the experiences of others (i.e., friends, children, clients etc) (Baez, 2002). Whilst they were known to the researcher, pseudonyms were assigned and any identifiable information removed when writing up the findings of these studies (see chapters six and seven).

4.5.1 Ethical Protocol

All studies conducted as part of this thesis received ethical approval from the University of Westminster Ethics Committee (see Appendix N). The British Psychological Society (BPS) ethical guidelines and standards (BPS, 2014) were always adhered to when designing and implementing this project, ensuring maximum benefit and minimum harm from this research. For all studies in this thesis, participants were provided with an information sheet about the study, explaining what participants could expect from taking part (see Appendix O). Participants had the opportunity to discontinue the research if they did not feel happy with what the study

would entail. For study one, participants had the right to withdraw at any time by exiting from the questionnaire. Written (either electronically or in person) informed consent was collected from all participants (see Appendix P). Either on completion of the questionnaire or on exiting, participants were automatically presented with a debrief page, providing contact details of the research team, as well as a list of resources detailing who they could contact should they feel any distress from completing the questionnaire (see Appendix Q). These resources were also provided within the information sheets at the beginning of the questionnaire (see Appendix O).

Interview participants (Study two and three) completed a personalised safety plan before the interview took place (see Appendix R), including a study overview and a requirement to provide the details of a named individual who they consented to be contacted should the researcher feel they have any concerns about the participant's safety. Advice on what to do should they feel distressed after the interview, including a list of resources, specifically self-help websites and phone numbers (e.g., Samaritans), were also provided. All participants were encouraged to use these if they expressed that any of the questions had caused them to feel any psychological distress, or if they felt worried about another individual’s self-harming behaviours. Further to this, participants' emotional state was measured before and after the interview using a Visual Analogue Scale (VAS) (see Appendix S). The VAS is a visual illustration for subjectively rating emotional state on a scale of 0–100, with 0 being the worst emotional state they could experience, and 100 being the best. These tools have been commonly used in self-harm and suicide-based research as a means of monitoring participant mood due to the emotive nature of these topics (Biddle et al., 2013).

When exploring sensitive issues and monitoring participant safety, I (the doctoral researcher) also drew upon my relevant experience and training within the field of mental health. Prior to

undertaking my PhD, I had completed an MSc in Clinical Mental Health Sciences, alongside working in NHS and voluntary settings. As part of these roles, I had undertaken safeguarding and risk training, suicide and self-harm awareness courses, and active listening workshops. Whilst completing my PhD, I worked as an assistant psychologist in two NHS services, involving therapeutic work with individuals who self-harmed and were experiencing suicidal ideations. Further, I had also encountered additional risk and social issues impacting the lives of many service users (e.g., domestic violence, financial constraints, housing difficulties etc). The influence of these experiences on the development of this thesis are further considered below (see section 4.6 – personal reflexivity). Therefore, the VAS enabled the researcher, alongside professional judgement, to monitor any participant distress resulting from taking part and implement any safety plan procedures when necessary. All participants were reminded throughout interviews that they had the right to withdraw from the study at any time. During the interviews, the researcher reassured participants that they could stop answering questions at any time, and/or could take a break or move on if they felt uncomfortable or distressed by a particular question.

4.5.2 Exclusion Criteria

For all studies within this thesis, the same exclusion criteria were applied. Participants under the age of eighteen years and those studying at a university outside of the UK were excluded. Given the sensitive nature of the interview topics within this research, the specific focus on self-harm, and that the research was conducted outside of a clinical setting in which thorough risk assessments are not possible, those who had attempted suicide in the last six months and/or those actively experiencing suicidal thoughts were excluded. Previous research suggests that following

a suicide attempt the risk of a repeated attempt is particularly high in the following six-month period (Inagaki et al., 2019; Kapur et al., 2006). Evidence also suggests that exploring trauma shortly after the event can negatively impact normal recovery processes (Brewin, 2001) and increase helplessness (Everstine & Everstine, 1993). If students had experienced suicide attempts (i.e., more than six months ago) or suicidal ideations previously, this was only discussed where relevant to their self-harm during university.

Following recommendations from the University of Westminster ethics committee, any individuals known to the researcher were excluded from studies two and three and not contacted for participation in an interview. This was to protect the confidentiality of the individual and prevent bias during data collection and interpretation.

4.6 Personal Reflexivity - The Doctoral Researcher

As discussed in section 4.4, the use of personal reflexivity is crucial within qualitative research for several reasons. Firstly, to provide the researcher with a safe space to reflect on and acknowledge their feelings and emotions when conducting research, especially amongst sensitive and vulnerable groups. Further, it also acknowledges the researchers' stance and personal experiences which may influence data collection and interpretation, allowing the validity and reliability of the findings to be assessed. Reflexivity is an overarching domain within the COREQ.

My interest in this area of research was initiated during my BSc in Psychology and Master's in Clinical Mental Health Sciences. As part of my MSc, I had the opportunity to complete a placement as an honorary assistant psychologist working in an adult mental health service. Further, I was a volunteer across several organisations including Mind, ChildLine, and Great Ormond Street Children’s Hospital. When starting my PhD, I was working as an assistant

psychologist in CAMHS (Child and Adolescent Mental Health Service) and more recently, at Alder Hey Children's Hospital. Through these roles, I became aware of the difficulties faced by individuals earlier in their lives and became particularly interested in the impact of studying alongside additional life stressors. When conducting and designing my PhD research, I drew upon these experiences of working in clinical settings with individuals experiencing mental health difficulties, specifically self-harm. From these roles, I have undertaken extensive training in building rapport, displaying empathy, and listening skills, as well as an awareness of different therapeutic approaches with individuals of all ages and backgrounds. I feel that this has been a particularly positive asset when carrying out my doctoral research and allowed me to feel comfortable and confident in exploring potentially sensitive issues. However, at times, I had to ensure that I did not try to use therapeutic techniques and that clear boundaries were maintained between myself and the participants (e.g., maintaining a neutral stance).

For both qualitative studies presented in this thesis, individual reflective accounts have been included (chapters six and seven). Following every interview, I kept a journal of my thoughts and feelings regarding how the interview went and any improvements that I felt I could make going forward. This offered insight into my personal experiences and an opportunity to consider the context of each interview (Sullivan et al., 2012), promoting rigour and reflexivity. This also helped to guide future interviews and developed my skills as a qualitative researcher. I thoroughly enjoyed conducting all my interviews and feel extremely privileged that participants felt able to open up and share their personal stories and journeys with me. I very much hope that the findings within this thesis can be used to support students engaging in self-harm, and those individuals providing support and care for them.

5. Chapter Five: Study One - Exploring Student Emotions, Self-Harm and Experiences of Seeking and Providing Support in Higher Education

5.1. Introduction

This chapter presents data collated as part of two online questionnaires aimed at exploring experiences of personal self-harm and providing support to people who self-harm within a university setting. As discussed in chapter two, this study aimed to build upon the work of Borrill et al. (2009) using a series of psychosocial measures and open-ended questions related to self-harm and support provisions within universities.

5.1.1 Aims

This study had five overarching aims:

1. What are the most common methods and functions of self-harm reported amongst university students?
2. Are there differences between scores on psychosocial measures of friendship, emotional inhibition, rumination, and alexithymia between students who report lifetime self-harm and those with no experience of personal self-harm?
3. Are there differences between scores on psychosocial measures of friendship, emotional inhibition, rumination, and alexithymia between students with experience of supporting self-harm and those with no experience of supporting self-harm?
4. To explore experiences of those providing support for students engaging in self-harm.

5. To explore experiences and awareness of support services amongst current UK university students and identify any differences in experiences of help-seeking for students engaging in self-harm.

5.2. Method

Data presented in the current chapter were collected over two separate questionnaires. Initially, students with experiences of self-harm over their lifetime, or those who had provided support for another student engaging in self-harm, were recruited to take part. As a result of the initial questionnaire mostly collating psychometric data for students indicating lifetime self-harm, a comparison group of students with no experience of self-harm was needed. Therefore, an adapted version of the first questionnaire (version II) was produced, utilising a wider recruitment strategy.

5.2.1 Participants and Recruitment

For both questionnaire versions, all universities across the UK were contacted and asked to advertise the study to their students. A list of all UK universities (n=143) in 2018, taken from the complete universities guide website, was used to collate contact details from university websites of student union (SU) teams, as well as well-being and support services. These individuals and/or teams were then contacted by the researcher to inform them about the research and ask for their aid in recruitment. Most universities were contacted, with exceptions to those in which contact details were not accessible to external parties. Further, several key organisations and charities aimed at supporting students and/or self-harm posted the study on their website and/or distributed among their users and staff (e.g., Mind, Student Minds, Nightline and The Wish

Centre). Recruitment of participants also took place through advertisement on social media platforms such as Twitter, as well as poster and leaflet distribution throughout universities and student organisations in the UK (see Appendix T). A direct link to the questionnaire, with further information about the study on opening, was used. Ethical Approval was granted by the University of Westminster ethics committee (*ETH1617-0083)* (see Appendix N). Psychology students at the University of Westminster received credits for taking part through the research participation scheme (RPS). Across the two questionnaires, a total of 493 participants took part. Following application of the exclusion criteria (see chapter four, section 4.5.2), a final sample of 399 participants who were currently studying at a UK university were included. Figure 14 provides a survey flow overview, including participant numbers, across the two questionnaire versions. An overview of participant demographics are presented in Table 1.

Figure 14

Overview of Participant Numbers and Survey Flow for Questionnaire Versions I and II

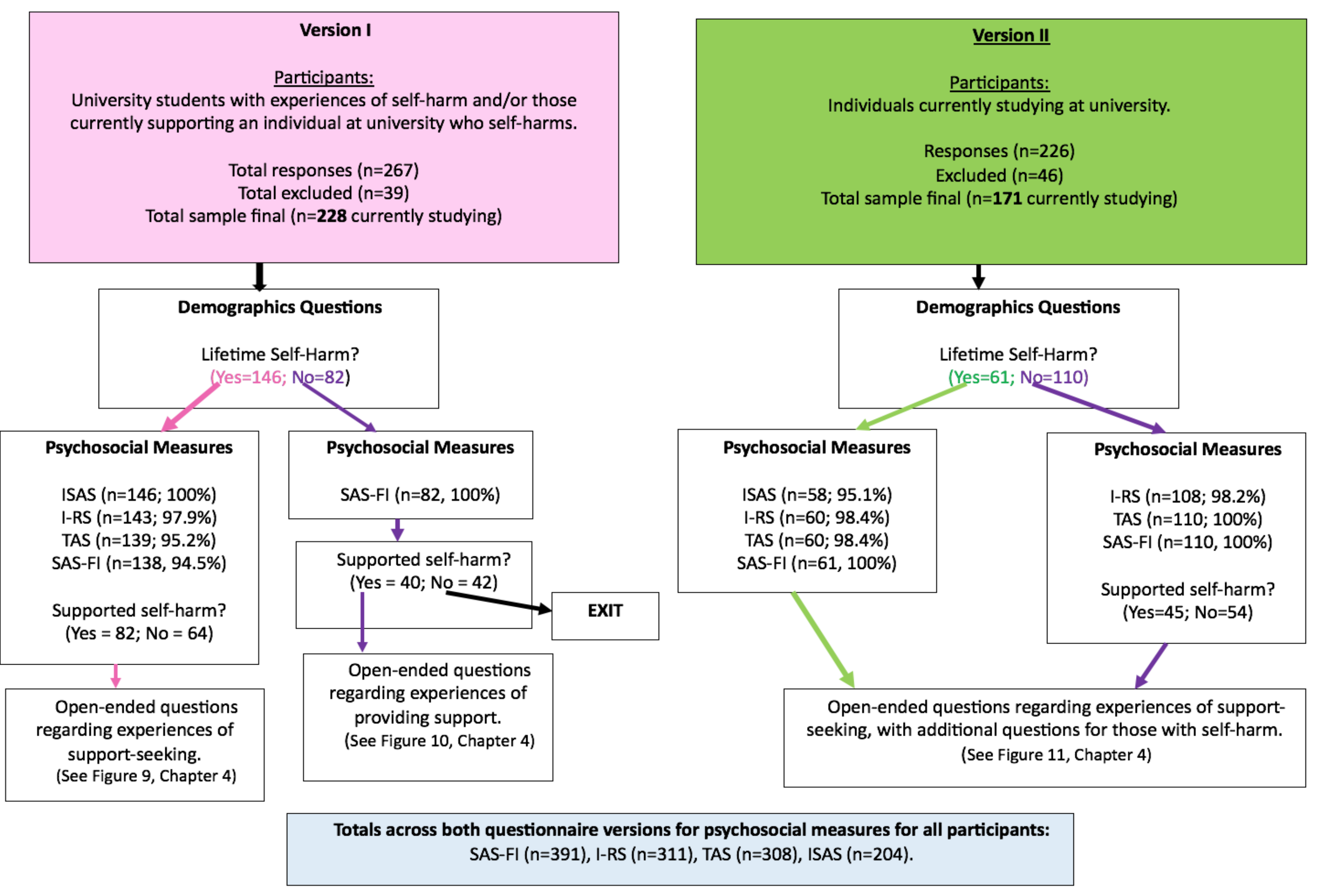


Table 1

Study One Participant Demographics for Whole Sample

Characteristic	**Whole Sample**	
	N	Valid %
Gender		
Female	325	81.4
Male	61	15.2
Gender Variant/Non-Conforming	6	1.5
Transgender Male	6	1.5
Other	1	0.4
Missing	-	-
Ethnicity		
White	278	70.2
Asian or Asian British	71	17.9
Black, African, Caribbean, or Black British	18	4.5
Mixed or multiple ethnic groups	16	4.1
Other	13	3.3
Missing	3	-
Marital Status		
Single	326	82.7
Married, or in a domestic partnership	61	15.4
Divorced	3	0.8
Widowed	1	0.3
Separated	3	0.8
Missing	5	-
Highest Qualification		
GCE/A-levels/BTEC National Diploma/Higher School Certificate	260	65.5

GCSE/O-Levels/CSE	9	2.3
Bachelors/Undergraduate Degree	89	22.4
Master’s Degree	37	9.3
Doctorate	2	0.5
Missing	2	-
University Country		
England	318	80.1
Northern Ireland	10	2.5
Scotland	26	6.6
Wales	43	10.8
Missing	2	-
University Study Year		
First Year	170	42.6
Second Year	102	25.6
Third Year	60	15.0
Fourth Year	26	6.5
Other	41	10.3
Missing	-	-
Number of years studying at university		
<6 months	119	29.9
6 months – 1 year	51	12.8
1-2 years	110	27.6
2-3 years	54	13.6
>3 years	64	16.1
Missing	1	-
Degree level currently being studied		
Foundation Degree	10	2.5

Undergraduate Degree	316	79.2
Postgraduate Degree	73	18.3
Missing	-	-

5.2.2 Psychosocial Measure and Open-Ended Questions

A detailed overview of the psychosocial measures and open-ended questions included within both questionnaire versions is detailed in chapter four (see sections 4.2.1 and 4.2.2). For the purpose of the reader, a brief overview is included here. Across both questionnaires, participants were asked to complete a series of demographic questions including age, gender, ethnicity, marital status, and highest qualification level. Specific demographics related to university were also collated such as the country in which their university was located, current year of study, number of years studying, and degree level being studied (see Table 1). For students who indicated lifetime self-harm, additional demographics related to age of first self-harm, main method of self-harm, whether they wished to stop self-harming, and whether they had ever sought support for self-harm were included (i.e., ISAS – Section I). Further, functions of self-harm were assessed using the ISAS-II Short Form, with a higher score indicating greater endorsement of that specific function (see Appendix A). As the ISAS was only completed by those reporting lifetime self-harm, analyses are presented separately below. Open-ended questions included reflections from students with and without experiences of a) self-harm and/or b) providing support for another student/s, including personal experiences of help-seeking and awareness of university support.

Friendship was measured using the Self-Report Friendship Index of the social adjustment scale (SAS-FI), consisting of a total score, as well as two subscales measuring quantity and

quality of friendship (Marver et al., 2017) (see Appendix D). For the total score, higher scores indicate greater impairment in quality and frequency of recent friendship contacts. Higher quality scores indicate greater impairment in friendship quality (e.g., closeness and relational stress), and higher quantity scores indicate greater impairment in friendship quantity (e.g., number of friends and frequency of contacts). Alexithymia was measured using the 20-item Toronto Alexithymia Scale (TAS-20) (Bagby et al., 2003) (see Appendix B), with the following scoring categories: ≤ 51 = Non-Alexithymia, 52-60 = Possible Alexithymia and ≥61 = Alexithymia. The TAS is made up of three subscales capturing difficulty identifying feelings, difficulty describing feelings, and externally-oriented thinking, with higher scores indicating greater impairment on that specific domain. Emotion Inhibition (EI) and Rumination were measured using the 39-item Inhibition-Rumination Scale (I-RS) (Roger & Najarian, 1989; Roger at al., 2011), with higher scores showing greater inhibition/rumination. An overview of the psychosocial measures completed in each version of the questionnaire and for which groups is presented in Table 2.

Table 2

Overview of Measures Completed for Those with Lifetime Self-Harm vs No Lifetime Self-Harm by Questionnaire Version

Questionnaire Version	Measure			
	ISAS	SAS-FI	TAS	I-RS
I				
Lifetime Self-Harm	✓	✓	✓	✓
No Lifetime Self-Harm	N/A	✓	-	-
II				
Lifetime Self-Harm	✓	✓	✓	✓
No Lifetime Self-Harm	N/A	✓	✓	✓

Note. ISAS = Inventory of Statements About Self-Injury, SAS = Social Adjustment Scale – Friendship Index, TAS = Toronto Alexithymia Scale, I-RS = Inhibition-Rumination Scale. N/A = Not Applicable, ISAS measure not distributed to those with no experience of self-harm.
✓ = Measure Completed. - = Measure not presented to this group.

5.2.3 Statistical Analysis

All measures were scored in line with their individual scoring guidelines (see chapter four, section 4.2.1). Due to an error in questionnaire design, question 20 from the TAS was missing for all participants. Similarly to the procedure followed for missing responses, participants' individual scores were used to compute a mean value. Descriptive and frequency statistics were produced for demographics and self-harm data using IBM SPSS Statistics, Version 25. Mean

scores across measures were compared using independent samples t-tests for students with lifetime self-harm vs students with no lifetime self-harm, and students with experience of supporting self-harm vs non-supporters. A one-way between-subjects analysis of variance (ANOVA) was conducted to compare mean scale scores across the four participant subgroups. Assumptions for parametric tests (i.e., normality, linearity, and equality of variance) were checked and met prior to running statistical tests. To avoid exclusion of any further participants, Winsor scores were calculated and applied for normality outliers on the SAS quality sub-scale. A binary logistic regression was conducted to determine the contribution of psychosocial measures in predicting lifetime self-harm among university students.

To determine reliability, correlations using Cronbach's alpha were produced for scales and subscales where applicable. Due to conducting multiple statistical tests, Bonferroni calculations were performed. For the overall scores on the SAS-FI and TAS, as well as scores for EI and Rumination on the I-RS, equating to four statistical tests, an adjusted p-value of .0125 was established. For subtest calculations, in which nine tests were performed, a further adjusted p-value of .006 was used.

5.2.4 Qualitative Analysis

Data gathered from open-ended questions were collated across the two questionnaires and analysed using TA, with a critical realist (CR) epistemological position taken (see methods section 4.3.1 for further details). This included reflections from students with and without experiences of a) self-harm and/or b) providing support for another student/s. Due to the differing questionnaire branches (see chapter 4), the amount of qualitative data differed between questionnaires and specific questions. A semantic approach to coding was taken, with analysis

carried out in line with Braun and Clarke's (2006, 2019) 15-point checklist stages of TA (see chapter four, section 4.3.2 for a more in-depth overview). Open-ended questionnaire data were read several times to allow the researcher to familiarise with the data. Initial coding was then carried out based on individual responses to each specific qualitative question, followed by team meetings to discuss interpretations and resolve any discrepancies and uncertainties. A thematic map was used to summarise the data into overarching categories (see Appendix H), resulting in the development of final themes to reflect the patterns within the data set (Braun & Clarke, 2006, p.82).

5.3 Results

5.3.1 Scale Descriptives and Reliability for Psychosocial Measures

Descriptive statistics and reliability scores were calculated for all scales included within both questionnaire versions (i.e., SAS-FI, I-RS, TAS and ISAS-II) (see Table 3). The I-RS, TAS and ISAS-II indicated good reliability. The TAS externally-oriented domain, and the SAS-FI indicated fair reliability, though scores were comparable to that reported in the literature (Bagby et al., 2020; Marver et al., 2017). Pearson's correlations were conducted for the three measures completed by the whole sample, with all items positively correlated (see Table 4).

Table 3

Reliability and Descriptive Statistics for all SAS-FI, I-RS, TAS and ISAS-II Responses Across Both Questionnaire Versions

Measure	Descriptor						
	N	*M*	*SD*	Poss Min-Max Score	Sample Min- Max Score	α	Adjusted p-value
SAS-FI							
Quality Index	391	7.4	2.8	4-24	3.3 - 19.5	.62	.006
Quantity Index	391	6.4	2.4	3-15	2.3 - 11.7	.62	.006
SAS-SR Total	391	2.5	.8	1-5.6	1.0 - 5.6	.72	.013
I-RS						.90	
Emotional Inhibition	311	11.1	5.4	0–21	0-21	.98	.013
Rumination	311	12.6	4.7	0–18	0-18	.98	.013
TAS							
Difficulty identifying feelings	308	20.8	7.4	7-35	7-35	.96	.006
Difficulty describing feelings	308	15.8	5.1	5-25	5-25	.85	.006
Externally oriented thinking	308	18.6	4.8	8-40	8.3- 33.1	.68	.006
Alexithymia Total	308	55.2	14.3	20-100	22.1-91.6	.89	.013

<u>ISAS – Functions (Short Form)</u>						.82
Affect Regulation	204	3.2	1.1	0-4	0-4	.68
Interpersonal Boundaries	204	0.8	1.1	0-4	0-4	.71
Self-Punishment	204	3.1	1.2	0-4	0-4	.83
Self-Care	204	0.6	1.0	0-4	0-4	.69
Anti-Dissociation/Feeling-Generation	204	2.2	1.5	0-4	0-4	.82
Anti-Suicide	204	1.5	1.4	0-4	0-4	.80
Sensation-Seeking	204	0.3	0.7	0-4	0-4	.18
Peer-Bonding	204	0.1	0.3	0-4	0-4	.45
Interpersonal Influence	204	1.0	1.2	0-4	0-4	.75
Toughness	204	1.1	1.2	0-4	0-4	.75
Marking Distress	204	2.2	1.4	0-4	0-4	.76
Revenge	204	0.4	0.9	0-4	0-4	.76
Autonomy	204	0.6	1.0	0-4	0-4	.74

Note. SAS-FI = Social Adjustment Scale – Friendship Index, I-RS = Inhibition-Rumination Scale, TAS = Toronto Alexithymia Scale, ISAS = Inventory of Statements About Self-Injury. Differences in the number of participants completing the SAS and I-RS/TAS are due to I-RS and TAS only being completed by all participants on questionnaire version II. The ISAS was only completed by those reporting lifetime self-harm and analysed separately, therefore not requiring an adjusted p-value. For SAS-FI, higher mean scores on indexes and total score indicate greater impairment.

Table 4

Pearson's Correlations for Total and Subscale Scores Across Psychosocial Measures for the Whole Sample

Domain	SAS-FI Total	SAS-FI Quality	SAS-FI Quantity	I-RS EI	I-RS R	TAS DIF	TAS DDF	TAS EOT	TAS Total
SAS-FI Total	-								
SAS-FI Quality Index	.85***	-							
SAS-FI Quantity Index	.75***	.35***	-						
I-RS EI	.43***	.39***	.28***	-					
I-RS R	.36***	.34***	.14**	.34**	-				
TAS DIF	.38***	.36***	.17**	.44***	.59***	-			
TAS DDF	.37***	.34***	.20***	.68***	.46***	.71***	-		
TAS EOT	.34***	.30***	.26***	.50***	.20***	.39***	.46***	-	
TAS Total	.44***	.40***	.24***	.63***	.53***	.89***	.87***	.70***	-

Note. SAS-FI = Social Adjustment Scale – Friendship Index, I-RS = Inhibition-Rumination Scale, TAS = Toronto Alexithymia Scale. EI = Emotional Inhibition; R = Rumination; DIF = Difficulty Identifying Feelings; DDF = Difficulty Describing Feelings; EOT = Externally-Oriented Thinking; TAS Total = Total Alexithymia Score

**p<.01, ***p<.001

5.3.2 Student Self-Harm – Psychosocial Measures

A total of 207 students (51.9%) reported that they had self-harmed within their lifetime, of which 204 proceeded to complete the ISAS. Section I of the ISAS highlighted that cutting was the most common method of self-harm reported (42.7%; N=85), followed by severe scratching (9.3%; N=19). Over a quarter stated that they used two or more methods of self-harm (26.0%; N=53). The average age of initial self-harm was 14.17 (range 5 - 24 years), and over half indicated that <1 hour passed between the urge and act of self-harm (59.3%, N=121). Experiences of physical pain when self-harming were reported as occurring all the time or sometimes by 93.6% (N=191), and 87.3% were always alone when they self-harmed (N=178). The majority reported that they wished to stop engaging in self-harm (82.8%; N=169).

Answers to the fixed-response questions devised by the researcher indicated that, of the participants asked (i.e., those completing questionnaire version II with lifetime self-harm (N=61)), 39.3% (N=24) had self-harmed since attending university. Across both questionnaires, more than half of participants had never received support specifically for their self-harm (52.0%, N=106). Qualitative data relating to experiences of self-harm and support-seeking are further explored below.

On the ISAS-II, 'Affect Regulation' was the greatest endorsed function of self-harm (96.6%; N=197), followed by 'Self-Punishment' (94.1%; N=192). Of the remaining functions, five were indicated as being present based on mean scores >1 (Anti-Dissociation/Feeling-Generation; Anti-Suicide; Interpersonal Influence; Toughness and Marking Distress), whilst six had mean values of <1 (Interpersonal Boundaries; Self-Care; Sensation-Seeking; Peer-Bonding; Revenge and Autonomy) and therefore were not detected as functions of self-harm amongst this sample (see Table 3).

Mean scores for students who reported lifetime self-harm trended higher when compared to those who reported no self-harm across SAS-FI, TAS and I-RS, indicating greater difficulty with friendships and heightened rates of alexithymia and rumination (see Table 6). These differences reached statistical significance on the total friendship score ($p=.001$), quality friendship index ($p<.001$), rumination ($p<.001$), emotional inhibition ($P<.001$), total alexithymia ($P<.001$), difficulty identifying feelings ($P<.001$) and difficulty describing feelings ($P<.001$) (see Table 6), suggesting greater impairment in quality and frequency of recent friendship contacts and higher rates of rumination, emotional inhibition and alexithymia amongst students who report lifetime self-harm.

Table 6

Descriptive Statistics for SAS-FI, I-RS and TAS Scores by Self-Harm Status

Measure	Self-Harm Status							
	Lifetime Self-Harm			No Lifetime Self-Harm				
	N	*M*	*SD*	*N*	*M*	*SD*	*t*	Cohen's d
SAS-FI								
Quality Index	199	8.1	3.1	192	6.7	2.4	4.8*	2.3
Quantity Index	199	6.8	2.4	192	6.0	2.3	3.6	2.4
SAS-FI Total	199	2.7	.8	192	2.2	.6	6.5*	.7
I-RS								
Emotional Inhibition	203	12.2	5.1	108	8.9	5.2	5.4*	5.2
Rumination	203	14.2	3.6	108	9.5	5.0	9.5*	4.1
TAS								
Difficulty identifying feelings	198	23.2	6.3	110	16.4	7.0	8.9*	6.6
Difficulty describing feelings	198	17.1	4.6	110	13.2	4.9	7.0*	4.7
Externally oriented thinking	198	19.1	4.7	110	17.9	4.8	2.2	4.7
Alexithymia Total	198	59.4	12.9	110	47.5	13.5	7.7*	13.1

Note. SAS-FI = Social Adjustment Scale – Friendship Index, I-RS = Inhibition-Rumination Scale, TAS = Toronto Alexithymia Scale. For SAS-FI, higher mean scores on indexes and total score indicate greater impairment.
$p <$ adjusted p-value of .01

A logistic regression was performed with self-harm status as the dependent variable (i.e., lifetime self-harm vs no lifetime self-harm), and total friendship score (SAS total), Rumination, EI, and total alexithymia score (TAS total) as predictor variables. A total of 303 cases were

analysed, and the overall model significantly predicted self-harm status (omnibus x^2 (4) = 83.60, $p<.001$). The model accounted for between 24.1% and 33.1% of the variance in self-harm status, with 86.7% of those who engage in self-harm predicted. Predictions for those with no self-harm were accurate for 51.9%. Overall, 74.3% of predictions were accurate. Of the predictor variables, rumination (B = -.19, $p<.001$) and total alexithymia (B = -.03, p=.04) solely predicted self-harm status. Coefficient values indicate that an increase in rumination and alexithymia scores are associated with a decrease in the odds of not self-harming by a factor of 0.83 (95% CI 0.77 and 0.89) for rumination and 0.97 (95% CI 0.95 and 1.0) for alexithymia.

5.3.3 Providing Support for Students who Self-Harm – Psychosocial Measures

Of the 327 participants who responded, a total of 167 participants (50.9%) reported that they had provided support for another student engaging in self-harm. Across mean scores of friendship, rumination, EI and alexithymia, no statistically significant differences were detected between those who had experience of providing support for another student engaging in self-harm, and those with no experience of support (see Table 7). These findings indicate that the role of providing support for self-harm does not impact on these factors.

Table 7

Mean and Standard Deviations for SAS-FI, I-RS and TAS Scores by Supporter Status

Measure	**Supporter status**							
	Self-Harm Supporter			No support for Self-Harm				
	N	*Mean*	*SD*	*N*	*Mean*	*SD*	*t*	Cohen's d
SAS-FI								
Quality Index	167	7.1	2.3	160	7.2	2.4	-.33	2.31
Quantity Index	167	5.9	2.3	160	6.5	2.5	-2.03	2.38
SAS-SR Total	167	2.4	.7	160	2.4	.7	-1.21	.68
I-RS								
Emotional Inhibition	126	10.8	5.0	118	11.1	5.6	-4.17	5.33
Rumination	126	12.9	4.7	118	11.7	5.0	1.88	4.85
TAS								
Difficulty Identifying Feelings	127	21.0	7.4	118	19.8	7.6	1.30	7.47
Difficulty Describing Feelings	127	15.6	5.1	118	15.8	5.3	-.28	5.16
Externally Oriented Thinking	127	18.1	4.8	118	19.3	5.1	-2.0	4.94
Alexithymia Total	127	54.7	14.2	118	54.6	15.1	.01	14.63

Note. SAS-FI = Social Adjustment Scale – Friendship Index, I-RS = Inhibition-Rumination Scale, TAS = Toronto Alexithymia Scale. For SAS-FI, higher mean scores on indexes and total score indicate greater impairment.

For individuals who had provided support for self-harm vs those with no experience of providing support, subgroup analyses were conducted in which self-harm status was also considered. As a result, four distinct groups were identified: 1) No personal self-harm and no experiences of giving support; 2) No personal self-harm and experiences of giving support; 3)

Personal self-harm and no experiences of giving support; and 4) Personal self-harm and experiences of giving support.

There was a statically significant difference between groups as determined by a one-way ANOVA across all measures and subscales (see Table 8). Bonferroni post hoc calculations revealed that across all domains on the SAS-FI, I-RS and TAS, mean scores were significantly higher for those with personal experiences of self-harm compared to those with no personal experiences of self-harm, regardless of supporter status (see Table 8). These findings suggest that experiences of personal self-harm compared to experiences of support are more influential in increased difficulties with friendship quality and number of friendship contacts, EI, rumination, and alexithymia.

Table 8

ANOVA Results Broken Down by Self-Harm and Supporter Subgroups

Measure	**Supporter/Self-Harm Subgroup**												
	No personal SH/No support			No personal SH/SH Supporter			Personal SH/No support			Personal SH/SH Supporter			
	N	*M*	*SD*	*N*	*M*	*SD*	*N*	*M*	*SD*	*N*	*M*	*SD*	F(df)
SAS-FI													
Quality Index	106	6.6	2.0	85	6.7	2.0	54	8.5	2.5	82	7.6	2.5	11.19* (3,323)
Quantity Index	106	6.1	2.4	85	5.8	2.1	54	7.2	2.6	82	6.1	2.4	4.10* (3.323)
SAS-SR Total	106	2.4	.7	85	2.2	.6	54	2.8	.7	82	2.5	.7	5.43* (3,323)
I-RS													
Emotional Inhibition	64	9.0	5.3	44	8.7	5.2	54	13.6	5.1	82	11.9	4.6	12.19* (3,240)
Rumination	64	9.5	4.9	44	9.6	5.2	54	14.4	3.7	82	14.6	3.3	28.55* (3,240)
TAS													
Difficulty Identifying Feelings	64	16.5	7.1	45	16.1	7.0	54	23.7	6.3	82	23.6	6.1	24.78* (3,241)
Difficulty Describing Feelings	64	13.8	4.8	45	12.4	4.9	54	18.1	4.9	82	17.2	4.3	18.63* (3,241)
Externally Oriented Thinking	64	18.3	4.9	45	17.2	4.5	54	20.6	5.2	82	18.6	4.9	4.22* (3,241)
Alexithymia Total	64	48.6	13.5	45	45.7	13.4	54	62.2	13.8	82	59.4	12.0	20.83* (3,241)

Note. SAS-FI = Social Adjustment Scale – Friendship Index, I-RS = Inhibition-Rumination Scale, TAS = Toronto Alexithymia Scale, ISAS = Inventory of Statements About Self-Injury. SH = Self-Harm. For SAS-FI, higher mean scores on indexes and total score indicate greater impairment.

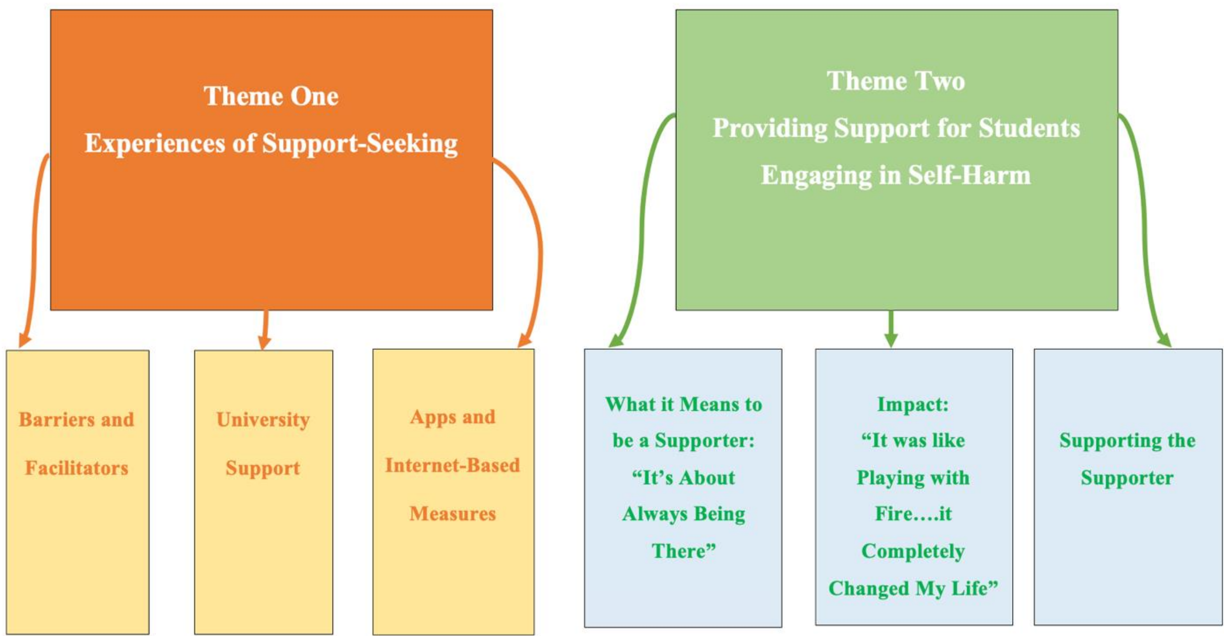
*$p<.01$

5.3.4 Experiences of Support: Descriptive and Qualitative Findings

Qualitative data from across study one questionnaires were combined. Consistency in experiences relating to help-seeking were apparent, regardless of whether students reported lifetime self-harm. Comments specific to self-harm, or providing support, are presented separately where applicable, with nuances and discrepancies explored within individual themes. Two overarching themes were identified: 1) Experiences of Support-Seeking, and 2) Providing Support for Students Engaging in Self-Harm, each with three corresponding sub-themes (see Figure 15).

Figure 15

Overarching Themes and Sub-Themes for the Open-Ended Questionnaire Data



5.3.4.1 Theme One: Experiences of Support-Seeking. Of the participants completing questionnaire version II, 39.3% (N=24) had self-harmed since attending university. Across both questionnaires, more than half of participants had never received support specifically for their self-harm (51.2%, N=106), despite the majority indicating that they wished to stop self-harming (82.6%, N=171). Amongst supporters, 70.1% (N=117) felt as though they needed support for themselves. However, experiences of directly receiving support and awareness of supportive organisations were limited.

For students with lifetime self-harm who had sought professional support (N=77, 55.8%), the most common types were counselling (N=63, 81.8%) and therapy (N=55, 71.4%), with CBT

most often specified. This was similar when considering the sub-sample of individuals who specifically indicated accessing university support in questionnaire version II (i.e., including general support and support for self-harm specifically) (N=56, 39.7%), however the use of tutors and lecturers were also noted by several participants (N=8, 14.3%). 'Samaritans' was the main support organisation noted, and 'Calm Harm' (N=19) and 'Headspace' (N=16) when asked about apps and internet-based measures. Qualitative experiences of support-seeking revealed three emergent themes: 1) Barriers and Facilitators, 2) University Support, and 3) Apps and Internet-Based Measures.

5.3.4.1.1 Barriers and Facilitators. Participants who had sought support (N=186) offered reflections on what had been both helpful and unhelpful about their general experiences of help-seeking. Positive reflections often related to having a safe space to share difficult emotions and receive advice, as well as providing explanations for why they may be experiencing challenging thoughts and feelings. One individual noted that whilst CBT did not help them in practice, it "helped me understand things in theory" and "did help me to help others".

Others noted that the helpfulness of support was limited by the number of sessions available and the individual delivering the support lacking confidence or guiding it in their own direction due to "having their own agenda". One student noted that they found it easier to seek support from family: "It's easier to confide in those you love in comparison to doctors". Individuals who had not sought support attributed this to a lack of awareness regarding how to access support, or a belief that it would not be helpful: "I didn't feel confident that it would change anything".

For those specifically with experiences of self-harm, the majority had not sought support due to a fear of being judged, not feeling as though their situation warranted support, or uncertainty regarding how their information would be shared: "I'm too scared they will put it on my record

(NHS) and then I will have to declare it for my entire life". Whilst some individuals with experiences of self-harm had accessed support for their general well-being and mental health, many had not disclosed their self-harm to therapists/counsellors due to similar worries regarding sharing of information and fear of being judged: "I went to therapy and told them a bunch of things, but never about self-harm. I was too ashamed and thought they wouldn't take me seriously…I also think others have it worse so there's no point saying anything". For those who had sought help, the majority did not feel as though their self-harm was adequately understood: "On occasions where self-harm has put me in hospital, I have found doctors unhelpful and felt judged and uncomfortable".

5.3.4.1.2 University Support. For participants completing questionnaire version II, a total of 39.7% (N=56) indicated that they had accessed support directly from their university, either for their own well-being as a supporter and/or for their self-harm. The majority (60.7%) rated the support they received as either very helpful (N=22) or somewhat helpful (N=12). All participants were asked about their general awareness and views around university support, with many sharing similar experiences regarding barriers and facilitators identified more broadly outside of university settings (i.e., fear of being judged). However, comments regarding university support specifically highlighted that service hours and availability of appointments frequently clashed with lectures, causing anxiety regarding missing studies and other people knowing, consequently preventing students from accessing sessions: "the support which university offers me is part-time in office hours. I have to skip lectures and seminars or work….I cannot afford skipping".

A lack of awareness of specific support available at university was indicated by 27.9% (N=39) of participants, with comments suggesting uncertainty regarding how to ask for support: "I'm not sure where or who to go too". Several students noted that they did not need to access

university support due to having friends and family who they are able to rely on. For those who had attempted but not successfully accessed support, reasons included significant waiting times, minimal numbers of sessions, and limited staffing within services:

> Our mental health services are a joke. They don't have enough staff to deal with the capacity of mental health issues. I think we literally have one councillor. I got offered 4 sessions that would have started in 8 months.

Suggested improvements to university support services included greater understanding of student mental health amongst tutors, sessions outside of teaching hours, education to reduce stigma around support-seeking, information about available support, and increased staffing to reduce waiting times: “Even though I’m aware where to get help, more work needs to be done to promote help-seeking behaviour, so students feel comfortable to express their worries”.

5.3.4.1.3 Apps and Internet-Based Measures. In total, 30.7% (N=67) of both supporters/individuals with experiences of self-harm had accessed apps/internet-based means of support, most often from ‘Calm Harm’ (N=19), ‘Headspace’ (N=16), and ‘Samaritans’ (N=10). Participants reflected that apps had been helpful in the short term, acting as a means of ‘distraction’ and providing encouragement to take part in different techniques (e.g., mindfulness and meditation). It was also noted that they could be easily accessed, and reduced the shame and stigma experienced by other support-seeking due to the anonymity of these platforms: “It's more accessible and good for a first step if too scared to speak in person”. The use of these platforms was particularly seen to be advantageous in the context of mental health difficulties, particularly for those who may be experiencing anxiety or depression which may reduce engagement in

alternative methods of support: “The advantage would be being able to access support at home when you have low mood or anxiety, leaving the house is difficult”.

Whilst apps and internet-based support were largely felt to have some benefits, others commented that the cost of some apps limited access and consequently, helpfulness. Further, the need for human contact and connection was discussed, particularly with regards to apps feeling impersonal, creating a sense of ‘disconnection’: “Disadvantages are being impersonal and cannot have the same level of intimacy to help in recovery as a session with a counsellor in person”.

5.3.4.2 Theme Two: Providing Support for Students Engaging in Self-Harm. Open-ended questionnaire data was collected for two distinct groups of self-harm supporters: 1) those with their own personal experiences of self-harm, and 2) those with no personal experiences of self-harm. Three subthemes were identified in relation to participants' experiences of supporting an individual/s engaging in self-harm: 1) What it Means to be a Supporter: “It’s About Always Being There”, 2) Impact: “It was like Playing with Fire…It Completely Changed My Life”, and 3) Supporting the Supporter.

5.3.4.2.1 What it Means to be a Supporter: “It’s About Always Being There”. Participants commented on their experiences of providing support, prompting reflections on the ways in which they offered care. Amongst supporters, there was a sense of needing to ‘always’ be available, with several stating that they told the individual to “call me anytime”. The platform of telephone calls as a means of providing support was most common, with one individual commenting: “I ring every day and night to make sure that nothing too serious is going on”.

Listening and offering a non-judgemental space, as well as providing a confidential and trustworthy relationship, were commonly noted when describing approaches to support and what their role involved: "...as a friend, I have the unique ability to comfort and support them with confidentiality and be there as a stable person/object with whom they can really have a dialogue with their emotions and feelings." Whilst emotional support strategies were frequent, others tended to focus more on practical methods of support, including taking the individual out, buying plasters/bandages, or accompanying them to the emergency department for medical attention.

Supporters without their own experiences of self-harm commented more frequently on the need for them to get the individual to stop self-harming and to seek professional help. Interestingly, those who had engaged in self-harm themselves recognised the difficulty in stopping, and instead focused more on sharing their own strategies and being understanding: "I share what has helped me and try to find information to share…I just listened when they wanted to speak and was there when they just needed a person". Views on reasons for engaging in self-harm were also shared, often relating to feeling overwhelmed and numb as a result of difficult situations (e.g., family circumstances). Several supporters without personal self-harm commented that they felt the motivation for engaging in self-harm was to seek attention: "the reason for doing it is for attention".

5.3.4.2.2 Impact: "It was like Playing with Fire… It Completely Changed My Life". Across questionnaires, 83.8% (N=140) of students had felt out of their depth as a supporter. Participants most often linked this to a lack of knowledge regarding self-harm, and in particular, not knowing what to say and/or fear of saying the wrong thing: "I just didn't know what to do….it was like playing with fire". The notion of openly exploring the individuals' triggers and the emotions they

were experiencing was felt to be more helpful than focusing directly on the self-harming behaviour/method: “I find it helpful to talk through the behaviour triggers rather than the actual behaviour….getting to the root of the problem rather than the superficial reasons.”

The impact of providing support on triggering, or even introducing the concept of self-harm was often mentioned: “It was actually how I was introduced to self-harm and first decided to try it”. Several individuals shared how it was “therapeutic” and validating to have a “shared understanding”, alongside offering a distraction: “It was helpful to be able to stop thinking about my own feelings and distract me by helping others”. However, the majority described a sense of being “hypocritical” due to their own self-harm. Interestingly, one individual commented on the conflict between their own experiences and the individual they provided support for: “Even though you have done it yourself it’s hard to understand the other person's perspective”. Further, for some, the supportive role acted as prevention for their own self-harm: “When providing support, I was able to find myself a bit more and use my friend as an example…I realised that regardless of whatever I’m feeling I should never use self-harm as a way to cope”. Across all supporters, providing support was frequently described as a “difficult”, “tiring” and “overwhelming” experience, with one participant reflecting that “it completely changed my life, it was exhausting”.

5.3.4.2.3 Supporting the Supporter. Ways of managing these experiences tended to relate to whether the individual had their own identified coping mechanisms. For some, it was particularly important to establish boundaries, and several spoke about “detaching” from the situation and/or the emotional impact. Others used their own support mechanisms to talk about their difficulties and the impact that providing support had on their own well-being (e.g., friends/family

members). This led to reflections about the importance of loved ones, with a sense of increased gratitude: "It made me realise how important it is to surround ourselves with people that love and care about us, they're the only ones that can get us out of these kinds of situations".

Several common coping strategies were identified, including journaling, meditation, listening to music and watching TV, with a preference for something "humorous" mentioned by several participants. Those with personal experiences of self-harm regularly referenced their own engagement in self-harm as a means of coping with their role as a supporter: "My primary coping mechanism was self-harming…I did try writing my feelings down and collecting them and then burning them too". Those with personal experiences of self-harm shared that having 'realistic expectations' of what could be achieved through their role as a supporter was important for both the individual and their own well-being: "You have to be understanding that they are not suddenly going to stop. Self-harm like many other things is an addictive behaviour and expecting someone to just stop, especially if they have mental health problems is unrealistic."

Comments relating to what would allow supporters to feel more supported themselves also suggested a need to reduce the stigma associated with self-harm by increasing awareness. Participants suggested that acceptance and education during school would be particularly helpful, as well as further information on healthcare websites*:* "perhaps more info available on NHS website on how to help a suicidal friend rather than just telling them to see a doctor". The idea of also requiring guidance from 'professionals' was noted in response to feeling uncertain about how to respond.

5.4 Discussion

Study one aimed to establish methods and functions of self-harm amongst university students, identify the role of alexithymia, rumination, friendship, and emotional inhibition on self-harm

status, and explore the experiences of students both providing and accessing support for self-harm. University students in the presented study reported both current and previous self-harming behaviours, which on average initiated during early teenage years. More than half of those individuals had never received support for their self-harm, despite the majority wishing to stop self-harming, with concerns regarding being judged and confidentiality. Of those asked, 39.3% had specifically self-harmed during their time at university. This shares similarity with previous findings in the UK and the US (e.g., Borrill et al., 2009; Gratz, 2006; Gratz & Chapman, 2007), whilst also extending the literature with the inclusion of students from multiple UK universities, alongside collating the views and experiences of both students who self-harm, and those providing support. The reports of feeling ashamed of self-harm, uncertainty about where to access support, and the need for tailored support for carers in university settings require attention.

The most common methods and functions of self-harm reported amongst students echo research among child and adolescent samples (i.e., cutting and affect regulation) (Madge et al., 2008; Klonsky & Glenn, 2009). For university students reporting lifetime self-harm, significantly greater difficulties with friendships, specifically reduced quality and contact, were reported. Given that the most common support systems for adolescent self-harm are friends and family (Rowe et al., 2014), with similar preferences expressed in the current study, the context of university may further isolate individuals with a history of self-harm from accessing their usual means of support and outlet, further increasing the level of stress experienced as a result of their studies (Ray et al., 2019). Isolation has been identified as a risk factor for higher stress and poor mental health across students, including both undergraduate and postgraduate cohorts (Hazell et al., 2020). This may also shed light on the increased rates of rumination among students in study

one, previously associated with reduced social connectedness (McMahon et al., 2022). Given the established link of these factors (i.e., limited social contact and rumination) with poorer mental and physical health (Alsarrani et al., 2022; Watkins & Roberts, 2020), and that the majority wished to stop self-harming, greater support for this group is crucial. Despite this, the present study revealed that more than half of students with a history of self-harm had not received or accessed any form of support.

Key barriers to accessing support specifically for self-harm, and satisfaction once accessed, were identified. Students commonly reported fear of judgement and shame around their self-harm, as well as concerns around how their disclosure and information would be handled. This appears to be a continuation of reservations reported among adolescent samples regarding help-seeking for self-harm (Rowe et al., 2014). Increasing the amount of information around confidentiality and service provisions, ensuring that this is accessible and widely available, may be beneficial in increasing support-seeking behaviours. Further, both rumination and alexithymia were significant in predicting self-harm status. Therefore, strategies for reducing negative ruminations, as well as identifying and regulating emotions (e.g., grounding and stabilisation skills) (Andover & Morris, 2014; Fisher, 2017), may be particularly important for university students with a history of self-harm. To fully establish these needs, further research exploring motivations and triggers specifically for student self-harm are needed.

Participant reflections also offer insight into the way in which support is delivered and accessed, both during university and wider afield, providing helpful pointers regarding support platforms. The mixed views of the desire to access face-to-face support to promote connection versus the advantages of apps and internet-based support in overcoming fears regarding disclosures, particularly for those self-harming, suggest that multiple avenues for promoting

supportive resources are required. The findings suggest that apps and internet support may be a particularly effective way for those who self-harm to initially access support, as well as alongside other means of help-seeking (Grist et al., 2018). Web, app-based support and psychoeducation have also been associated with improved well-being among those caring for individuals with chronic diseases and bipolar disorder (Fitriani & Suryadi, 2019; Lorca-Cabrera et al., 2020). Therefore, these platforms may provide an opportunity to address the concerns raised by supporters in study one regarding limited knowledge of self-harm and how to respond, whilst also providing a means of personal support. However, student supporters indicated a limited awareness of existing support organisations. Further, information targeted specifically at those in supportive and caring roles was felt to be lacking. Therefore, current support platforms likely require development to tailor resources for this group, as well as wider advertisement to increase awareness of existing provisions.

These findings offer a nuanced perspective to the experiences of those providing support for student self-harm, with just over half of participants undertaking supportive roles. Comments about their experiences of providing support for self-harm having negative impacts on their well-being, and the majority feeling out of their depth when giving support, are comparable to the existing carers literature (Byrne et al., 2008; Simpson et al., 2019; Hazell et al., 2021; Lascelles, 2021). However, it is also important to note that a sub-sample of individuals had both a history of self-harm and supporting roles, with suggestion that providing support may also act as a trigger for personal self-harm. Given the negative impact of caring for others on personal well-being, and the increased stress associated with studying at university (Beiter et al., 2015; Duffy et al., 2019; Smith, 2016), these individuals present a particularly vulnerable group, warranting further research exploring and identifying their own support needs.

5.5 Study Limitations

There are several limitations that are important to recognise for study one. As noted within the methods of this chapter, there were two versions of the questionnaire due to limitations of version I (i.e., no comparison group, and limited information specific to university self-harm). Whilst the revision of the questionnaire aimed to address these gaps, the sample size and data available regarding support-seeking and self-harm specifically within a university setting were limited to version II only. Additionally, although qualitative responses provided insight into participants' experiences, collection via an online questionnaire meant that length and depth of responses varied, with positive experiences often having less data available. It could also be difficult to determine whether comments related specifically to university experiences, limiting the study's ability to fully explore university support systems and triggers/motivations for self-harm within this context. Limitations relating to the wider thesis are considered in chapter eight.

5.6 Conclusion

This study builds on previous research by expanding the sample to university students across the UK, as well as exploring the well-being and impact of students providing support for another individual engaging in self-harm. An updated understanding of student self-harm within the UK is presented, identifying key functions of self-harm and support-seeking behaviours amongst this group. Whilst there is a need to quantify and measure self-harming behaviours, it is important to appreciate that with the sensitive nature of this topic, adjustments to detection and terminology may be required to truly understand the complexity of self-harm. Therefore, exploring views and perceptions of the way in which self-harm is defined from a student and supporter perspective may aid development of existing resources for self-harm regarding relatability and validation.

Further research is required to identify appropriate support methods and potential nuances in the support needs of university students, particularly those with a history of self-harm or caring for others. A more in-depth understanding of self-harm specifically in a university context, including triggers and experiences of support-seeking, as well as the impact of providing support for self-harm on an individual's own self-harming behaviours, are warranted. To do so, the next chapter (chapter six) presents the findings from a qualitative interview study with university students engaging in self-harm.

6. Chapter Six: Study Two - A Qualitative Exploration of Student Self-Harm and Experiences of Support-Seeking within a UK University Setting

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Edwards-Bailey, L., Cartwright, T., Smyth, N., & Mackenzie, J. M. (2022). A qualitative exploration of student self-harm and experiences of support-seeking within a UK university setting. *Counselling Psychology Quarterly*, 1-25. https://doi.org/10.1080/09515070.2022.2146054

6.1 Introduction

This chapter presents the findings of the second study conducted as part of this doctoral thesis. A qualitative interview design was employed to build on the findings presented in chapter five.

6.1.1 Aims

The current study aimed to qualitatively explore the experience of self-harm amongst UK university students across varying locations/institutions. To do so, students' own understanding and experiences of managing self-harm at university, including triggers, maintenance factors, coping strategies and support-seeking were considered. A specific focus was given to how these experiences changed or differed, if at all, since attending university. It is hoped that these findings will be useful in identifying ways in which universities and student services may need to be developed or adapted to provide effective and tailored support to this vulnerable group.

This study had three overarching aims:

1. To qualitatively explore experiences of self-harm amongst university students across varying university locations, including students' own understanding and experience of managing self-harm at university, as well as triggers, maintenance factors and coping strategies.
2. To explore experiences of support-seeking for self-harm whilst studying at university.
3. To determine how experiences of self-harm and support-seeking change or differed, if at all, since attending university.

6.2. Method

A qualitative semi-structured interview design was adopted. Qualitative interviews allow for the exploration of under-researched issues and 'hard-to-reach' groups (Ritchie et al., 2013), identifying the nuances and meanings of individual experiences in relation to a particular topic (Robertson et al., 2018). In line with the critical realist (CR) epistemological position taken, it was recognised that participant accounts provided information about a reality, without directly echoing reality (Harper, 2011). Therefore, to further understand participant experiences of self-harm in a university setting, the researcher offered a level of interpretation by critically reviewing findings within their wider context. A viewpoint that attending university and engaging in self-harm is an existing reality was taken, whilst recognising that each individual will have their own views on their involvement in both university life and self-harm. To understand and develop knowledge about the individual's involvement, students with experiences of self-harm during their time at university were invited to take part. A detailed rationale for the chosen methodology is provided in chapter four (see section 4.2.3).

6.2.1 Participants and Recruitment

Sixteen participants (13 Female, 2 Male, 1 Gender-Variant/Non-Conforming), aged 18-38 years (M=25.9 (±5.5)) with experiences of self-harm during their time studying at a UK university were interviewed (see Table 9). The sample included students from 13 different UK universities, with all participants reporting initiation of self-harm before attending university. Whilst self-reported methods of self-harm varied amongst the sample, cutting was most common (93.8%). The researcher had no prior relationship with interview participants.

The sample were recruited via the two online surveys reported in the previous chapter (chapter five). Those with experiences of self-harm specifically during university were invited to leave their contact details to partake in further research. Initially, the researcher monitored the questionnaire for participants who indicated an interest in further research and sent invitations for interviews on a rolling basis. Once several interviews had been conducted, a maximum variation sampling approach was adopted (Marshall, 1996), aiming to promote data collection from a wide range of perspectives by recognising key factors of variation and recruiting individuals who differ, as guided by these dimensions (Patton, 2014). Following several interviews, the characteristics and demographics of the sample were considered. Given that the majority of those who had taken part in an interview were white, British, female, London-based university students, those identifying with other genders (e.g., male/transgender) and ethnic groups, as well as those from differing UK university locations, were selected for interview. To widen the diversity of the sample, individuals who were not currently studying but had attended a UK university in the last three years, were included. This approach allowed for a deeper understanding by exploring a range of perspectives (Patton, 2002), recognising similarities and differences across the sample. Overall, 62.5% were current university students (n=10) (Table 9). All participants held or were currently completing an undergraduate or higher degree.

Table 9

Study Two Interview Participant Demographic Information

Participant	Gender	Age	Currently studying at university?	Degree level of study / highest degree level owned[a]	Time since leaving university (Years)	Ethnicity	Length of self-harm (Years)	UK University Location (Country)
Elaine	Female	20	Yes	UG[b]	-	White	6	England
Sam	Gender variant	19	Yes	UG	-	Asian/Asian British	6	England
Roberto	Male	30	Yes	UG	-	White Mixed	5	England
Tom	Male	20	Yes	UG	-	White	4	Wales
Alice	Female	22	Yes	UG	-	White	9	Scotland
Lucy	Female	28	Yes	PG[c]	-	White	10	England
Joanne	Female	29	No	PG	1	White	8	Scotland
Jessica	Female	28	No	UG	1	White	11	England
Sarah	Female	25	No	UG	1	White	9	Scotland
Steph	Female	38	No	UG	3	White	29	Wales
Vicky	Female	30	No	PG	2	Asian/Asian British	6	England
Sophie	Female	23	Yes	UG	-	White	7	Scotland
Charlotte	Female	31	No	UG	1	White	19	England
Amelia	Female	24	Yes	PG	-	White	14	England
Chloe	Female	30	Yes	PG	-	White	12	England
Camilla	Female	18	Yes	UG	-	White	2	England

Note. [a]Recorded as degree level being studied if currently attending university, or highest degree level owned to date for those who were no longer at university at the time of the interview.
[b]UG = Undergraduate
[c]PG = Postgraduate

6.2.2 Data Collection

A semi-structured interview schedule was devised following the framework for qualitative interviews guide (Kallio et al., 2016) (see chapter four, section 4.2.3.1). The interview schedule incorporated questions from previously developed interview agendas exploring self-harm amongst adolescents (e.g., Klineberg et al., 2013). These were also influenced by existing research amongst students relating to self-harm (e.g., Borrill et al., 2009) and the themes identified from the open-ended questionnaire data in study one (see chapter five), with the inclusion of questions specifically aimed at addressing self-harm within a university context. The interview schedule initially focused on rapport building by getting to know the participant (e.g., education, hobbies etc), before exploring more personal experiences of self-harm (e.g., how participants define self-harm and initiation of self-harm), and specifically their experiences of self-harm at university (e.g., motivations/triggers and support-seeking) (see Appendix E).

On average, interviews lasted 58 minutes (range 34–108 minutes) and were conducted via face-to-face (N=4), skype (N=5), telephone (N=6), or instant messenger (N=1) depending upon participant preference. As detailed within the ethics protocol within chapter four (see section 4.5), participants' emotional state was measured before and after the interview using the Visual Analogue Scale (VAS) (see Appendix S).

6.2.3 Data Analysis

A detailed overview of the analysis of interview data is provided in chapter four (see section 4.3). For the purpose of the reader, a summary is provided here. Interviews were conducted, transcribed, and initially coded by the researcher to establish trustworthiness and credibility.

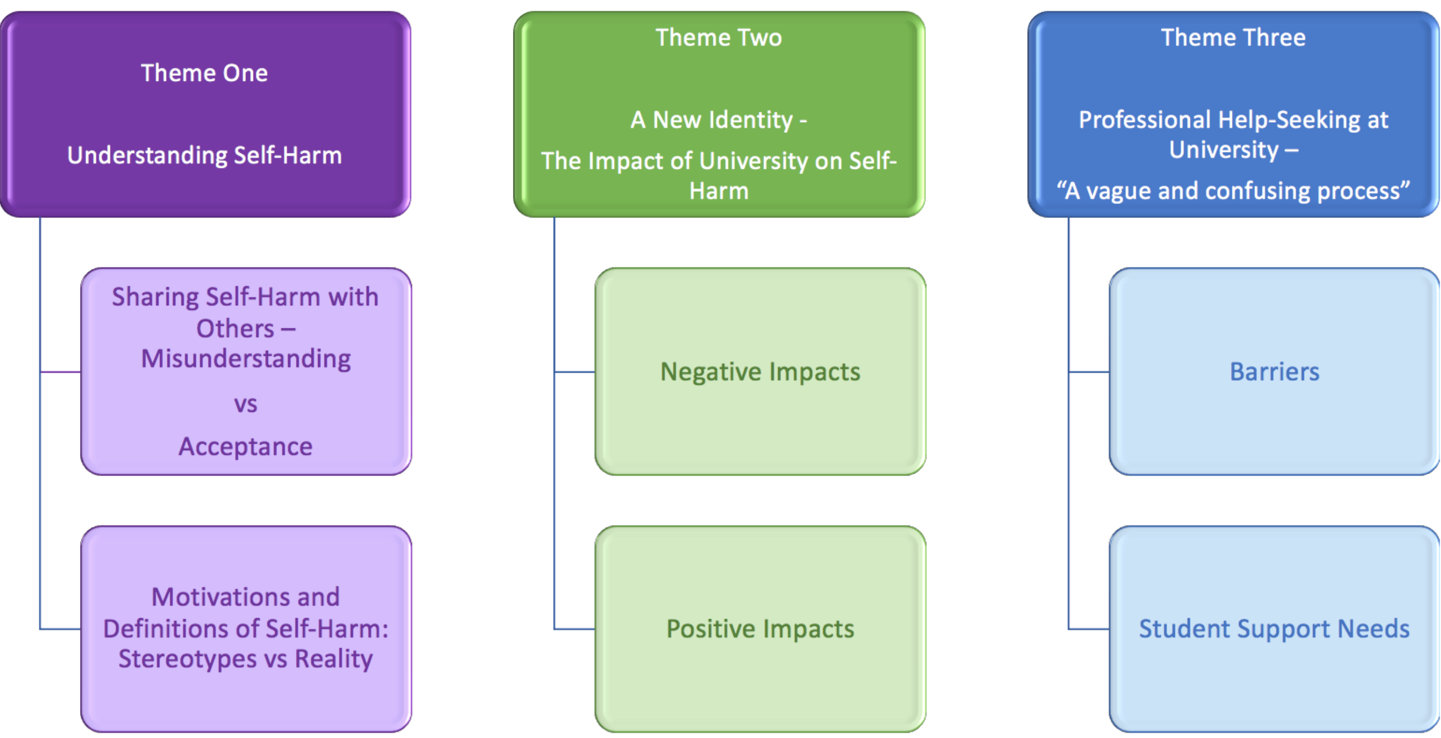
Analysis was carried out using reflexive TA (Braun & Clarke, 2006, 2019, 2021). The 15-point checklist of TA was followed using a semantic and inductive approach to analysis, with coding and themes guided by the data (Braun & Clarke, 2006). Codes were used to identify and describe extracts of data that may be relevant to the research topic (e.g., "relationships in university") (Clarke & Braun, 2013). Pseudonyms were given to participants, removing identifiable information to ensure anonymity. For this study, the instant messenger transcript (n=1) was analysed last. Whilst the level of depth was not as developed as the rest of the dataset, consistency with existing themes and codes was detected. Participant quotes representing each theme are presented throughout the results.

6.3 Results

Data collected during interviews highlighted individual differences, as well as similarities, in experiences of self-harm amongst university students. Whilst participants mainly focused on a university context, throughout all interviews, reflections on the way in which self-harm had been perceived and understood both within and outside of this setting were discussed. As a result, three main themes were identified, alongside six corresponding sub-themes (see Figure 16). Theme one focuses more broadly on experiences both within and outside of university, providing context to specific encounters that university students described in themes two and three.

Figure 16

Main Overarching Themes and Sub-Themes for Interviews with Students who Self-Harm



6.3.1 Theme One: Understanding Self-Harm

Theme one describes participants' experiences of the way in which broader society views and perceives the concept of self-harm. A lack of understanding regarding reasons for engaging in self-harm, the contrast between 'stereotypical' definitions of self-harm vs lived experiences, as well as their ability to openly talk about and visibly show their self-harm to different individuals, were prominent themes within participant accounts.

6.3.1.1 Sharing Self-Harm with Others - Misunderstanding vs Acceptance. Several participants discussed experiences of sharing their self-harm with others, either through talking about their self-harm or showing visible signs such as scars. Throughout these accounts, most described friends and loved ones being confused and upset when they found out about the self-harm: "They (parents) just didn't get it, it was like they just couldn't comprehend something like that or why I'd even think about doing it…..my dad pretty much ignored me after that" (Lucy). This common experience of feeling that self-harm was misunderstood by others induced feelings of shame and embarrassment. Whilst on placement as part of her university studies, Charlotte described an incident at work in which her manager saw scars on her arm and told her to "cover-up" as he did not want her to "be seen as weak", reinforcing her existing belief that self-harm is shameful and easier to hide to avoid judgement. Steph shared a similar belief following an interaction during sixth form when her sports teacher had "pulled a disapproving face" at her scars. These experiences led participants to feel isolated, which they reported increasing engagement in self-harm.

Based on similar experiences of feeling judged and misunderstood, several participants described how this had influenced the times at which they felt the need to physically cover up their self-harm, explaining that they would not let family members, friends or university staff see their scars. Chloe reflected on a time when she had been travelling during a summer break from university, sharing that she could "finally wear a vest top because no one knew who I was". Amelia had a similar experience, explaining: "Sometimes when myself and my partner have been away, I don't mind showing the scars. I don't know anyone, and it doesn't matter...but if there is anyone around who does know me, I would feel very embarrassed".

In contrast, some participants reflected on feeling able to discuss their self-harm with friends and family; however, strangers would be challenging as “they just wouldn’t get it” (Joanne). This lack of understanding was commonly viewed as the reason for experiences of dismissal, including several participants being described as ‘attention-seeking’ and that self-harm is ‘just a phase’. For others, particularly those studying for, or those who held, an undergraduate degree, the thought of telling anyone about their self-harm, particularly the emotional distress that they were experiencing, was difficult. This seemed to prompt reflection amongst several participants on the need for self-harm to be talked about more frequently:

> It would help if people spoke about it normally and were not scared by it because that makes it all the more hard to admit to anyone if you’re doing it. It needs to be spoken about more openly in my opinion (Jessica).

6.3.1.2 Motivations and Definitions of Self-Harm: Stereotypes vs Reality. Several participants explored reactions to their self-harm from others, offering suggestion as to why it may be difficult for friends and family members to discuss self-harm due to perceptions of the behaviour as ‘scary’ and ‘challenging’. Definitions of self-harm were felt to influence these viewpoints: “most people only think of cutting when you mention self-harm” (Vicky). Camilla added that when attending a mental health webinar at university, they’d talked about the “stereotypical ways of self-harming”. She went on to explain that this felt like ‘ignorance’ to the underlying intentions and methods of her own self-harm: “Actually, this is self-harm, I do want to hurt myself…the important thing is the intent to harm yourself rather than focusing on the actual way the individual is doing it”. In many instances, participants expressed that other people relied on the physical presentation of self-harm to define and characterise their behaviour, but

this often led to the underlying motivation being missed or ignored. Resultantly many participants were responded to with unhelpful misconceptions about their self-harm based on stereotypes, leaving no room for them to share their true motivations and experiences. For example, with regards to suicidal ideations, most participants felt that self-harm was “very different” to suicidal thoughts or intentions, describing self-harm as a “way of coping” rather than a desire to “end it all”. Lucy shared: “it’s just this horrible feeling inside…it was almost like a burning sensation, and I just had to get rid of it…self-harm is basically a survival tool for when things get really tough”. However, people close to Lucy were “horrified” when she told them about her cutting due to assuming that this must mean she wants to “kill herself”.

Many participants expressed how they felt the language around self-harm contributed to negative stereotypes and misconceptions of self-harm. Sarah shared that during university she had watched a programme with her flatmates featuring a scene around self-harm. She recalled that one individual responded by saying: “but isn’t that just so weird…who would ever choose to hurt themselves”, leading her to feel ashamed and isolated about her own experiences. Further, some participants found the label of ‘self-harm’ particularly unhelpful. Whilst Alice accepts the term, she also felt that the inclusion of ‘harm’ can lead people to neglect the emotions experienced by the individual who is self-harming. When discussing their personal definitions, participants consistently highlighted that self-harm is complex, involving many behaviours and actions:

> It’s (self-harm) just any way, any way in which you are hurting yourself, so like restricting food is going to affect you, you are going to be weak and tired. Scratching yourself, the same thing, and then, I know people like they pull out their hair on

purpose…that's self-harm as well. I think maybe like putting yourself in bad situations. I'd consider that self-harm too (Sam).

6.3.1.3 Theme One Summary. Participants lived experiences of feeling as though self-harm is shameful and often misunderstood were influential in promoting feelings of isolation and resultantly, maintaining self-harming behaviours. Existing definitions of self-harm were felt to be non-specific, lacking depth around what motivates self-harm by overly focusing on methods, and the majority viewing suicidal intentions and ideations as separate from self-harm. Whilst feeling understood and accepted enabled individuals to talk about or show their self-harm, this was rarely experienced by participants, indicating the need for self-harm to be more widely discussed to promote openness.

6.3.2 Theme Two: A New Identity - The Impact of University on Self-Harm

All participants explored the impact of their university experience upon their self-harm, with the majority describing university as a unique environment presenting new challenges and changes they had not previously encountered. These were often expressed as environmental and academic pressures, frequently linked to increases in harmful behaviours as a means of coping. Whilst participants discussed various aspects of university that triggered their self-harm, others felt able to develop their identity and relationships which reduced their self-harm in this setting.

6.3.2.1 Negative Impacts. Self-harm as a means of managing 'challenging emotions', as discussed in theme one, remained consistent throughout university for many participants. However, triggers and maintenance factors of self-harm seemed to shift based on new changes to

their environment and lifestyle that university presented. The majority described their experience at university as having some negative impacts on their self-harm. Several discussed comparing themselves to high-achieving peers, resulting in a lack of self-confidence in their academic abilities. For example, Elaine, who identified as being 'top of the class' during high school, felt the shift to university challenged her identity as an overachiever leading to feelings of hopelessness:

> When I feel like it's too much pressure, or I don't understand an assignment or something, or, you know because you are there with so many other students, I compare myself to them and feel worthless and then, it's that downward spiral of bad thoughts, and that's where the self-harm comes in (Elaine).

Similarly, other participants struggled to manage the additional demands of university. For example, some commented on the pressure surrounding exam periods and understanding assessments, something which Roberto felt was even more difficult for those completing assignments in a second language: "The language, writing in a second language is definitely a stress and self-harm pusher for sure…. I absolutely think that for international students it's a total other level of challenge". He expressed that his peers lacked understanding about the demands of studying internationally and that university staff were not always 'accommodating' of his need for additional support. Vicky and Sam also explored the influence of their heritage and ethnic background in relation to 'belonging' and 'fitting in' at university, with Vicky sharing feelings of being an outsider: "We come from extremely different backgrounds…it's a whole new thing. If

you don’t look how people expect you to, it’s like you don’t exist”. These experiences led to both participants engaging in self-harm due to feeling isolated.

Several participants highlighted how some behaviours they were exposed to during university increased their engagement in self-harm, including ‘binge drinking’ and ‘recreational drug use’. Jessica specifically reflected on the relationship between excessive drinking and self-harm:

> Definitely alcohol, without a shadow of a doubt. I would say that over fifty per cent of my self-harm has involved alcohol…..you know, you get to university and all this binge drinking is really encouraged… that had quite an impact on the severity and frequency of my self-harm personally.

Participants who discussed their self-harm with friends, particularly those who also engaged in self-harm, tended to reflect negatively about friendships. Joanne described her friendship group that she shared accommodation with at university as ‘toxic’ with a sense of ‘competitiveness’ concerning their self-harm: “it was almost like, boastful, like how many times we’d self-harmed and how we’d done it….it wasn’t healthy at all”. She added that leaving university and moving home provided a new perspective that there were other ways of managing her ‘unpleasant’ emotions.

6.3.2.2 Positive Impacts. The positive impact of university was also discussed by several participants, providing a safe space and a sense of ‘belonging’ which offered protective factors in preventing self-harm. For some, this reduction in self-harm was felt to be due to new and exciting opportunities offered at university: “I could finally just be me” (Tom). For Jessica,

university positively influenced her ability to accept who she really was: "It was like I had been lying to myself and those around me, like I'd never really been 'me'….I finally felt able to express myself at uni". She later added that this resulted in her no longer self-harming as the "negative thoughts and feelings about myself just stopped bothering me".

Others reflected that their self-harm had reduced at university due to opportunities to meet new people and form new relationships. These participants tended to report that this opportunity allowed them to feel 'cared for', for example, Sophie shared that meeting a partner at university led her to reflect on the impact that her self-harm may have on others:

> Being really cared about by someone, even loved, had a hugely restorative effect at uni. Especially as I'd never really felt it before. So, it was like, I don't need to hurt myself anymore because I don't deserve it. Other people care, and by hurting me, I also hurt them.

In theme one, Lucy explained that her family had dismissed her self-harm and ignored her when she had told them about her difficulties. However, Lucy's experience of friendship during university provided an opportunity to talk to others about her feelings and distress: "they were all a lot more open-minded, they weren't from my little town with no awareness of people's difficulties, it was like they just listened without judging" which reduced the urge to self-harm as she was "able to release that burden of emotion in a different way". Some participants discussed the positive impact of university in relation to providing a 'distraction' from their negative thoughts and feelings. For Vicky, her university studies and career aspirations offered a "sense of purpose and a good balance" which she had not experienced before. Similarly, Alice described

that studying was "better than doing nothing at all" as she no longer had time to ruminate on the negative views that she held about herself describing university as a 'positive distraction'.

6.3.2.3 Theme Two Summary. Both these positive and negative experiences at university highlight key aspects of university life including social connectedness and identity, which have the potential to influence student well-being, and consequently, self-harm. Achieving a sense of belongingness and stability was helpful; however, living with others who self-harm, binge drinking, and feeling like an outsider based on ethnicity and individual characteristics increased engagement in self-harm. Similarly, academic studying and achievement offered some enhancing and purposeful experience; however, this poses a risk of comparison to others and feeling overwhelmed.

6.3.3 Theme Three: Professional Help-Seeking at University - "A Vague and Confusing Process"

This theme captures participants' experiences of professional help-seeking, including the different processes involved when accessing university-based support for self-harm. Participants commonly reported barriers, particularly about how they had to share personal information in order to access services. Reflections on supportive resources for self-harm were explored, highlighting potential areas for improvement and development across university services.

6.3.3.1 Barriers. The most common barriers to accessing professional support for self-harm at university were discussed in relation to confusion over whom to contact, and the way in which

students were asked to share personal information. When Sam initially wanted to talk to someone at university he found the information about accessing student support confusing:

> It would just be nice to maybe have a very direct flow chart of questions, you know 'what's the issue', ' yes', 'no', 'this would be the best person for you to contact'…instead, it tends to be quite a vague and confusing process.

Several participants expressed that whilst they had an awareness of available resources for mental health support, how they were required to share personal information was felt to be 'unsettling'. For example, when making a self-referral to university services, Amelia was asked to detail on a referral form whether she had engaged in self-harm or was currently experiencing any suicidal ideations. She described this experience as 'incredibly distressing', adding that a tick box for her self-harm felt 'insensitive', minimising the emotional distress that she often experienced alongside self-harm. For Amelia, this way of asking about self-harm acted as a barrier to sending the referral as she felt the service "clearly didn't understand self-harm to ask about it like that" and that sending off a form containing her personal information and "not knowing who was on the other end" was worrying.

Alice and Camilla both sent referrals to university counselling services for self-harm support to receive no reply on several occasions, leaving them to feel "let down" and "disappointed". Alice added to this, sharing that after several follow-ups, she was placed on a waiting list, but a few weeks later received an email saying she had been removed due to being "too risky" for the service. She was then signposted to community services and told she "wasn't suitable", leading to feeling "straight up abandoned" by professionals and that self-harm was

something "even professionals didn't understand". This resulted in her feeling hopeless and embarrassed to talk about her self-harm at all. Camilla's referral to university counselling was only acknowledged when it had been sent from her GP which she found particularly irritating. She explained that telling anyone about self-harm is challenging, and to receive no response given how difficult that process can be was really upsetting: "I think it's absolutely not right. I think that it shouldn't take a GP for you to get help, because a lot of people can find involving a doctor far too overwhelming".

For those able to access support, several questioned the effectiveness and purpose of these services. Elaine recalled feeling uncared for during her sessions due to the counsellor "constantly checking her watch". Elaine expressed hopelessness following this experience stating: "these uni services are just there because they have to be…it's all just a front so they can say we support our students". Sophie's view was very much alike, explaining that whilst support services were available, they did not appear 'sincere': "she (the counsellor) would often not remember what I'd told her from one week to the next", resulting in Sophie feeling like a "burden" to her student counsellor and so she stopped attending the sessions. Tom described how his university does not have a "particularly good counselling service" due to offering a set number of six sessions. He shared how this led him to feel as though his personal story "wasn't of any relevance or interest" and that it would be much better if "services treated you like an individual, you know like on a case-by-case basis". As a result, Tom felt unable to share and talk about his self-harm, adding "what's the point, it takes so much energy to talk about self-harm and everything that's happened, it's not like six sessions are going to get me anywhere, I may as well just keep struggling through". Availability and quantity of sessions was discussed by most participants, specifically in relation to preventing support-seeking for self-harm, suggesting that limited

sessions wouldn't allow them to feel 'comfortable' enough to talk about their self-harm. Like Camilla, Roberto shared that he found self-harm particularly distressing to tell professionals about, describing "feeling sick at the thought of it" due to worrying about whom they would tell, and therefore a sense of familiarity and trust would be needed before feeling able to do so. Several participants experienced poor communication from support services, with Sarah sharing that her counsellor had failed to show up to an appointment without letting her know. Sarah interpreted this as "not being important enough to get help" and similarly to her experience in theme one, this left her feeling ashamed and isolated: "I clearly didn't deserve the help, and therefore will never ask for it again". Lucy also reported a time when a mental health advisor had not called her back when she had reached out for support resulting in feelings of hopelessness: "it's like self-harm is the only thing I can rely on".

6.3.3.2 Student Support Needs. Ways in which universities can provide effective support for students were discussed extensively by most participants, particularly what they would find helpful in initiating conversations with professionals about their self-harm. The need for a space in which they did not feel judged, allowing exploration of all experiences related to self-harm, was suggested. For example, Vicky, who discussed in theme two that her self-harm at university was often triggered by a sense of isolation when studying in a second language, added: "having a space to talk would have helped…I felt like an outcast at that time….which was often why I self-harmed". Similarly for Charlotte, who feared being judged by others following her experience in theme one when she was told to cover up her scars, she felt that "if I'd been able to get professional support at uni, maybe I would have felt less isolated about what happened". Despite this need for a safe space both participants described a lack of awareness of any student support

services at their university. Whilst an absence of services was only discussed by Charlotte and Vicky who were no longer attending university, targeted support for student mental health, and specifically self-harm, was felt to be lacking by nearly all participants: "there is a lot of support for things such as learning difficulties, but for the mental health side of it, there's none" (Chloe).

Some felt that knowledge of ways to support students relating to common university stressors such as academic deadlines, relationship difficulties, homesickness, and general mental well-being amongst lecturers and those working directly with students would be helpful. Elaine expressed that well-being and pastoral support directly from subject staff would help overcome the lack of consistency across the university: "because the university is really big and you have all these different places to go to, but they never really sit together, if someone familiar to you offers that listening ear, I think you'd be a lot more likely to talk to them". She went on to reflect that this felt particularly important for self-harm as knowing the person would "make it much easier to open up". However, this conflicted with other student viewpoints that telling subject and departmental staff about their mental health difficulties, including self-harm, would be particularly "challenging" due to concerns about confidentiality. Sam felt that speaking to someone "not associated with the course would be much more appealing" allowing him to "be more honest and just speak freely", specifically when discussing self-harm.

Several participants suggested hearing from other students who experienced similar difficulties at university was a potential way to encourage people to talk about their self-harm and reduce stigma. Following her experience of a negative reaction from a schoolteacher before university, as explored in theme one, Steph commented: "hearing from someone else with similar experiences would have helped me feel able to open up at uni". Roberto felt this would be more "relatable" and Amelia shared her positive experience of attending an external peer

support group: “talking about self-harm in that space was very much supported and non-judgemental”.

Chloe described university support as a useful “top-up” to more in-depth methods of care that she had accessed prior to university which allowed her to recognise “when things were getting too much for me at uni”. However, she was uncertain about how effective university support would be in isolation: “it would really depend upon the university and the individual”. Many participants also explored the importance of the transitional journey before and after university and felt that a greater awareness of services before commencing their studies would be particularly helpful. Lucy added that it would be useful to have access to this information when applying to universities giving “reassurance that they prioritise and recognise the importance of their student's well-being”. Access and greater signposting from university personnel to external support services were also proposed, especially considering the limited number of sessions available within the university and those wanting a confidential space away from the university environment.

6.3.3.3 Theme Three Summary. This theme highlights the different stages to accessing student support for self-harm, including barriers to initial help-seeking (e.g., lack of responses and referral forms). When accessing support, the number of sessions, professional engagement, and familiarity vs anonymity of the individual offering the support were influential in students' perceptions of effectiveness. Clear pathways and information helped promote support-seeking for self-harm during university.

6.3.4 Visual Analogue Scale

Of the 16 participants, 10 reported no change, five reported an increase, and one reported a five-point decrease, in their emotional state after the interview. For the one participant with a decreased emotional state, they acknowledged that whilst they felt better for sharing their experiences, it had brought up some difficult feelings. For the 10 participants who reported the same scores before and after interview, they often commented that they had enjoyed talking and had been happy to share their experiences. For the five individuals who indicated increased emotional state, which on average rose by 14%, they shared that the process of talking about their difficulties had been helpful and how they were proud of themselves for being able to talk and share their experiences on a topic that had been so secretive and close to them for such a long time. Overall these scores indicate that for the majority of participants, participation had either no impact, or a positive impact, on their emotional state. All participants were debriefed following interviews and offered a list of supportive resources (e.g., Samaritans). Implementation of participant safety plans was not required by the interviewer on any occasion.

6.4 Discussion

To the best of the researchers' knowledge, this is the first study to explore experiences of self-harm and support-seeking specifically amongst UK university students. Whilst the function of self-harm as a means of coping remained fairly consistent across experiences before university, the impact of academic pressures, shame, isolation, and social demands was particularly influential in increased episodes and re-occurrence of self-harm at university. For others, university offered a sense of belonging and purpose, providing opportunities to build support networks and develop their own identity. This allowed some to express themselves for the first

time, reducing or ceasing self-harm. A preventative rather than a reactive approach to self-harm support may encourage help-seeking and prevent escalation. Key time points and areas for implementing effective interventions were identified, particularly related to stereotypical beliefs about self-harm and transitional periods before, during, and after university.

The functions and motivations for self-harm described by participants in this study align with existing research among adolescents and students (Gratz, 2006; Guérin-Marion, 2018; Hambleton et al., 2020). Participants detailed increased incidents of self-harm during stressful exam periods, or when they felt emotionally overwhelmed. This offers further insight into previous findings which reported a rise in hospital presentations for self-harm in the trinity term amongst Oxford university students, coinciding with times of increased workload and exams (Hawton et al., 2012a). In the present study, self-harm was often explained as a coping mechanism for difficult situations and feelings arising in the university environment, including isolation, problems with alcohol, and failure to understand their work, with some having the additional stress of studying in a second language. These triggers for self-harm share similarities with those previously identified as impacting student well-being (e.g., academic pressures and social adjustments) (Stoliker & Lafreniere, 2015). Interestingly, students who were able to develop connections and build support networks noticed a reduction in their reliance on self-harm as a means of coping, particularly when they had experienced negative reactions from family and friends prior to university. Initiatives to promote social connectedness (e.g., social prescribing) have been shown to positively impact mental well-being amongst the general population (Brown et al., 2012), posing a potential means of improving university students' psychological health and consequently, reducing self-harm.

Participants offered contrasting views on how self-harm is defined and categorised in the wider population compared to their own experiences, with this conflict often acting as a key barrier to disclosure and preventing acceptance of their identity. Reluctance to discuss their self-harm with others was linked to stigma and feeling misunderstood, comparable to findings identifying shame and fear of confidentiality breaches as barriers to help-seeking for mental health and self-harm (Clement et al., 2015; Rosenrot & Lewis, 2020; Rowe et al., 2014). It was also found that several participants had attempted to seek support at university but had faced additional obstacles when doing so, such as being required to disclose particularly sensitive information via email and online formats, unclear support pathways, and in some cases, a lack of response from services. A report by the HE Policy Institute (HEPI) aiming to identify ways to improve students' mental health (Brown, 2016) may shed light on these experiences. Findings revealed limited funding for university support provisions, concluding that to meet the current demands for student mental health support, university services would need to triple in size. Therefore, the barriers described by participants in the current study may highlight the unprecedented demands on services and the adaptations they have had to make in response (e.g., online referral systems). Whilst the researcher recognises the strain on university support services, the impact of the experiences described in this study, such as students feeling worthless and undeserving of support, warrants further action.

Both positive and negative influences of the university environment on self-harm engagement may be explained by existing models (see chapter two, section 2.3 for a detailed overview of theories). The two-factor structure of self-harm (Klonsky et al., 2015) emphasises the influence of interpersonal factors in reducing self-harm, including the importance of communicating emotional pain to those around us. Participants described the positive influence of new

relationships and friendships on reducing self-harm, providing an opportunity to be themselves and motivation to engage in self-care for the sake of their friends and partners. The EAM (Chapman et al., 2006) suggests that emotional responses to certain environmental stimuli can lead to feelings of anger and shame, triggering episodes of self-harm. Students commonly described these feelings in the context of university self-harm, including academic comparisons with peers and increased isolation. These feelings were also explored in relation to their identity, offering accounts of university experiences that either challenged (e.g., no longer being an overachiever and not fitting in) or promoted (e.g., meeting new people) their existing sense of self. The impact of these experiences on either reducing or increasing engagement in self-harm may be explained by the importance of healthy identity development (Erikson, 1968), providing meaningfulness and clarity on how we fit into the world (Bronk, 2011). To develop self-identity, it is suggested that an individual requires opportunities to expand and explore their desires and emotions, thereby providing a sense of stability (Erikson, 1994; Rossouw & Fonagy, 2012), which was either offered or disrupted for participants when attending university. Therefore, interventions aimed at promoting self-awareness at university may be helpful in reducing self-harm, with the potential to build resilience and increase well-being (e.g., Renn & Bilodeau, 2005). This could possibly include stabilisation and distress tolerance skills (e.g., grounding strategies and mindfulness) (Yardley et al., 2019), offering alternative coping mechanisms during times of distress. These interventions have previously indicated effectiveness in reducing incidents of self-harm (Gelinas & Wright, 2013).

The Health Theory of Coping presents a continuum model, including unhealthy and healthy coping strategies (Stallman, 2020). Those who reported more positive aspects of university life may have had greater opportunity to develop healthier coping methods (e.g., social

connectedness), whereas those with more negative experiences (e.g., due to academic pressures and social comparison) may have had fewer opportunities to experience healthier strategies, relying on more harmful means of coping (e.g., self-harm) to reduce their distress (Stallman et al., 2021). To help manage increasing distress and promote stability for students, information related to student well-being and support before attending university is crucial. To do so, more proactive rather than reactive approaches to supporting student self-harm may be required, such as offering mentoring schemes during the transition to university. Such initiatives have been shown to increase academic performance and connectedness/purpose among first-year psychology students (Chester et al., 2013).

6.5 Study Limitations

Retrospective accounts were gathered from participants who had finished university in the last three years (N = 6, 37.5%), therefore relying on recall with the potential for bias. Whilst it may be argued that their views may not be representative of current university provisions, experiences between those currently at university, and those who were no longer studying, were not dissimilar, indicating the relevance of their voice. Any contrast in views between these participants was highlighted within the results. Limitations relating to the wider thesis are considered later in chapter eight.

6.6 Conclusion

This study provides a novel in-depth perspective of self-harm amongst university students, specifically highlighting the challenge of support-seeking and areas of development for universities in supporting student self-harm. Whilst the majority of self-harm initiated before

studying, there were several triggers and maintenance factors that were unique to the university environment. Further exploration of referral processes, university services demand and population-level perceptions of self-harm are required in order to ensure that support and disclosure of self-harm is one of unity rather than confusion and rejection. Given the mixed experiences of students across studies one and two with regards seeking and accessing support, and its effectiveness, a greater understanding of how university support systems are set up and delivered would provide a greater context to these findings. Further, a unique group of supporters have been suggested within chapters five and six, with individuals with personal experiences of self-harm also offering support. To further understand these experiences, the impact on supporters and their own support needs, the next chapter (chapter seven) offers a qualitative exploration of those providing support for university students engaging in self-harm.

6.7 Personal Reflexivity

I found these interviews thoroughly enjoyable to conduct and felt particularly privileged that individuals had felt able to share such personal stories and experiences with me. When initially commencing this study, I did at times feel apprehensive about how the questions would be received and how participants would respond. In my first interview, I felt that I could have picked up on more of what the participant had said instead of worrying about covering all the questions and finishing within a specific time frame. I also felt aware of filling pauses and silences, with a need to clarify myself further (see Appendix U). However, I felt that as time went on, my confidence as a researcher and interviewer developed greatly. I found it helpful to leave the participant time to sit with the questions, providing them with the opportunity to digest and then ask for further clarification themselves if they felt this was necessary (see Appendix U). I learnt that you can never prepare for these types of interviews or what participants will bring,

because every experience is so different and unique to that individual. Participant feedback and positive reflections was something that I found particularly helpful and reassuring in confirming my belief that this research is particularly important and needed at this time.

7. Chapter Seven: Study Three - The Spectrum of Care Within a University Context: The Differing Roles of Carers in Supporting Students who Self-Harm

This chapter is a slightly modified version of the researcher's publication in the International Journal for Care and Caring which is currently in press.

Edwards-Bailey, L., Smyth, N., Cartwright, T., & Mackenzie, J. M. (2023). The spectrum of care within a university context: the differing roles of carers in supporting students who self-harm. *International Journal of Care and Caring*, *7*(4), 708-734. https://doi.org/10.1332/239788221X16890865425257

7.1 Introduction

The previous two chapters presented data highlighting the importance of support for students who self-harm. Study one (chapter five) highlights that many students at university had supported a fellow student with their well-being. Further, findings from study two (chapter six) highlighted key areas of improvement for university support provisions, as well as providing insight into the impact of those individuals who had also provided support for friends, family members and colleagues alongside their own experiences of self-harm. Based upon these findings, it was felt that further exploration amongst those providing support for student self-harm would be particularly useful.

The limitations and experiences of support services offered at university were explored in study one, and extensively in study two. Gaining a greater understanding of the university support system, as well as the demands of providing support, are imperative to implement positive changes. To understand these further, qualitative interviews were conducted with individuals who had experience of providing support for university students engaging in self-harm. To provide an in-depth understanding and to address the original aims of this thesis (see chapter 3, section 3.6), the views of professionals, friends, family members, and carers (i.e., formal vs informal) were sought.

7.1.1 Aims

The present study aimed to provide a novel insight into the experiences of people providing care to UK university students who have self-harmed during their time at university. Given the additional stressors of caring for people who self-harm, and the negative impacts of carer burnout and compassion fatigue for both those providing and receiving care, further research

amongst carers/care workers in this setting is required. Study three aimed to understand the experiences of the different groups of carers in universities, what caring means to them, as well as identify any areas in which they may require further support when providing care specifically for self-harm.

7.2 Method

A qualitative design, using in-depth, semi-structured interviews was adopted. As the researcher took a critical realist (CR) epistemological stance, it was recognised that participant accounts provided information about a reality, without directly echoing reality (Harper, 2011). Therefore, to further understand participant experiences of providing support for self-harm to university students, the researcher offered a level of interpretation by critically reviewing findings within their wider context. A viewpoint that providing care for self-harm is an existing reality was taken, whilst recognising that each individual will have their own views on their involvement in both providing support and self-harm. Further, for those directly working or studying at university, perceptions on personal involvement in university life and systems will exist. To understand and develop knowledge about the individual's involvement, participants' experiences of providing support for a university student engaging in self-harm were explored. All participants in study three experienced providing support for another individual who had self-harmed during university.

7.2.1 Participants and Recruitment

Twenty-four participants (19 Female, 5 Male) aged 18-55 years (M = 29.7, SD = 9.8) were interviewed. The wide age range represents the broad spectrum of carers within universities, with

any individual with experience of providing support to another individual engaging in self-harm during their time at university, either professionally, as a friend, volunteer, colleague, parent, or in any other capacity included. Given the limited knowledge of carers within a university setting and what this means to this group, inclusion was purposefully broad, allowing participants to self-define as supporters based on their experiences.

Recruitment took place through a variety of means. Individuals who had previously taken part in the online survey as part of study one (chapter five) were able to leave their contact details to take part in further research. Of those, individuals who indicated they had provided support for a university student engaging in self-harm were contacted and invited to take part in an interview. Participants recruited via this method mainly consisted of friends and family providing support, and those with both personal and supporter experiences of self-harm. In addition, posters calling for those with any experience of supporting students engaging in self-harm (see Appendix V) were sent to all UK university counselling and well-being services, student unions, and key support organisations (e.g., student minds, nightline). Adverts were also posted on social media (e.g., Twitter and Facebook). Nonprobability sampling techniques (i.e., convenience and purposive) were thus used to recruit for interviews (Etikan et al., 2016).

Initially, a convenience sampling approach was taken, with participants contacted on a rolling basis. Following conduction of several interviews, a spectrum of individuals in university caring roles emerged (e.g., trained professionals, family, friends, and those who also had personal experiences of self-harm alongside caring for other students). Given that the categories of carers did not fit with 'typical' definitions, a purposive sample technique was adopted to capture experiences from differing geographical locations across the spectrum of university supporters. Individuals based in different UK locations to those already interviewed, as well as supporters

with limited representation (i.e., friends and family), were selected. The final sample consisted of three distinct groups of carers: professional carers (N=10) (e.g., university counsellors, mental health advisors and a GP); carers with no personal experience of self-harm (e.g., friends/family members) (N=6); and carers with personal experiences of self-harm (N=8). One professional carer also had experience of supporting a friend they lived with at university, and this dual role was explored. To maintain anonymity, pseudonyms were assigned to all participants (see Table 10).

Table 10

Study Three Participant Pseudonyms and Demographics

Participant (Pseudonym)	Supporter Category	Gender	Age
Karen	Informal carer – Parent	Female	55
Naomi	Informal carer – Friend	Female	18
Charles	Informal carer – Friend	Male	23
Katherine	Informal carer – Friend	Female	23
Molly	Informal carer – Friend	Female	25
Neyo	Informal carer – Sibling	Male	25
Mia	Informal carer – Friend Personal SH	Female	20
Olivia	Informal carer – Friend Personal SH	Female	25
Leah	Informal carer – Friend Personal SH	Female	22
Ruby	Informal carer – Friend Personal SH	Female	21
Maya	Informal carer – Friend Personal SH	Female	24
Ben	Informal carer – Friend Personal SH	Male	21
Eva	Informal carer – Friend Personal SH	Female	28
Sadie	Informal carer – Friend Personal SH	Female	24
Claudine	Professional care worker – University GP	Female	47
Jenny	Professional care worker – University Mental Health Advisor	Female	40
Madison	Professional care worker – University Mental Health Advisor	Female	35
Zoey	Professional care worker – University Counsellor	Female	35
Laurence	Professional care worker - University Counsellor	Male	38
Josephine	Professional care worker - University Counsellor	Female	48
Julia	Professional care worker - University Counsellor	Female	33
Lydia	Professional care worker - University Counsellor	Female	29
Mike*	Professional care worker – University Mental Health Advisor	Male	24
Eliza	Professional care worker – University Mental Health Advisor	Female	31

Note. SH = Self-Harm.

*Participant (Mike) also had informal caring experience with housemate at university.

7.2.2 Data Collection

A detailed overview of the methodology applied in this study is provided in chapter four, section 4.2.3. For the readers reference, a brief summary has been included here. Qualitative interviews were selected due to the extensive and under-researched nature of those providing support for student self-harm (Ritchie et al., 2013). The interview guide was developed through consideration of previous findings specific to self-harm (e.g., Wadman et al., 2018), including those in studies one and two, and team discussions, with gaps in the existing carers literature (e.g., the influence of compassion (Schulz et al., 2007)) used to tailor the interview schedule. Given the limited understanding of university support roles, initial questions were designed to understand what the role meant and what this involved for the individual (see Appendix F).

All interviews were carried out by the researcher via face-to-face (N=1), skype (N=4) and telephone (N=19), lasting an average of 44 minutes (range 31 – 65 minutes). The researcher drew upon their clinical experiences of working psychologically with patients, families, and multidisciplinary teams (MDTs) within healthcare, facilitating the interview process and promoting a relational focus (Dejonckheere & Vaughn, 2019). Similarly to study two, pre and post-interview scores of participants' emotional states were recorded using the Visual Analogue Scale (VAS).

7.2.3 Data Analysis

Interviews were anonymised and transcribed verbatim by the researcher, with a reflexive thematic approach to analysis (Braun & Clarke, 2006, 2019, 2021). Development of coding and themes were guided by the data using a semantic and inductive process, following the 15-point

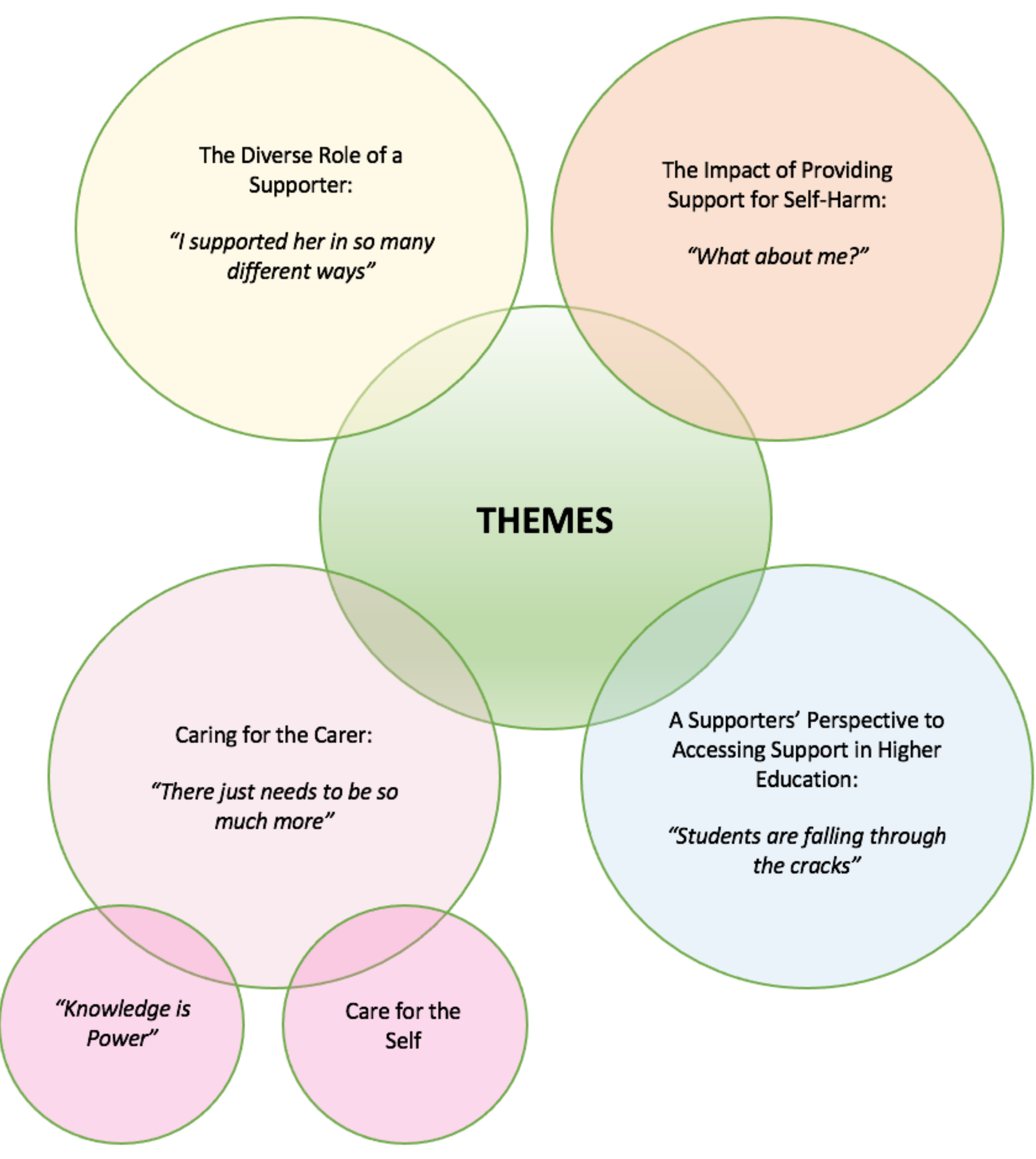
checklist of TA (Braun & Clarke, 2006). A detailed overview of the analysis of interview data is provided in chapter four (see section 4.3).

7.3 Results

Participants explored their experiences as carers in rich detail, offering differing perspectives with regards to what being a carer meant for them and how they offered support within their role. Reflections of personal development throughout their journeys as supporters, with experience and understanding of self-harm often growing along the way, were commonly discussed. Key similarities and differences in perceptions of the impact of the caring role and experiences of accessing and offering support for university students was highlighted. Four main themes were identified, with two corresponding sub-themes (see Figure 17).

Figure 17

Main Overarching Themes and Sub-Themes for Interviews with Individuals Supporting Students who Self-Harm



7.3.1 The Diverse Role of A Supporter: "I Supported Her In So Many Different Ways"

All participants reflected on what their 'role' in providing support for self-harm involved, with the majority highlighting the significance of being present and listening. Understanding and sense-making of being a carer were shaped by their personal experiences of, or knowledge about, self-harm. Professional and 'informal' supporters frequently described offering practical support for the individual engaging in self-harm, however the way in which they did this, and reasons for doing so, differed between these groups.

Charles, who had supported his housemate at university, expressed a sense of helplessness due to not knowing what his friend needed. As a result, he described doing what he would personally find helpful, taking on a "parental role", often cooking, and helping them with day-to-day activities, e.g., getting to university. Karen, a parent supporter, commented on the challenge of adjusting when her daughter moved away to university, with her usual ways of caring (e.g., giving lifts and making dinner) no longer being possible:

> When she first moved away, we were worried…you know I was concerned as I couldn't do the usual things I would do to take care of her, she was moving six hours away…it's almost like a different world when they are away at Uni.

The need to keep the individual safe and promote recovery was a commonality amongst participants, and for 'informal' carers, this sometimes involved accompanying them to medical appointments and emergency departments: "I feel I supported her in so many different ways and really pushed her to get better, like I took her to A&E a few times." (Kathryn, friend). For others, this related to encouraging support-seeking, however success was mixed. If the individual did

not feel ready to access support services, ‘informal’ supporters felt unsure about what to do*:* “She didn’t want to get help, and I just felt like I didn’t know what more I could do, or where to go next.” (Ruby, friend/personal self-harm). Several friends and family members described relief when the individual was able to access professional support due to others being aware of the individual's self-harm. In contrast, others felt ‘pushed out’ due to a lack of awareness of what was being discussed and limited recognition of the impact this also had on them:

> ...my mum said that the first session she went to with my sister, they weren’t helpful at all. They seemed really unempathetic. Like not heard and feeling like they didn’t understand. They said to my mum that she couldn’t be included… (Neyo, sibling)

Conversely, Naomi had experienced joining her friend for several counselling sessions which she felt had been a helpful and a positive experience for them both, allowing her friend to “openly talk about all her problems”.

For professional supporters, the set-up of university support services impacted the way they discussed their role, particularly the extent to which further support could be offered. Due to limited resources and funding, several professionals mainly conducted assessments and signposted to other services. Madison reflected that because of this, her role felt more about “prevention as opposed to directly curing”. For others, mainly university counsellors, their role was to provide longer-term therapeutic support over numerous sessions. Interestingly, Mike worked as a university mental health advisor, signposting students to external services. He explained this was more common (i.e., signposting) for those experiencing self-harm due to limited counselling capacity for ‘risky’ students. This led to him advocating for increased

support within the university for these individuals. However, when taking on a caring role for his housemate, this was about distraction and spending time with them:

> ...even driving around for half an hour, forty minutes, and just chatting about crap is actually really helpful for her. And like coming home she was saying how she felt so much better…

7.3.2 The Impact of Providing Support: "What About Me?"

Negative impacts resulting from providing care were commonplace, particularly relating to participants' health and well-being, as well as their social and personal lives. Some professionals reported feeling overwhelmed due to the lack of resources and demands of the role (e.g., small teams caring for many students), impacting their physical and mental health:

> ...I mean, really, really challenging. I had some time off sick at Christmas because I was just done. I just couldn't safely see anyone. I couldn't sleep, I couldn't eat, I was just exhausted... (Julia – university counsellor)

Managing the uncertainty and flexibility required (e.g., finishing work late) was often detrimental for all groups of supporters in relation to their social lives and relationships with friends and family. Lydia (university counsellor) described feeling "tired and emotionally drained" at the end of most days, preventing her from playing with her children and struggling to engage in conversation with her partner. The majority of all supporters mentioned feelings of

shame and guilt. For professionals, this related to not wanting to let their colleagues or students down, whereas for informal carers, this was about wanting space and time for themselves:

> ..there's that immense feeling of guilt that I can't do more. And there have been times when I've wanted to leave the house in order to like to spend time with some other friends who are my support...but I always feel guilty.. (Mike - professional and friend).

When these feelings arose, establishing boundaries was felt to be crucial, acting as a source of protection for their own well-being. Josephine (university counsellor) explained that whilst the role impacts upon her to an extent, including missing lunch breaks and experiencing stress during the working day, she'd learnt to "develop ways of keeping working and home as separate as I can", such as not taking her work laptop home.

The ability to establish boundaries was more challenging for those living with the individual (i.e., friends/family), with a sense that physical proximity can mirror emotional distance. This led to a conflict between wanting to help the individual, whilst recognising the need to protect their own well-being by creating distance, which was a common theme for all friends and family. For Molly (friend), this resulted in her ending the friendship entirely: "I got to the point where I just couldn't have that in my life anymore." Others felt the supportive relationship was one-directional, with Katherine (friend) sharing:

> The main thing is that you're providing support to somebody, but then you don't necessarily get that support back for yourself. And you feel a bit like your problems

aren't as bad as somebody else's. So, then you feel like you can't share those things with them because they already have their own things going on.

Several carers, specifically those with personal experiences of self-harm, commented that providing support was a cathartic experience, offering "relatability", "validation" and "true understanding". However, this also presented difficulties in relation to triggering their own self-harm due to discussing difficult emotions and experiences. Leah explained she'd often feel like a "hypocrite" as she would not follow the advice she'd given to her friend when in those "dark places".

7.3.3 Caring for the Carer: "There Just Needs To Be So Much More"

The majority of participants discussed a need to have support for their own well-being, as well as greater knowledge of self-harm and the desire to connect with others in similar roles and positions. The findings relating to the wider theme of carers needs are presented below across two subthemes.

7.3.3.1 "Knowledge is Power". At the beginning of their careers, some professionals felt unprepared to support students with self-harm due to limited training. Further, others recalled stigma amongst senior colleagues towards those who self-harmed, meaning it would not be discussed with trainees and junior members of staff. When reflecting on their current insight into self-harm, several professionals noted that even if they had discussed self-harm with seniors, it would likely have resulted in an inaccurate perception of self-harm due to many believing it was simply 'attention-seeking'. Claudine (university GP) shared: "when I was a foundation doctor in

A&E, no one paid people presenting with self-harm any compassion. I even remember my consultant telling me to ignore them so they'd stop coming in". For professionals in the present study, understanding of self-harm often developed once working with it directly: "I think my way of managing it (self-harm) then and supporting people was probably quite different then to what it is now, or hopefully anyway". (Eliza – mental health advisor).

The need for greater resources and information relating to self-harm was felt to be crucial when responding to distress and providing support, particularly amongst supporters with no personal experiences of self-harm. Gaps in their knowledge about self-harm, for example, the reasons why individuals may engage in harmful behaviours, what to say or how to respond, and when to seek medical attention, were a real challenge. The majority expressed that more information and resources specifically aimed at those in 'informal' caring roles would be particularly helpful, with the potential to encourage those who self-harm to speak more openly:

> I definitely did not have enough knowledge at all...you automatically think that when someone is cutting themselves that they are trying to end their life….if people do know about it, that would help people supporting, and also help people say if they are doing it. (Naomi - friend)

Professional supporters also discussed the importance of information and knowledge, with Lydia (university counsellor) expressing that a basic understanding of self-harm enabled her to empathise with what the student may be experiencing (e.g., "distress" or "feeling numb"). Jenny (mental health advisor) added the need for training to focus on "squashing" stereotypes,

including the common belief that individuals self-harm because of wanting to end their life, as well as the need to recognise the diversity and breadth of self-harm:

> So learn the theory, learn the stereotypes, learn misconceptions, learn the myths, learn what it actually looks like….then what are your solutions, what are your strategies, what are your recommendations, what could you signpost someone to, how do you have those conversations?

7.3.3.2 Care for the Self. A desire for personal support due to the responsibilities and impacts of the caring role was frequently mentioned. For family and friends, resources aimed specifically at strategies for promoting their own well-being whilst caring for others who self-harm was important, with existing provisions described as limited: "I just think there needs to be so much more...one worksheet on looking after yourself isn't going to hack it." (Eva, friend/personal self-harm). Several friends who were caring for other students at university described a lack of awareness of how to access university support services, questioning its usefulness: "…there would be advertisements for mental health and stuff in the uni, but like, where do I actually go to talk to someone? Is it actually going to be of any use to me?" (Molly – friend).

Neyo (sibling) felt that offering different platforms for support, including face-to-face, apps and websites, may promote help-seeking, with less invasive platforms (e.g., apps) feeling more accessible, particularly initially. For professionals, their support needs were discussed mainly in relation to personal and well-being support for their role, given the demands of working in a university setting. Julia (university counsellor) suggested that building "rest days" into her job plan would help to manage this, as well as prevent future sicknesses and absence. Whilst peer

support and supervision were felt to be particularly useful, provision was inconsistent and appeared to be dictated by service structure (i.e., leadership priorities and larger staffing teams). Several professionals reflected that space for sharing new ideas and research with others working in similar areas would be invaluable: "I think time as a group would be really helpful to have that space. I remember once myself and my colleague had the chance to attend a conference and we learnt so much, it was absolutely amazing". (Jenny – mental health advisor).

7.3.4 A Supporters' Perspective to Accessing Support During University: "Students Are Falling Through the Cracks"

Based on their caregiving experiences, participants offered unique perspectives on the way in which support systems and services are structured across universities. Many felt that adequate services for students were lacking, including limited sessions, staffing shortages and an overreliance on external support provision. This presented common challenges, with services often not accepting university referrals due to students not meeting service criteria in terms of severity. Several supporters described how this resulted in students not receiving the support they need:

> It's like the people who are in too much of a crisis, to only be seen once a week for six or twelve sessions, they aren't unwell enough to be sectioned or to go to a crisis unit or anything, they really fall through the cracks….there is a lack of resources for those people who just need a bit more support. (Zoey – university counsellor).

Professional supporters shared insight into how student support services are set-up, highlighting differences between institutions with regards to whom students could access support from, the

level of support available (e.g., number of sessions), as well as divergence in referral systems and steps needed to access support (e.g., contact forms and assessments). Several student supporters felt that awareness of support provision at university was insufficient, with advertisement of services only present at specific times (e.g., mental health weeks), providing difficulty for student carers to navigate and signpost their friends. In addition, those with personal experiences of self-harm offered a distinct perspective on their personal encounters of using these systems, with Maya (friend/personal self-harm) describing the requirement to share sensitive information with multiple people: "...you're having to tell all these people your problems and what support you need...you don't want to have to deal with all those steps to getting eventually to the support."

Timely access to appropriate support was felt to be influenced by the individual with whom the student chose to discuss their self-harm. Several supporters, including professionals and friends, described students initially approaching course staff (e.g., lecturers) due to a sense of familiarity. However, some professional supporters were apprehensive about understanding of self-harm amongst lecturers and tutors:

> They develop a warmer relationship with one of their lecturers, and that will be the first person they go to in some cases, we had some inappropriate responses and that really shut the student down….which just exacerbates the problem. (Laurence – university counsellor).

Several supporters offered suggestions as to what would be needed to help bridge this gap. Claudine (university GP) commented..."I mean I completely believe that we need to have a

standardised approach to support for students". However, she also noted that these issues can be hard to address due to funding challenges and repeated service structure changes. The majority of professionals discussed the need for clearer communication between services, either within the university, or more generally in the community, and that recognition from senior levels within institutions is needed:

> Whether it's about self-harming, suicidal ideation or so on...communicating that this isn't something to be ashamed of at an institutional level would carry a lot of weight. (Julia – university counsellor).

Based on their experiences, friends and family offered less service-related insight, instead suggesting greater awareness of resources available to students before arriving at university, with a clearer pathway on where to access support. Those with personal experiences of self-harm shared first-hand accounts of the difficulty in knowing where to go for help, often requiring them to "jump through hoops" due to services being "disjointed". There was a consensus that by addressing these gaps, positive impacts on the health and well-being of students who self-harm, and those offering 'informal' and 'professional' care, would occur.

7.3.5 Visual Analogue Scale

As in study two, the VAS was completed before and after interviews. Based on the 24 participants, 13 reported the same score before and after taking part in the interview, with nine reporting an increase and two reporting a decrease. Similarly to study two, increased scores were often attributed to the interview offering a safe space to talk openly about their difficulties, whilst

also recognising that this brought up some difficult feelings. As explained in the ethics procedure (see chapter four, section 4.5) and as done in study two, any participants reporting a lower score were assessed and reminded of the resources available to them should they need further support. No safety plans were felt to be needed by the researcher.

7.4 Discussion

The findings of study three provide a nuanced, context-specific understanding of the experiences of those providing support for university students who self-harm. A broad spectrum of care for self-harm was explored, revealing distinct groups of supporters within a university setting: professional/'formal' supporters (e.g., counsellors, well-being advisors, GP) vs 'informal' supporters (e.g., friends/family with and without personal experiences of self-harm). This research offers a unique perspective of the challenges faced, including limited staffing and opportunities for networking, lack of ability to establish boundaries (e.g., living with the individual and working longer hours than contracted), as well as inadequate training and information specific to self-harm, with negative impacts on the well-being of all supporters (e.g., burnout and guilt). Participants appeared to share a commonality in that knowledge and understanding of self-harm was something that developed over time and through experience. The need for greater awareness of self-harm, particularly amongst academic staff outside of formal support pathways (i.e., lecturers and personal tutors), increased training and awareness earlier on in professional careers, as well as availability of information for friends and families during their journey as a supporter, was highlighted. Limitations and challenges of student support provisions, including restricted number of sessions and difficulties in onward referrals, require increased attention at an institutional level.

To provide effective support for others, individuals need to practise self-care and ensure emotional availability (Glass & Rose, 2008). Most supporters shared a broad range of negative impacts on their well-being as a result of providing support (e.g., reduced sleep and eating, and social withdrawal). Previous research highlights that carers, both professionally and informally, face heightened emotional demands, leading to increased stress and higher risk of burnout (Shah et al., 2010; Simpson et al., 2019; Sin et al., 2021). Similar experiences in the present study may be indicative of compassion fatigue and empathic distress, which is commonly experienced amongst healthcare professionals and carers providing regular support for those in distress (Figley, 2002), with negative health impacts at both a physical and emotional level for supporters and the individual/s being supported (Lombardo & Eyre, 2010; Smith, 2015; Hall et al., 2016). Interestingly, females report greater empathic distress compared to males which may reflect the higher proportion of female participants in this study (Smith & Rose, 2011). Research with a larger sample of male supporters is needed to examine this further.

The additional impact of the caring role reported by all groups of supporters, including cancellation of social events and limited time to complete university work, shares similarities with research amongst young adult student carers (Sempik & Becker, 2014), and may be understood in the context of existing theoretical models (as discussed in detail in chapter three, section 3.4.2). The transactional model of stress suggests that those with limited social support and coping strategies are at a greater risk of experiencing negative impacts on physical and psychological health (Murfield et al., 2020). Most carers described behaviours and feelings indicative of high levels of compassion (e.g., feelings of concern, as well as desire and motivation to help). However, given that the individuals they were caring for experienced high levels of distress and engaged in self-harm, carers may have felt that the individual they were

caring for showed little to no improvement despite their support. In line with the caregiver suffering-compassion model (Schulz et al., 2007, 2017), this increases the likelihood of empathic distress, in which the carer takes on the individual's distress as their own (Smith & Rose, 2011). Resultantly, these findings may be best understood in the context of a supporter 'cycle'. When supporters in the current study described taking direct responsibility for the care of another's self-harm (i.e., presenting to A&E or taking them out for a drive), a reduction in their own well-being frequently occurred when the self-harm continued despite these efforts. Due to the close proximity and shared environments of some university carers, particularly friends who described greater difficulties in establishing boundaries and maintaining personal space, and that many are young adults and may still be developing their own emotional regulation strategies, the findings here may indicate an increased risk of empathetic distress amongst these supporters (Powell, 2018). This may explain why professional supporters reported less personal impact as a direct result of continued engagement in SH, with greater ease in establishing distance, more advanced training, and supervision for their own emotional distress. Further, non-suicidal ideations and behaviours (e.g., self-harm) are more likely to occur when an individual is at an increased need of emotion regulation (Kranzler et al., 2018), offering explanation as to why some carers experienced their supporting role as triggering for their own self-harm. Study three findings suggest that greater resources aimed at increasing self-care and employing strategies for managing guilt, burnout and worry for all individuals caring for students are required. One method may include compassion-focused interventions, with previous evidence supporting a reduction in feelings of guilt and shame (Sirois et al., 2019), warranting further research exploring the utilisation of these methods within a university setting.

In line with the impact on carers well-being, these factors may also prevent supporters from accessing their own support. Burnout acts as a key barrier to help-seeking amongst professionals (Bearse et al., 2013), with lack of time and fear of leaving the individual they are caring for (Fisker & Strandmark, 2007; Ingleton et al., 2003). When exploring experiences of young student adult carers, almost half reported difficulties with their own mental health. Despite this, the majority were not accessing support due to feeling as though their difficulties were not recognised by their universities/colleges (Sempik & Becker, 2014). Therefore, increased service provisions for student mental health would allow for greater student support, as well as the potential to reduce the negative impact on those in supportive roles.

A more nuanced finding within the current study was the challenge of supporting self-harm specifically, with many professional and 'informal' supporters experiencing fear and worry with regards to what to say and how to respond, often related to limited training and information specific to self-harm. These findings echo that of existing research amongst those providing support for self-harm, emphasising the role of educational settings in enhancing knowledge of self-harm and the need for more open dialogues to promote help-seeking (Hall & Melia, 2022; Reichardt, 2016). This appeared to be more manageable for experienced professionals and supporters with personal experiences of self-harm, with relatability and a deeper understanding having a cathartic role. This lends support to previous findings exploring self-help groups for self-harm, with attendees reporting that the non-judgemental space with peers was a positive experience, reducing isolation and providing a safe setting to understand and manage their self-harm (Boyce et al., 2018). Further research exploring whether similar initiatives would be helpful amongst the student population, and the way in which they could be adapted (e.g., online), would be valuable.

Due to working in small teams, and/or in a specific university, opportunity to connect with others working in similar settings, and sharing of resources, was lacking for several professional university supporters. Despite this, the majority felt this would be helpful, providing space to learn from others and promoting collaboration. Research conducted among school teachers found that those with little opportunity to interact with other professionals in their area often felt isolated (Kim et al., 2017), leading to burnout and poor job satisfaction, negatively impacting student achievement (Cooper & Alvarado, 2006; Johnson et al., 2012). When strategies to encourage collaboration have been introduced, positive impacts on teacher and student well-being and satisfaction have been reported (Jackson, 2013). Differences between school and university settings are acknowledged, both at an individual and systemic level, however, a more standardised approach to student support and greater opportunities for professional networking may promote staff well-being, as well as increased satisfaction amongst students in relation to the support available during university.

The need for greater awareness of mental health, and self-harm specifically, amongst all university staff, has been proposed (Oliver et al., 2016). These findings provide further evidence of students disclosing to tutors, with professional and 'informal' supporters sharing accounts of negative reactions (e.g., dismissal) when the individual they cared for disclosed their self-harm to these individuals. Research exploring suicidality amongst doctoral researchers shares similar accounts, reporting supervisors and university staff as ill-prepared and 'freaked out' when discussing suicide (Hazell et al., 2021). This knowledge gap is important to address given that response at disclosure is particularly influential on future support-seeking, specifically for those perceiving stigmas, which is common amongst those who self-harm (as highlighted in study two) (Williams & Mickelson, 2008). Further, students have also suggested that lecturers and tutors

being more approachable and acknowledging of the key difficulties experienced during university, would positively impact on their well-being (Baik et al., 2019). In study three, some professionals reported delivering mental health training, with a specific focus on self-harm and suicide awareness, to both students and staff at their university to address this. However, a greater understanding of how, if at all, this lack of knowledge is being addressed across universities more widely is needed.

Berry et al. (2021) found that reduced communication with supervisors was predictive for student mental health symptoms amongst postgraduate researchers. Therefore, alongside training regarding self-harm specifically for university staff (e.g., personal tutors), strategies for promoting the supervisory relationship may also be beneficial. Hughes and Byrom (2019) explored academics' experiences of managing student mental health, identifying key difficulties such as boundaries, responsibility, and competence. However, this was limited to staff teaching on healthcare courses. Therefore, further research exploring the views and experiences of lecturers and personal tutors across academic disciplines with regards to disclosure of mental health difficulties, and more specifically self-harm, would be helpful in establishing the extent to which they may also present as a unique group of carers within the university context.

Study three findings present evidence for a possibly overlooked group of non-identified potential carers who are crucial in supporting university students. Previous literature has defined non-identified potential carers and young adult carers as between the ages of 15-24 (Hill et al., 2009; Becker & Becker, 2008), however adaptations to existing definitions to ensure recognition of the breadth of carers within a university context may be beneficial. Carers in this study were often attending university themselves, managing their own personal lives and academic demands alongside their supporting role, with some also having personal experiences of self-harm. This

group commonly described ‘just being there’ for the individual and ‘listening’ to their concerns, viewing their support as a part of their relationship and/or friendship. These relationships have been recognised as significant by students engaging in self-harm, allowing them to feel ‘cared for’, a factor in reducing their self-harm (Edwards-Bailey et al., 2022 – see chapter six). This vital role of unpaid care alongside the demands of university life further builds on earlier work amongst young adult carers at college and university (Sempik & Becker, 2014). Whilst recommendations were made to increase support provisions for this “hidden army” of university carers, study three findings suggest that further exploration of different forms of support, and the ways in which this may be impacting on the mental health and well-being of student carers are warranted on a wider scale. This is particularly critical given the increasing rates of poor mental health amongst university students (Kumaraswamy, 2013; Duffy et al., 2019), the established links of caring with higher rates of depression (Pinquart & Sörensen, 2003; Geng et al., 2018), and the limited help-seeking amongst this group (Sempik & Becker, 2014).

7.5 Study Limitations

The inclusion of multiple groups of supporters offered a broader understanding of individuals in supporting roles for students who self-harm. However, as a result, factors specific to the individual groups may not have been explored as extensively due to the broader recruitment strategy. Similarly, it is recognised that several supporters noted that there may be another sub-group of individuals providing care for university students – those in academic roles without professional support training such as lecturers and personal tutors. Whilst implications of this research may also be applicable to this group, this group were not included in the presented research, warranting further investigation. As noted previously, limitations spanning this thesis more broadly are discussed in the preceding chapter (see chapter eight).

7.6 Conclusion

These findings highlight the diversity of supporters and their roles within a university context, consisting of a spectrum of individuals from friends and family to healthcare professionals and well-being advisors, both within and outside the university setting (e.g., parents at home vs friends living with the individual). This multifaceted dynamic often presented challenges when accessing and delivering student care, as well as highlighting the differing needs and shared experiences of those in university caring roles. Coherent pathways for student support are vital in ensuring that those in need of care can access it without delay or the risk of being missed by services. Greater information around self-harm, recognition of the impact of the role and those who may be offering care in a university setting, as well as increased opportunities for networking and sharing experiences of providing support are suggested.

7.7 Personal Reflexivity

Conducting these interviews and this study was probably my favourite experience throughout my doctoral research journey. As with the interviews conducted in study two (chapter six), I felt privileged to hear the stories and experiences of this group, particularly the multiple perspectives and understanding more about the university systems and how it all works. I also felt that these interviews allowed me to gain a greater understanding of all the data that I have collected throughout my PhD, providing another layer to the way in which I interpreted and viewed the data, particularly with regards to the implications and understanding where the gaps lie within higher education support systems, as well as knowledge around self-harm and the impact that providing support can have on so many individuals involved in the university system.

When starting this study, following what students had shared in study two, I felt apprehensive. When conducting qualitative research, it is always challenging to separate yourself from your participants' stories. Given what students had disclosed to me in study two, I felt a sense of responsibility to discover how we could make a difference to students, and initially, expected that professionals would not be open in sharing any difficulties they had within their institutions. However, once I started these interviews, my perceptions shifted, and I felt particularly encouraged to hear that many professionals had an awareness into the struggles of university students, and the importance of understanding self-harm across the board. I found keeping a reflective diary after all these interviews was particularly useful to ensure I was aware of any feelings I may have been left with, and I would use these to think about how I could also develop my interview style and personal development moving forward (see Appendix U). Further, I drew upon my experiences of working as an assistant clinical psychologist, utilising supervision to reflect on this interview journey.

8. Chapter Eight: General Discussion

The overarching aim of this thesis was to gain a greater understanding of self-harm and help-seeking among UK university students. In addition, the current work aimed to explore the experiences of individuals providing support for UK university students engaging in self-harm, with specific attention to the impact of this role and the needs of university supporters. By adopting a mixed-methods approach across three individual studies, this thesis sought to bridge the gap between our existing knowledge of self-harm, the well-being of university students, support-seeking, and the role of both formal vs informal student carers.

Study one adopted a broader approach, collating quantitative data over a range of psychosocial measures for both university students reporting lifetime self-harm and those without, as well as those providing support to student self-harmers. The selection of measures was informed by previous self-harm literature, including methods, functions and motivations, rumination, alexithymia, and friendship. Open-ended questions allowed for greater knowledge of self-harm, support-seeking, and caregiving to be obtained. Studies two and three used qualitative designs to build on the findings of study one, capturing the experiences of university students who self-harm and those providing either professional or informal care for student self-harmers.

Whilst each study in the current thesis presents important findings, bringing these together offers a more comprehensive picture of self-harm, support-seeking, and the experiences of carers/supporters within a university context. As a result, this chapter will draw on the findings of the three studies, with an overview and summary of the key messages for each. The main findings of the overall thesis will then be explored in relation to the existing literature, with recognition of original contribution, strengths, and limitations. Finally, the implications and

suggestions for areas of future research are presented, with a summary of the researchers' reflections, ending with final conclusions.

8.1. Summary of the Current Thesis and Key Findings

8.1.1 Study One

In accordance with the aims of this thesis, study one consisted of an online questionnaire to build upon previous research conducted amongst university students. This included surveying a wider sample of students from across the UK, rather than being limited to particular universities (e.g., Borrill et al., 2009), as well as including those with experience of providing support for student self-harmers. The findings offered an updated understanding of self-harm, with similar functions and methods (i.e., affect regulation and cutting) reported amongst students with lifetime self-harm when compared to the existing literature amongst adolescents (Madge et al., 2008). Similarly, increased rates of alexithymia, EI, and rumination, as well as reduced social contacts, were detected. No differences were found across these variables between supporters and non-supporters. Whilst self-harm, on average, was initiated in early teenage years, more than a third indicated that these behaviours continued during university, and over half of participants had provided support to another student.

Open-ended data relating to support-seeking suggested mixed experiences. Stigma, fear of being judged and uncertainty with how information would be shared, were barriers to help-seeking for those with a history of self-harm. Further, a lack of awareness of how to access support and limited session availability was commonly reported across all students. For those who had accessed support, mainly through therapy or counselling, this was felt to be helpful by

the majority. Varied perceptions of the usefulness of apps and internet-based measures were expressed, particularly in relation to cost of use, ease of access, and anonymity. The findings also suggest that the majority of those supporting self-harm feel out of their depth and in need of their own support. This was often related to a lack of knowledge regarding self-harm and a fear of saying the wrong thing, revealing a potentially unique group of carers who are also managing their own study needs and well-being alongside supporting roles. For some, this triggered engagement in their own self-harm.

These findings identified the need for a more in-depth exploration of the direct impact of university on self-harming behaviours (i.e., specific triggers) and the experiences of those providing support, with a paucity of literature existing in these areas. Future directions for research following this study also suggested a need to explore the dual experience of personal self-harm and providing support for student self-harmers.

8.1.2 Study Two

Through interviews with students, study two aimed to address a key gap within the existing literature, as well as areas identified in study one, by qualitatively exploring self-harm in a UK university context. In particular, university triggers and experiences of help-seeking specific to self-harm were addressed. Reflexive TA identified three key themes relating to more general views and perceptions of self-harm, the positive and negative impacts of university on self-harm, and experiences of aiming to seek professional support whilst studying. Participants expressed feelings of isolation due to being misunderstood, particularly relating to their reasons for engaging in self-harm. This led to reflections on the way in which self-harm is defined, with the focus on methods rather than the emotional undertones being particularly unhelpful due to

reinforcing stereotypes. Suicidal ideations were felt to be separate to motivations behind self-harm. Whilst limited, when individuals had a safe and non-judgemental space to talk about their self-harm, this was particularly helpful. The need for self-harm to be spoken about more openly in order to address these stereotypes was a frequent suggestion among participants.

Key findings relating specifically to the university context indicated that increased academic workload and comparisons with peers led to increased engagement in self-harm, with studying in a second language being particularly difficult. In contrast, university offered a safe space and a chance to develop new relationships, as well as providing a sense of belonging and identity, consequently reducing self-harm. Experiences of help-seeking at university were mixed and highlighted disparity across institutions with regards to accessing support, availability of resources, and general awareness of service provision.

Overall, study two allowed for a deeper understanding of findings from study one. Students' ability to disclose their self-harm was limited due to fears of being judged, influenced by experiences of self-harm being misconstrued with regards to reasons for engagement (i.e., attention-seeking). The lack of trust relating to how information would be shared by professional supporters acted as a key barrier to accessing university support specifically for self-harm. Despite the growing recognition of university as a key time for supporting well-being and mental health (Universities UK, 2018a), as far as the researcher is aware, this is the first study to provide a qualitative exploration of student self-harm and support-seeking behaviour among a UK sample of university students.

8.1.3 Study Three

In line with the thesis aim to understand the experiences of individuals providing support for university students engaging in self-harm, study three presented findings from interviews with twenty-four supporters. The groups of individuals who had provided support revealed the broad spectrum of care within a university setting, ranging from professional support to more 'informal' supportive roles, often from friends and family. Findings also offered a unique insight into the experiences of those with their own experiences of self-harm alongside providing support, and how university life specifically affected engagement, or disengagement, in personal self-harming behaviours.

The spectrum of care for self-harm during university influenced the ways in which individuals delivered support (i.e., listening and practical support vs therapy and advice). Amongst 'informal' supporters there was a sense of helplessness and uncertainty when offering support, whereas professionals commented more frequently on funding and service constraints to existing provisions. The impact of providing support often had negative impacts on supporters' well-being, with many feeling overwhelmed. Establishing boundaries was helpful for overcoming this, but more difficult for individuals who shared accommodation with the self-harmer. For those with personal experiences of self-harm, their role of providing support was mixed, acting as a self-harm trigger for some, whereas others expressed feeling validated. However, some felt hypocritical when giving advice due to not following this themselves when considering their own self-harm. The needs of those providing support were expressed, including greater awareness and knowledge of self-harm, alongside personal support and strategies for managing their own well-being. The views of carers on university support provisions indicated that adequate support is lacking, with limited sessions and small staff teams. Increased awareness of

student mental health and self-harm among general university staff (e.g., tutors) would help to increase access to support and reduce shame, and information regarding how to access support needs to be clearer.

Findings from study three offered a nuanced perspective regarding the diverse nature of university care and support for student self-harm, and to the researcher's best knowledge, is the first study of its kind to explore the views of those offering support for university students engaging in self-harm.

8.2. Overall Key PhD Findings in the Context of the Existing Literature

The studies conducted within this thesis offer a broader and more in-depth understanding of self-harm and help-seeking specifically within a university context. This research captured the lived experiences of those with both personal self-harm and supporting roles, providing greater insight into individual factors, as well as wider organisational and social issues impacting student self-harm and care-seeking. This section aims to highlight the key and novel findings across the presented research, integrating the results within the existing evidence base. Recognition of the original contributions of this thesis to the literature are noted, including the development of existing concepts.

8.2.1 Definitions and Stereotypes Associated with Self-Harm

Individuals with personal experience of self-harm often felt that self-harm was misunderstood and stigmatised by others (studies one and two), attributed to focusing on the act/method of self-harm, rather than the underlying motivations and emotions associated with the behaviour (study two). This may be due to the stereotypical depictions of self-harm amongst the general

population that students described facing in their lifetime (study two), leading to stigma and limited understanding of self-harm amongst many of those offering support (study three). Understanding what may contribute to these existing beliefs about self-harm is important. Recent research focusing on the use of language regarding self-harm and suicidal behaviours found that over one-third of research studies between 2000-2015 included the word ‘commit’ when discussing these concepts (Nielsen et al., 2016). In light of research which has built on this by exploring preferred language among those affected by suicide, the use of ‘commit’ varies in its acceptability, with other terminology preferred (e.g., “died by suicide” or “attempted suicide”) (Padmanathan et al., 2019). Whilst this study looked less specifically at self-harm, in the context of the findings presented in the current thesis, including gaps in knowledge surrounding self-harm as reflected in the accounts of those offering support, consideration to the way in which self-harm is discussed, and the terminology used, may be crucial for reducing stigma and promoting openness. Those with personal experiences of self-harm, including individual’s with a dual role of offering support, also felt that an increased awareness and understanding would help to address the reluctance to openly discuss self-harm, as well as overcoming the supporters' sense of being out of their depth. Crucially, these findings suggest that raising awareness of self-harm, and considering the acceptability of language, has the potential to have positive effects for those both self-harming, and those in caring and supportive roles for this vulnerable group.

A particularly nuanced finding in the current research relates to views surrounding the language and terminology used to describe ‘self-harm’. Those with lived experiences of self-harm noted that the use of ‘harm’ added to the focus on the behaviours. There was also a tendency for those providing support, particularly ‘informal’ groups with no personal self-harming experience, to link self-harm behaviours with suicidal ideations. Whilst self-harm has

been identified as a potential risk factor for later suicide (e.g., Da Cruz et al., 2011; Joiner Jr et al., 2005), particularly among younger age groups, the findings of this thesis suggest a clear distinction between the two, particularly regarding motivations for self-harm. A meta-analysis of longitudinal studies reporting associations between self-harm as a risk factor for future suicide attempts, ideations, and death indicated that the predictive value of self-harm was weaker than expected (Riberio et al., 2016), supporting previous suggestion that self-harm may not be indicative of variable degrees of suicidality (Miller et al., 2013). Therefore, this emphasises the importance of considering self-harm in a wider context of the individual's life (e.g., childhood, support networks, relationships etc) (Riberio et al., 2016), rather than the tendency of the general population to focus on the behaviour itself, as described by both those with personal experiences of self-harm and those offering support.

8.2.2 Student Self-Harm - Understanding Across the Studies

Time spent at university is associated with both academic and personal benefits, including increased employability, opportunities for developing social and intimate relationships, as well as developing key life skills such as managing finances and a healthy diet (Hughes & Spanner, 2019). However, for some, this can lead to increased pressures and difficulties with adjusting to university life (Bantjes et al., 2022; Holm-Hadulla & Koutsoukou-Argyraki, 2015; Hughes & Spanner, 2019). The focus of the presented thesis on the influence of a university context on self-harm behaviours revealed both positive and negative experiences.

Onset of self-harm for participants in the presented thesis was most common during adolescence, in accordance with the existing literature (Madge et al., 2008), therefore, initiation of self-harm being prior to university. Methods and functions of self-harm amongst university

students in the current thesis shared similarities with the existing evidence-base amongst adolescents (e.g., cutting, experiential avoidance and poor emotion regulation) (Brereton & McGlinchey, 2020; Madge et al., 2008; Selby et al., 2013). However, the identification of both motivational, maintaining, and protective factors for self-harm that were specific to a university context provides expansion on the existing literature. Consistent with findings among first year university students, the initial transition period into university was felt to be particularly challenging (Conley et al., 2014, 2020). However, students and supporters commented on time points of heightened stress when self-harming behaviours specifically were felt to increase, including exam periods and feeling as though they did not understand assignments. These accounts offer further understanding to previous research with Oxford university students presenting to hospital as a result of self-harm, with increased referrals in the tertiary term, which is commonly associated with increased deadlines and exam-periods (Hawton et al., 2012a). Interestingly, students in study two noted that advertisements of supportive resources were often at specific times (e.g., freshers and mental health week). Whilst this is important given the established difficulty with transitioning to university, it appears that a more consistent approach throughout the year may be more helpful due to the differing needs and demands of individual students and their learning experience. A recent cohort study in Sweden found that university students studying health and nursing-related degrees were at a higher risk of suicide and self-harm than other programmes of study (Lageborn et al., 2023). Whilst some vulnerabilities prior to university may influence this, presentations emerged during university. Therefore, future research specifically exploring the experience of those at increased risk may help to tailor the findings of the presented thesis further. Universities may benefit from increasing awareness and support provisions for those individuals on health-related courses.

The influence of social connectedness and friendships on self-harm during university appears multifaceted when interpreting the findings across this thesis. Study one indicated that students who reported lifetime self-harm experienced reduced social contacts and poorer friendship quality compared to those without experiences of self-harm, in accordance with the existing literature (Plener et al., 2015). Findings from study two allowed for a greater understanding of these findings, with some expressing shame and guilt regarding their self-harm, encouraging withdrawal and isolation due to family members and support networks being less aware of their whereabouts and routines. On the other hand, attending university also provided an opportunity to promote friendships and relationships, which students in the presented research linked to a reduction in self-harm enactment and urges. This increase or reduction was also influenced by self-identity, which for some developed through these friendships, and for others related to the sense of purpose that studying at university brought. In contrast, some students felt that university challenged their existing sense of self (e.g., being 'top of the class' at school), reducing well-being. Previous research amongst doctoral researchers highlighted that increased social support and a positive relationship with university supervisors were protective for student mental health difficulties (Hazell et al., 2020). These findings, and those of the current thesis, may be understood in the context of 'positive psychology' literature. The concept of positive self-identity and 'mattering' (i.e., a sense of feeling important to others) is related to increased psychological well-being, with those who do not feel important to others being more likely to experience depression and suicidal ideations (Flett et al., 2019; Vaughan & Rodriquez, 2014). Flett et al. (2019) proposed strategies to be used by universities to promote self-identity and 'mattering', such as peer-mentoring and creating roles and opportunities for students to become involved with during their studies. The findings of the current thesis indicate that these principles

could be particularly important for students engaging in self-harm given several comments regarding the positive impact that hearing from others with lived experience could have with regards to validation, and the power of connecting with others. Therefore, further research in which these techniques are applied with this distinct group is warranted.

Whilst cutting was the most common form of self-harm reported for university students on psychosocial measures (study one), qualitative accounts indicated that existing definitions and outcomes may not recognise other ways of self-harming which may be more socially accepted within a university context, for example binge-drinking and engagement in risky behaviours (studies two & three). This poses potential conflict in connection with the findings regarding language and the way the general population perceive self-harm. Is it that our 'definitions' of self-harm need to be broader and more inclusive of all behaviours discussed in this thesis to promote understanding and openness, or would a shift away from viewing these behaviours as 'committed actions' and 'harmful' by adjusting terminology and language be more helpful? Clearly the feelings and needs of those who self-harm require validation and empathy, and these findings ask the question of how this can be achieved. This is not a question that the current thesis can answer due to its scope but presents an interesting question and point of discussion for academics and professionals working directly with self-harm, and the student population more specifically. When considering binge-drinking, a recent study with prospective university students reported that individuals view drinking at university as a way of forming connections and friendships, therefore highlighting the potential difference in motivations for binge-drinking at university (i.e., integration vs harming behaviours) (Gambles et al., 2022).

8.2.3 Student Support: Platforms, Barriers, and Facilitators

It is evident from the current literature and the recent publication of several key documents regarding student mental health and suicide (e.g., The Student Charter and Suicide-Safer Universities (De Pury & Dicks, 2023; Hughes & Spanner, 2019; Universities UK, 2018b) that existing approaches to student support requires change. Further, the importance of a joint collective to prioritise student mental health between universities, the National Health Service (NHS) and the UK government has been suggested (Brown, 2016). Students and supporters in the current thesis expressed frustration with existing waiting lists, and the lack of communication between university-based services vs external support pathways (e.g., NHS), with students reaching 'crisis' point before presenting to services (e.g., the emergency department). Due to the long waiting lists and limited availability of support, students did not disclose about their self-harm, or were unable to access the support when they felt they needed it most. This suggests that following the evidence-base (e.g., specific psychological therapies as per NICE guidelines, see chapter two, section 2.6) with regards to supporting self-harm is particularly challenging in a university setting, offering further support for the need to alter existing practice, specifically regarding clearer pathways to prevent students being missed. Considering this in light of study two findings, those with lived experience of self-harm expressed that whilst feeling understood and accepted enabled them talk about or show their self-harm, this was rarely experienced.

Data collated across the three studies highlighted diversity in experiences of support-seeking, as well as preferences of the ways in which support could be delivered. Consistent with qualitative findings amongst indigenous Australian students (Oliver et al., 2016), individuals in the present research felt that a greater understanding of self-harm amongst university personnel, including lecturers, personal tutors, and peers, would be beneficial. Evans et al. (2018) found that

approximately half of teaching staff in UK secondary schools had received training on self-harm, and only 22% rated this training as adequate. Further, doctoral researchers in a previous study reported supervisors and university staff as ill-prepared and 'freaked out' when discussing suicide (Hazell et al., 2021). Whilst research has yet to be conducted from a university staff perspective, given the comments of students and professional supporters concerning a lack of understanding around self-harm, and several finding subject staff easier to talk to than support services, it is likely that there is demand for further training and education across all university personnel on the topic of self-harm. Further, the preference of several participants to seek support from course staff shows a clear distinction amongst university students, considering adolescents most often report family and friends as their preferred means of support (Rowe et al., 2014), indicating a potential separation from previous support networks as they advance into adulthood. This may also explain why positive supervisory relationships have been identified as protective for mental health difficulties in doctoral researchers (Hazell et al., 2020).

In response to existing barriers identified for accessing support for mental health and self-harm specifically, the use of internet-based measures including apps have been suggested (Cliffe et al., 2021). Findings from the current thesis offer a novel perspective on the use of these supportive resources from students who self-harm and their supporters. Nearly a third of students had accessed apps and found these helpful as a means of distraction in the short-term. However, similarly to previous research, both supporters and students who self-harm often noted the limitations that they may have regarding long-term effectiveness and a lack of face-to-face and personal connection (Cliffe et al., 2023; Witt et al., 2018). When considering the findings relating to the positive impact of connecting with others at university in study two, this suggests that online support could offer this to an extent and may act as an initial stage to help-seeking,

however due to the differing needs of students who self-harm, alternative means of support alongside these resources are needed. By only offering online support, we risk isolating a group who are already battling with loneliness and feeling ostracised.

There is often a conflict in the literature related to what self-harm carers feel their role involves and what they offer, vs what the cared-for find helpful and what they are seeking (e.g., Jeffery & Warm, 2002; Warm et al., 2003). By collating multiple perspectives, the factors that may be similar and different with regards to what a 'supporter' is, and what students who self-harm felt was helpful, can be considered in conjunction. In the presented thesis, different views regarding what behaviours are considered self-harm between those with personal experience and those offering support influenced their perception of what the individual needed and the meaning of support. Evidence of this came to light during interviews with supporters (study three), who tended to focus on stopping the individual engaging in self-harm, commonly attributed to the risk associated with injuries and fear of self-harm resulting in suicide attempts or death. Some supporters, particularly friends and family, expressed a sense of needing to 'do' something, which for most was perceived as a direct action (e.g., getting the individual professional help). This contrasts with qualitative research among parents with adolescents who self-harm, with parents often underestimating associated risk and delays in addressing the self-harm (Oldershaw et al., 2008). Therefore, this may indicate a greater understanding of self-harm developing within the general population, or the difference in adolescent vs adult relationships. Interestingly, when considering the perspectives of those with personal self-harm in studies one and two, the majority indicated that they just needed someone to listen/be with them, rather than a need to address the self-harm specifically.

8.2.4 The Impact of Providing Support for Student Self-Harm

A key finding of the presented work is the spectrum of care and support within a university setting, ranging from professionals to friends and family, as well as students with their own mental health difficulties and experiences of self-harm. This presents a novel angle, with the existing literature often focusing on specific groups of supporters, thereby providing a broader and more holistic picture of university support.

Demand for overall student support, as well as counselling and disability services, has increased significantly in recent years (e.g., 'Suicide Safer Universities', University UK, 2018, p.13). Professional university supporters often worked within small teams and had limited capacity with regard to staffing and session numbers available, echoing the barriers to help-seeking identified by students in studies one and two. In the UK, talking therapy has been identified as an NHS 'blind spot' due to inconsistent waiting times (Cooper, 2018), and private counselling estimated to cost between £10-£70 per session (NHS, 2021a). Previous research has reported that anxiety, depression, and poor quality of life increase with treatment waiting times for both patients and carers (Reichert & Jacobs, 2018; Gagliardi et al., 2021). Further, professional carers in these systems are under increasing pressure due to extended waiting lists and demand to evidence the effectiveness of the services they provide (e.g., Randall & Bewick, 2016). Therefore, the increasing pressures on supporters reported in the present study, resulting in staff needing to take sick leave as a result of the stressful working conditions, may be influenced by these factors.

In the current research, those in professional supporting roles reported receiving little training and information regarding self-harm, often impacting their confidence in addressing and managing the behaviour. These findings share similarities with those of other professionals

working in educational contexts, with high school teachers feeling unprepared when dealing with self-harm and suicidal ideations amongst pupils (Berger et al., 2014). Across staff working in A&E, CAMHS and schools, the majority indicate that further training regarding self-harm is required (Rayner at al., 2019; Timson et al., 2012), with a recent systematic review indicating that greater awareness reduces stigma and increases confidence (Mughal et al., 2022). The findings presented in this thesis indicate that these knowledge gaps and uncertainty regarding self-harm extend into university settings. Therefore, further training for all those working in universities, including those who may be offering more ‘informal’ means of support specifically for self-harm, would likely benefit both students and those in supporting roles.

Friends are often the first individuals that adolescents who self-harm disclose too, offering the individual emotional support and help with reducing the behaviour and promoting help-seeking (Fortune at al., 2008; Rowe et al., 2014). However, this can also be overwhelming, and having a friend who self-harms can increase the chances of personally engaging in self-harming behaviours (Copeland et al., 2019; Hall & Melia, 2023). When considering this dynamic in a university context, the inclusion of participants with personal experiences of self-harm and caring roles offered an interesting perspective. The presence of a friend self-harming was triggering for some, however others suggested that this prompted a reduction of their own self-harm, with particular emphasis on living arrangements. Sharing accommodation with the individual (i.e., in halls of residence or shared housing, which is common among students) increased the likelihood of the supporter expressing their role as a carer as triggering for their own self-harm. This was also observed when focusing on well-being more broadly, with housemates finding difficulty in creating boundaries compared to professionals. When noting the influence of self-identity on increasing or decreasing self-harm at university, previous findings

suggesting that adolescents may self-harm as a way of conforming to group norms and achieving a sense of self (Heilbron & Prinstein, 2008; Muehlenkamp et al., 2012) may also be applicable to the university environment.

8.3 Thesis Strengths and Limitations

Limitations specific to the individual studies have been considered within the corresponding results chapters (five-seven). Therefore, this section will focus specifically on some of the key strengths and limitations across this thesis more broadly, including 1) Exclusion criteria, 2) Interview platforms, 3) COVID-19, 4) Multiple Perspectives, and 5) Dissemination.

8.3.1 Exclusion Criteria

Participants who had attempted suicide in the last six months and/or those experiencing active suicidal thoughts were excluded due to ethical considerations regarding participant safety. Given that those who self-harm are at an increased risk of suicide (e.g., Hawton et al., 2015), the study findings may be limited to a homogeneous sample of self-harm. In addition, this study only included students at UK-based universities. Considering definitions of self-harm, as well as university structures and environments that differ internationally, further research exploring experiences of university students who have attempted suicide, and those studying outside of the UK, would allow for any similarities or differences with the presented findings to be explored.

8.3.2 Interview Platforms

This thesis offers a first-hand account of experiences of self-harm and support from those studying and working across multiple institutions and geographical locations. In doing so, a variety of media platforms were used for interviews which may have impacted data quality. Most of the interviews conducted within this thesis took place via telephone, and the absence of visual cues can impact on the richness of data collected (Novick, 2008). However, research comparing transcripts between those conducted face-to-face vs telephone indicated no major differences in the depth of interview data collected (Sturges & Hanrahan, 2004). In study two, at times, the instant messenger interview lacked depth of information; however, this was only used for one interview in the instance that the participant did not feel comfortable using other platforms, promoting inclusion. In addition, given that this research aimed to collect data from a diverse sample across the UK, the use of telephone, skype and instant messenger for interviews enabled broader participation than would otherwise have been possible with only conducting face-to-face interviews.

8.3.3 COVID-19

The researcher acknowledges that since conducting this research, support systems may have altered within universities, both prior to and after the COVID-19 pandemic. The pandemic has significantly impacted the way in which universities in the UK, and worldwide, are set-up, including adjustments to online learning, with many students not being able to socialise or access face-to-face support. Research exploring the impact of the COVID-19 pandemic on student mental health is continuing to emerge, with negative impacts on students emotional and behavioural functioning reported globally (Cao et al., 2020; Copeland et al., 2021). Further,

negative health impacts on carers have also been documented among those caring for family members with mental health difficulties (Clark Bryan et al., 2020; Tuijt et al., 2021). Therefore, some of the experiences discussed in this study require further exploration in the context of COVID and university, including the significance of living with someone who may be engaging in self-harm, or living further away and not being able to visit or see their loved ones for considerable amounts of time (e.g., during lockdowns). In addition, many professional carers have been providing support from their homes and/or via online means, and research has yet to understand how this may have impacted their well-being, ability to establish boundaries, and social support. As the world continues to respond and monitor the pandemic, the significance of this time on these groups of university supporters, as well as students who self-harm, requires monitoring.

8.3.4 Multiple Perspectives

Across this thesis, the data has been strengthened and expanded by the inclusion of multiple participants involved in, or impacted by, a university context and help-seeking. By bringing these findings together, identification of the needs of students who self-harm alongside the set-up of university support and the needs of those in caring roles has been possible. This is particularly important given the secretive and private nature of self-harm, increasing the likelihood of omitting certain experiences, which additional perspectives of those in supportive roles may offer. Considering differences and similarities between the groups promoted further understanding regarding perceptions of self-harm and support pathways, increasing triangulation across the analyses. This has been particularly crucial for the suggestions and implications of the current research.

8.3.5 Dissemination

Strategies applied to share the findings of this thesis offer a particular strength to this research. At an academic level, results from all three studies have been presented at both national and international conferences (see page 15 for a summary), as well as publication in peer-reviewed journals (i.e., study two and study three). However, whilst these avenues of sharing research are crucial within the field of psychology and science, dissemination of research findings on a wider scale is frequently overlooked, despite forming a key part of the researcher's role (Langat et al., 2011). Given the original aims of this thesis and the reflections of participants regarding the inability to disclose their difficulties with family members, managers, and fellow staff, it was recognised that audiences beyond that of academics could benefit from the findings, and therefore several other dissemination strategies were used.

Based upon the findings from studies one and two, two key documents were devised in order to summarise the main messages that students explored across questionnaires and interviews, providing a platform to share their thoughts and views with those providing direct care to university students engaging in self-harm. Given the emphasis on time points, the transition to university, referral processes and the impact of leaving the university environment and support after studying, a diagram highlighting the key timepoints and how these could be addressed was devised (see Figure 18). To provide further information regarding the diagram, a leaflet offering more detail and insight into these key stages was also developed (see Appendix W). These documents were shared with all participants who indicated in study one and two that they were happy to be contacted, alongside all the universities and organisations contacted for recruitment.

Figure 18

What Support May be Helpful for Students who Self-Harm During the University Transition Process?

What support may be helpful for students who self-harm during the University transition process?

University Stages: Key time-points for support	Stage 1 BEFORE UNIVERSITY: Students consider universities for application, applications made, provisional offer received	Stage 2 BEFORE UNIVERSITY: Provisional Offer requirements met, student preparing for studies to commence	Stage 3 DURING UNIVERSITY: Enrolment and Induction/Welcome to University	Stage 4 DURING UNIVERSITY: Student accessing support services, referrals, assessment of needs	Stage 5 DURING/AFTER UNIVERSITY: Supporting students who self-harm with ongoing sessions/Ending of support
Areas of development	Accessibility Information Key Contacts		Visibility Promotion and Presence Encouragement	Differing approaches Communication Interventions – clear pathway Tailored and specific support for self-harm	Exploration Alternative support Endings Smooth Transition
Areas of development – what do students want?	**Accessibility** Review of information available for prospective students **Information** How to access University services before starting courses should be made available e.g. sending out leaflets, University websites, student prospectus, emails, advertise in offer and acceptance letters **Contacts** Opportunity for prospective students to contact University personnel and set up support for when arriving at University		**Visibility** Staff and supporting staff to be identifiable – e.g. badges, t-shirts **Promotion and Presence** Freshers events and specific well-being hubs/events to be used to promote services and conversations amongst the study body **Encouragement** Stories, talks and experiences of those who have accessed support or experienced difficulties to be shared. Peer-support and/or mentoring schemes to be offered	**Differing approaches** Learning support/options for those who may find aspects of University triggering – e.g. offering time out cards, flexible assessment procedures **Communication** Prompt response to referrals, cancellations and appointment changes need to be clearly communicated to students **Interventions** Clear support pathway and management of expectations. Number of sessions offered to be approached sensitively – validation of feelings **Tailored and specific support for self-harm** Leaflets and information should be specific to self-harm and recognised in isolation as well as alongside other mental health difficulties	**Exploration** Self-harm to be safely explored and support to be tailored to student specific difficulties **Alternative support** Options of other support services/methods outside of sessions and on ending of support (e.g. external, apps etc). Safe Spaces – Creation and development of 'safe' spaces and 'chill out/time out' zones for students **Endings** Allow for potential difficulties after ending support sessions from University to be addressed. Skills and Information into approaching conversations around self-harm with family members/friends/peers and University personnel to be explored. Follow-up/check-in sessions **Smooth Transition** Allowing students to feel supported after University is crucial. Care/Safety plans with additional information (e.g. how to access support after University)

In study three, participants disclosed difficulties managing self-harm, as well as uncertainty regarding where to find information about self-harm and support available for themselves and the individual they supported. In response, a website (www.cherishsupport.co.uk) was developed following a successful grant application with the Sir Halley Stewart Trust. CHERISH support (2020) (Caring for Self-Harm: Resources and Information for Supporting Students in Higher Education) offers a website for individuals providing support for university students engaging in self-harm with varying levels of experience and awareness of self-harm, as explored within this thesis. The website aims to bring together the findings from the current research and implement the need for a more unified platform of resources for those who may be providing support for self-harm, either informally or professionally (see Appendix X). The voice of those with lived experience of self-harm are shared on the website as a means of raising awareness. During the making of this website, focus groups and an online feedback questionnaire for professional supporters, friends and family, as well as those with personal experiences of self-harm, were utilised. This allowed for further adaptation and consideration to their needs and what would be most beneficial for the differing groups at which the website is aimed.

As part of the website launch, which coincided with World Mental Health Day (WMHD) 2020, an event was run all week in which blogs, videos, and resources were shared on the website and social media platforms. Following this, a new blog was released monthly to share research and relevant information regarding self-harm and mental health more broadly. The website was also picked up by local radio, and the researcher and a participant were interviewed on BBC Radio London by Vanessa Feltz on 9th October 2020. To mark the one-year anniversary of the launch, and in line with WMHD 2021, a video was created to share the key findings from across this thesis (see Appendix Y), hosted on YouTube and widely shared across universities

and support organisations. On YouTube alone, the video has 72 views. In addition, in line with carers week 2022, CHERISH hosted a carers event consisting of a day of presentations from individuals working in the field of education and care. A piece of artwork was created to summarise key messages from the day and posted on the website (see Appendix Z). Since launching the website, it has received over 4,800 views with users from across the globe (e.g., UK, Europe, and USA).

8.4 Recommendations and Implications of the Current Thesis and Future Research

Findings from the presented thesis have key implications for both research and practice. Understanding the experiences of students engaging in self-harm during university offers insight into the current barriers to accessing support, as well as key time periods and factors that may lead to increased self-harm engagement within the university environment. Universities may find these experiences useful in facilitating the development of current support provisions, referral pathways, and resources for students during their time at university (e.g., greater advertisements across universities about the support available as well as information regarding confidentiality and how information is shared). Further, if universities can promote the importance of student well-being and more specifically, encourage open discussion about self-harm (e.g., through mentoring schemes and psychoeducation resources specific to self-harm rather than mental health more broadly), this may help to address the stigma and shame that students experienced. These methods have been effective in school-based mental health programmes, acting as the most utilised setting in which children access support, as well as reaching groups who are less likely to approach conventional support services (Allison et al., 2007; Duong et al., 2021). Information about how to seek support prior to attending university, as well as maintaining

awareness of supportive resources throughout their studies (e.g., through regular promotions and advertisements), provides further opportunity to assist students in adjusting to university life.

Implications for both formal and informal carers for university students, as well as students engaging in self-harm, are highlighted. Whilst some participants reported negative impacts on their own wellbeing and issues with the support available to the individuals they cared for, as well as themselves, these experiences provide clear opportunities and areas in which universities and organisations can focus their attention. Supporting students experiencing mental health difficulties, and additional comorbid behaviours such as self-harm, is crucial. These findings also emphasise the need for supportive resources aimed specifically at those in caring roles. Individuals from differing backgrounds and experiences will likely benefit from tailored interventions (e.g., information about self-harm, establishing boundaries, and promoting self-care at home/in the workplace), which should be adapted to specifically meet the needs of different groups of carers within a university context that this thesis has brought to light. It is important to recognise that not all individuals may identify as a carer, and greater acknowledgement and normalisation of needing support when providing care or support for others is warranted. As mentioned above, findings of the current study have influenced the development of a website aimed at those caring for student self-harm (www.cherishsupport.co.uk). Additionally, recognition and attention at institutional and stakeholder level are required, such as promoting conversations around self-harm, increased resources for university-wide self-harm and suicide awareness training, and greater provisions for student and staff support.

Further research with regards to the specific models of support used in universities is needed. Students most frequently listed CBT and counselling for the types of professional support accessed, however university support specifically was limited in terms of session numbers and

scope of the individual's difficulties (i.e., often signposting to other services), therefore questioning the extent to which the evidence-base for supporting self-harm is being applied in this setting. It was also suggested that students were often at crisis point and/or in need of immediate support rather than having to wait for significant time periods during heightened stress points at university. Considering this, and the need for 'acceptance' regarding self-harm, future research may benefit from exploration of the utility of 'Acceptance and Commitment Therapy (ACT)' among this group, which is considered a third-wave approach of CBT. ACT has previously shown a significant effect on emotion control among adolescents who self-harm (Komarati et al., 2023), as well as reductions in self-harming behaviours linked to improving psychological flexibility (Bryan et al., 2015; Ducasse et al., 2014). A shorter-term intensive version of ACT called Focused ACT (fACT) has been developed, with a specific focus on repetitive negative thinking (RNT). A recent study compared two sessions of RNT-focused ACT to a waitlist control for individuals with depression and generalised anxiety disorder (GAD), with a significant reduction in depression, anxiety and stress scores immediately following the intervention, and at 3-month follow-up (Ruiz et al., 2020). Given the levels of rumination reported in study one, and qualitatively in study two, this may offer a potential approach more suitable for the university environment. However, due to the limited research in this area, further exploration is required.

Given that several students discussed the potential benefits of speaking to course and subject staff, and previous findings suggesting a positive supervisory relationship as protective for student mental health difficulties (Berry et al., 2021; Hazell et al., 2020), awareness of current provisions for training university staff around self-harm, and if existing, the effectiveness of these resources, would be helpful to establish. In addition, research from a university staff's

perspective on whether students approaching them for pastoral support is a common occurrence, and how they feel in responding to these situations, would enable a greater understanding of how students may be reaching out for support. Increased awareness of the different resources and strategies available across institutions, including what has been helpful and unhelpful for both students and those staff members delivering student care is needed, both within the UK and internationally. These multiple viewpoints would provide an opportunity for a more standardised and tailored approach to support for self-harm amongst university students, as well as the chance for institutions to learn from one another, ensuring that all those requiring support during their time of study have an equal opportunity to access and utilise effective resources. This particularly resonates with the 'Stepchange: Mentally Healthy Universities' initiative, promoting collaboration and alignment across institutions (De Pury & Dicks, 2023, p.5).

Considering this, one aspect that may be particularly important is whether the individual attends university in an urban vs rural setting and whether they have had to move to a different location for their university studies. In the US, those living in rural locations are more likely to engage in self-harm, including increased attendance at emergency departments, than those in urban settings (Hoffman et al., 2021). In contrast, UK-based studies show higher rates of self-harm in urban vs rural locations, non-white ethnicity, unemployment, and those living alone (Harriss & Hawton, 2011), providing an interesting phenomenon for further exploration. Similarly, all participants in the current study had started self-harming before attending university. Whilst consistent with the literature in that most self-harm initiates during adolescence (Evans & Hurrell, 2016; Swannell et al., 2014), future research exploring experiences of those who began self-harming during university would allow for any similarities, or differences, with the presented findings to be identified. Finally, whilst this study was not

able to explore the experience of ethnic minority groups and international students comprehensively, findings were suggestive of challenging experiences for these individuals. Further research focusing specifically on these groups would help identify their needs, and if required, ways in which universities can tailor support for these groups more specifically.

A clear strength of this research is the identification of factors relating to the motivations and maintenance of self-harm during university. However, whilst this can allow us to identify potential areas of intervention and support for students, the ability to distinguish why university had positive impacts for some, and not for others, is limited. Further research considering the influence of psychosocial factors prior to university may be helpful in further adapting and tailoring university support systems.

8.5 Reflexivity: Final Reflections from the Doctoral Researcher

For the interviews, particularly those in study three, I was able to draw upon my clinical experiences of working psychologically with patients, families, and healthcare MDTs, whilst also recognising the distinctions in my roles as a researcher vs clinician. As I conclude the work undertaken for my thesis, I have reflected on my journey as a doctoral researcher and how I have developed along the way.

Following the conduction of several interviews in study two, I believe that I started to develop my confidence with regards to my interview style, learning that some flexibility during interviews is helpful with regards to asking participants to expand on certain points. This facilitated deeper understanding of experiences and interactions, which I likely missed earlier on due to my anxiety relating to sticking to the interview schedule more rigidly. I believe this flexibility also enabled further alignment with my epistemological position of critical realism

(CR), with the greater depth of information elicited from participants influencing my critical thinking and consideration of their wider contexts in which these experiences occurred.

During my PhD, I also undertook training with regards to unconscious biases as part of my clinical NHS role. This brought up lots of questions and reflections for me, and I became aware of assumptions I may have made during my research. Again, alongside developing my confidence, this broadened my understanding of my own biases and led me to clarify pointers with participants more regularly, rather than assuming that my interpretation of their experience was correct. Again, this also led me to consider my epistemological stance (i.e., CR), and how my own awareness of certain settings and social structures likely influenced the way in which I interpreted the data and the critical lense applied. When considering the CR literature, Bhaskar (1993) discusses this in the context of 'absences', and that due to the complex layers that exist in the world, absences will always have some impact on us as researchers. I believe this encouraged me to reflect more broadly on the concept of epistemology, and my alignment with the belief that all research is subjected to a level of human bias, whilst acknowledging the importance of the reflective process in bringing my awareness of my own biases - or 'absences' in my knowledge (Bhaskar, 1993) - to light, which I believe have developed my ability and skills as a researcher.

I have also learnt the importance of research for influencing my clinical practice, and vice-versa, and how working at an interface between practice and research is a truly unique and rewarding experience. I have aimed to take the voice of my participants into my clinical work when discussing self-harm with adolescents and families and feel particularly grateful for what my participants have taught me. I have realised that whilst we have important knowledge and roles as both researchers and clinicians, the individuals we work with can teach us so much about ourselves and wider society, and to deliver the best level of care, we truly need to promote the

voices of those with lived experience. I truly hope I have done justice to my participants in this write up, whilst also noting the pressure this can place on researchers. I did at times find it difficult to cut down words and data with a sense of feeling as though I needed to share everyone's stories. I believe I have developed to some extent the ability to hold my research questions in mind and share the findings which are most important for practice, answering the questions that I initially set out to address.

8.6 Final Conclusions

The current thesis presents research that addresses a clear call for further exploration of student self-harm, as proposed in the 'Suicide-Safer Universities' publication (Universities UK, 2018). Unlike previous studies targeting how universities can boost student well-being (Baik et al., 2019), this thesis offered a distinct and nuanced perspective on how support can be enhanced, specifically for those with experiences of self-harm. Consideration to both those with personal self-harm, and the views of those providing support within a university context, added depth to our understanding of university support. For example, information regarding student support prior to making university applications would allow for this to be considered when students are deciding where to study. Once at university, certain time points within the academic year were related to increased occurrence of self-harm, which are important for universities and student support services to be aware of. This research also evidenced that many individuals providing support for students engaging in self-harm feel out of their depth. For the first-time, these findings shed light on the impact of providing support in a university setting, and consequently, the differing needs of those offering care to students. Evidence for a possibly overlooked group of non-identified potential carers who are crucial in supporting university students is presented.

Whilst previous literature has defined non-identified potential carers and young adult carers, results of this research suggest that adaptations to existing definitions are required to reflect the broad spectrum of university care that this thesis revealed. Carers in this study were often attending university themselves, managing their own personal lives and academic demands alongside their supporting role, with some also having personal experiences of self-harm. Resultantly, these findings are important for policy makers to consider when aiming to achieve 'mentally healthy universities' (De Pury & Dicks, 2023), given that those offering care also need to care for themselves in order to promote a positive supportive relationship.

Existing initiatives highlight the need for increased support provisions and greater communication between universities and external support services (including families and NHS services) (Brown, 2016), however attention is also needed regarding the barriers that students who self-harm face in accessing any support. Limited availability of support was noted, alongside additional variables such as awareness of organisations and experiences prior to university that are impactful. A more proactive approach during earlier educational journeys may be helpful in preparing students for university and supporting adjustment at an early stage to reduce the negative impact of university demands and lifestyles on student self-harm. Findings of the current research suggest disparity in what is proposed in existing policy vs what is occurring on the ground, with many students failing to access the support they need. Specifically for self-harm, limited sessions were key in preventing disclosure. Therefore, whilst broader policies and initiatives are crucial, there is a need for an individualised and flexible approach to support, specifically when considering student self-harm.

Findings relating specifically to triggers and protective factors for self-harm, which were unique to the university environment, are particularly important for expanding the existing self-

harm literature. By holding in mind the views of students engaging in self-harm, and those offering support, key opportunities for intervention and support are highlighted. Awareness of supportive pathways at university prior to attending would promote familiarity and a sense of university prioritising student difficulties, with the potential to increase access to support. Further, this may also reduce the anxiety and concerns of family and friends who may be offering informal support, allowing them to search and guide the individual/s to the available resources. This thesis has gone some way in addressing this (e.g., development of leaflets and websites), however there is still work to be done in order to implement change on a wider scale.

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Appendix A: The Inventory of Statements About Self-Injury (ISAS) (Klonsky & Glenn, 2009)

INVENTORY OF STATEMENTS ABOUT SELF-INJURY (ISAS) – SECTION I. BEHAVIORS

This questionnaire asks about a variety of self-harm behaviors. Please only endorse a behavior if you have done it intentionally (i.e., on purpose) and without suicidal intent (i.e., not for suicidal reasons).

1. Please estimate the number of times in your life you have intentionally (i.e., on purpose) performed each type of non-suicidal self-harm (e.g., 0, 10, 100, 500):

Cutting	____	Severe Scratching	____
Biting	____	Banging or Hitting Self	____
Burning	____	Interfering w/ Wound Healing (e.g., picking scabs)	____
Carving	____	Rubbing Skin Against Rough Surface	____
Pinching	____	Sticking Self w/ Needles	____
Pulling Hair	____	Swallowing Dangerous Substances	____

Other _______________, ____

****

***Important*: If you have performed one or more of the behaviors listed above, please complete the final part of this questionnaire. If you have not performed any of the behaviors listed above, you are done with this particular questionnaire and should continue to the next.**

****

2. If you feel that you have a *main* form of self-harm, please circle the behavior(s) on the first page above that you consider to be your main form of self-harm.

3. At what age did you:

First harm yourself? ____________ Most recently harm yourself? ____________
(approximate date – month/date/year)

4. Do you experience physical pain during self-harm?

Please circle a choice: YES SOMETIMES NO

5. When you self-harm, are you alone?

Please circle a choice: YES SOMETIMES NO

6. Typically, how much time elapses from the time you have the urge to self-harm until you act on the urge?

Please circle a choice:

< 1 hour 1 - 3 hours 3 - 6 hours

6 - 12 hours 12 - 24 hours > 1 day

7. Do/did you want to stop self-harming?

Please circle a choice: YES NO

INVENTORY OF STATEMENTS ABOUT SELF-INJURY (ISAS) – FUNCTIONS SHORT FORM

This questionnaire asks about a variety of self-harm behaviors. Please only endorse a behavior if you have done it intentionally (i.e., on purpose) and without suicidal intent.

Name:_______________

Date:________________

Instructions
This inventory was written to help us better understand the experience of non-suicidal self-harm. Below is a list of statements that may or may not be relevant to your experience of self-harm. Please identify the statements that are most relevant for you:

- Circle **0** if the statement **not relevant** for you at all
- Circle **1** if the statement is **somewhat relevant** for you
- Circle **2** if the statement is **very relevant** for you

"When I self-harm, I am …	**Response**		
1. creating a boundary between myself and others	0	1	2
2. giving myself a way to care for myself (by attending to the wound)	0	1	2
3. causing pain so I will stop feeling numb	0	1	2
4. avoiding the impulse to attempt suicide	0	1	2
5. bonding with peers	0	1	2
6. letting others know the extent of my emotional pain	0	1	2
7. seeing if I can stand the pain	0	1	2
8. creating a physical sign that I feel awful	0	1	2
9. getting back at someone	0	1	2
10. releasing emotional pressure that has built up inside of me	0	1	2
11. expressing anger towards myself for being worthless or stupid	0	1	2
12. trying to feel something (as opposed to nothing) even if it is physical pain	0	1	2
13. entertaining myself or others by doing something extreme	0	1	2
14. seeking care or help from others	0	1	2
15. getting revenge against others	0	1	2

Response Key: 0 – not relevant, **1** – somewhat relevant, **2** – very relevant

16. demonstrating that I do not need to rely on others for help	0	1	2
17. reducing anxiety, frustration, anger, or other overwhelming emotions	0	1	2
18. establishing a barrier between myself and others	0	1	2
19. reacting to feeling unhappy with myself or disgusted with myself	0	1	2
20. allowing myself to focus on treating the injury, which can be gratifying or satisfying	0	1	2
21. putting a stop to suicidal thoughts	0	1	2
22. pushing my limits in a manner akin to skydiving or other extreme activities	0	1	2
23. creating a sign of friendship or kinship with friends or loved ones	0	1	2
24. proving I can take the physical pain	0	1	2
25. signifying the emotional distress I'm experiencing	0	1	2
26. establishing that I am autonomous/independent	0	1	2

Appendix B: Toronto Alexithymia Scale (TAS-20) (Bagby et al., 1994)

Using the scale provided as a guide, indicate how much you agree or disagree with each of the following statements by circling the corresponding number. Give only one answer for each statement.

	Strongly Disagree	Moderately Disagree	Neither Disagree Nor Agree	Moderately Agree	Strongly Agree
1. I am often confused about what emotion I am feeling.	1	2	3	4	5
2. It is difficult for me to find the right words for my feelings.	1	2	3	4	5
3. I have physical sensations that even doctors don't understand.	1	2	3	4	5
4. I am able to describe my feelings easily.	1	2	3	4	5
5. I prefer to analyze problems rather than just describe them.	1	2	3	4	5
6. When I am upset, I don't know if I am sad, frightened, or angry.	1	2	3	4	5
7. I am often puzzled by sensations in my body	1	2	3	4	5
8. I prefer to just let things happen rather than understand why they turned out that way	1	2	3	4	5
9. I have feelings that I can't quite identify	1	2	3	4	5
10. Being in touch with emotions is essential	1	2	3	4	5
11. I find it hard to describe how I feel about people.	1	2	3	4	5
12. People tell me to describe my feelings more	1	2	3	4	5
13. I don't know what's going on inside me.	1	2	3	4	5
14. I often don't know why I am angry.	1	2	3	4	5
15. I prefer talking to people about their daily activities rather than their feelings	1	2	3	4	5
16. I prefer to watch "light" entertainment shows rather than psychological dramas	1	2	3	4	5
17. It is difficult for me to reveal my innermost feelings, even to close friends	1	2	3	4	5
18. I can feel close to someone, even in moments of silence.	1	2	3	4	5
19. I find examination of my feelings useful in solving personal problems.	1	2	3	4	5
20. Looking for hidden meanings in movies or plays distracts from their enjoyment.	1	2	3	4	5

Appendix C: Inhibition-Rumination Scale (I-RS) (Roger & Najarian, 1989)

I-RS

Name: *Gender:* *Age:*

Instructions : Indicate how you feel about each item by circling either "TRUE" or "FALSE". If an item is neither entirely true nor false, choose the alternative most like you. If you haven't been in the situation, please say how you feel you would behave in that situation.

1. I remember things that upset me or make me angry for a long time afterwards.	TRUE FALSE
2. I don't bear a grudge - when something is over, it's over, and I don't think about it again.	TRUE FALSE
3. When someone upsets me, I try to hide my feelings.	TRUE FALSE
4. Some people need somebody to confide in but I prefer to solve my own problems.	TRUE FALSE
5. I get worked up just thinking about things that have upset me in the past.	TRUE FALSE
6. I often find myself thinking over and over about things that make me angry.	TRUE FALSE
7. Even when I feel upset about something I don't feel the need to talk to anyone about it.	TRUE FALSE
8. People find it difficult to tell whether I'm excited about something or not.	TRUE FALSE
9. I like to talk problems over to get them off my chest.	TRUE FALSE
10. I feel vulnerable if I have to ask other people for help.	TRUE FALSE
11. In the past I have found a problem easier to solve if I have talked it over with someone.	TRUE FALSE
12. It is good to hear problems out loud.	TRUE FALSE
13. If I receive bad news in front of others I usually try to hide how I feel.	TRUE FALSE
14. It helps to discuss a problem even if it is impossible to reach a solution.	TRUE FALSE
15. I seldom get preoccupied with worries about my future.	TRUE FALSE
16. I have friends who I know would help me but I find it difficult to ask.	TRUE FALSE
17. I seldom show how I feel about things.	TRUE FALSE
18. If I see something that frightens or upsets me, it stays in my mind for a long time afterwards.	TRUE FALSE
19. I think people show their feelings too easily.	TRUE FALSE
20. My failures give me a persistent feeling of remorse.	TRUE FALSE
21. When something upsets me I prefer to talk to someone about it than to bottle it up.	TRUE FALSE
22. For me, the future seems to be full of troubles and problems.	TRUE FALSE
23. There are some situations in which I am unable to confide in anybody.	TRUE FALSE
24. I often feel as if I'm just waiting for something bad to happen.	TRUE FALSE

25. When I am reminded of my past failures, I feel as if they are happening all over again. TRUE FALSE

26. If I get angry or upset I usually say how I feel. TRUE FALSE

27. Sometimes I have to force myself to concentrate on something else to keep distressing thoughts about the future out of my mind. TRUE FALSE

28. Intrusive thoughts about problems I'm going to have to deal with make it difficult for me to keep my mind on a task. TRUE FALSE

29. I don't feel embarrassed about expressing my feelings. TRUE FALSE

30. I don't let a lot of unimportant things irritate me. TRUE FALSE

31. I wish I could banish from my mind the memories of past failures. TRUE FALSE

32. I am unable to trust anybody with my problems. TRUE FALSE

33. I am afraid that if I confide in someone they will tell my problems to others. TRUE FALSE

34. I never get so involved thinking about upsetting things that I am unable to feel positive about the future. TRUE FALSE

35. I am not afraid to ask somebody for help. TRUE FALSE

36. I worry less about what might happen than most people I know. TRUE FALSE

37. It takes me a comparatively short time to get over unpleasant events. TRUE FALSE

38. Sometimes I am unable to confide even in someone who is close to me. TRUE FALSE

39. Any reminder about upsetting things brings all the emotion flooding back. TRUE FALSE

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Appendix D: Social Adjustment Scale - Self-Report Friendship Index

(Marver et al., 2017)

SPARE TIME—EVE...
QUESTIONS 19–27.

Check the answer that best describes how you have been in the last 2 weeks.

19. How many friends have you seen or spoken to on the telephone in the last weeks?
    - 1 ☐ Nine or more friends.
    - 2 ☐ Five to eight friends.
    - 3 ☐ Two to four friends.
    - 4 ☐ One friend.
    - 5 ☐ No friends.

20. Have you been able to talk about your feelings and problems with at least one friend during the last 2 weeks?
    - 1 ☐ I can always talk about my innermost feelings.
    - 2 ☐ I usually can talk about my feelings.
    - 3 ☐ About half the time I felt able to talk about my feelings.
    - 4 ☐ I usually was not able to talk about my feelings.
    - 5 ☐ I was never able to talk about my feelings.
    - 8 ☐ Not applicable; I have no friends.

21. How many times in the last two weeks have you gone out socially with other people? For example, visited friends, gone to movies, bowling, church, restaurants, invited friends to your home?
    - 1 ☐ More than 3 times.
    - 2 ☐ Three times.
    - 3 ☐ Twice.
    - 4 ☐ Once.
    - 5 ☐ None.

23. Have you had open arguments with your friends in the last 2 weeks?
   1 ☐ I had no arguments and got along very well.
   2 ☐ I usually got along well but had minor arguments.
   3 ☐ I had more than one argument.
   4 ☐ I had many arguments.
   5 ☐ I was constantly in arguments.
   8 ☐ Not applicable; I have no friends.

24. If your feelings were hurt or offended by a friend during the last two weeks, how badly did you take it?
   1 ☐ It did not affect me or it did not happen.
   2 ☐ I got over it in a few hours.
   3 ☐ I got over it in a few days.
   4 ☐ I got over it in a week.
   5 ☐ It will take me months to recover.
   8 ☐ Not applicable; I have no friends.

25. Have you felt shy or uncomfortable with people in the last 2 weeks?
   1 ☐ I always felt comfortable.
   2 ☐ Sometimes I felt uncomfortable but could relax after a while.
   3 ☐ About half the time I felt uncomfortable.
   4 ☐ I usually felt uncomfortable.
   5 ☐ I always felt uncomfortable.
   8 ☐ Not applicable; I was never with people.

26. Have you felt lonely and wished for more friends during the last 2 weeks?
   1 ☐ I have not felt lonely.
   2 ☐ I have felt lonely a few times.
   3 ☐ About half the time I felt lonely.
   4 ☐ I usually felt lonely.
   5 ☐ I always felt lonely and wished for more friends.

27. Have you felt bored in your spare time during the last 2 weeks?
   1 ☐ I never felt bored.
   2 ☐ I usually did not feel bored.
   3 ☐ About half the time I felt bored.

Exhibit 4.11 *(Continued)*

Exhibit 4.11 *(Continued)*

   4 ☐ Most of the time I felt bored.
   5 ☐ I was constantly bored.

Appendix E: Study 2 Semi-Structured Interview Schedule (Student Self-Harm)

Overarching questions	Prompts
1. Can you tell me a little bit about yourself…	- Age - Hobbies - Education
2. Can you recall the first time that you thought about harming yourself?	- Prior to university? - Feelings at that time - Methods - Suicidal intent/ideation alongside self-harm - Has this changed over time, specifically thinking about your time at university?
3. What is your view on the term 'self-harm' and the way that it is defined (read Hawton et al (2003) definition to participants)?	- Advantages/disadvantages of definitions - Helpful language - Perceptions of self-harm - Self-harm/Suicide
4. Could you tell me, in your own way, about your most recent experience of self-harm at university?	- Thoughts/Feelings before & after the self-harm - Triggers - Did anyone else know how you were feeling/about the self-harm? - Location; Planned/Impulsive? - Was this your first time self-harming at University (if no – approx. how many times has this occurred during university)

	- How was this different/similar to self-harm prior to university? - Drugs/Alcohol?
5. There may be many reasons why people self-harm. What were the main reasons for you on this occasion? (*If not explored in Q3)	- Motivation on that day - Did this differ to motivations for self-harm prior to University? - Did this differ to motivations for self-harm on other occasions at university (if applicable) - Is this usually how you feel when you self-harm
6. Can you explain why you used this specific method? (*If appropriate/not explored previously)	- Main method of self-harm? - Use of other methods? - Positive/negative expectations
7. Thinking back to the hours, days or weeks BEFORE this incident of self-harm, what was going on at that time? What were you doing? What was going on in your life?	- Feelings/thoughts - Relationships, employment, studies, friendships etc - University life - Life changes
8. Can you tell me what happened in the time after the incident of self-harm that we have discussed?	- Mood/health - Thoughts around self-harm - Self-care; support-seeking?
9. How does this recent experience of self-harm compare with any previous experiences of SH/thoughts of self-harm – at university and prior.	- Mood/Motivations - Triggers/Location/Methods - Outcome/support-seeking - Injuries – have you ever sought medical attention for your self-harm? (If yes, was this during university?)

10. (Depending on response to support/help-seeking); What encouraged you OR prevented you from seeking help for self-harm during university?	- Awareness of support services at university - If sought help; what was your experience of this (what was helpful/unhelpful) - If haven't; what prevented you from seeking help, would you be considering seeking help in the future? - Have you ever sought help prior to coming to university and did this impact upon your decision to seek or not seek support at university? - Potential barriers/facilitators to seeking help for self-harm (for yourself and others during university) - Desire to stop self-harm?
11. Is there anything that you think your university could do to prevent/support students who self-harm (potential overlap with discussion in Q9).	- Could anything have prevented the self-harm? - Improvements to existing resources -

Ending – is there anything that you would like to add or ask? How are you feeling now (completion of the VAS)

Appendix F: Study 3 Semi-Structured Interview Schedule (Supporters)

Overarching questions	Prompts
1. Tell me a little bit about yourself…	- Age - Hobbies - Education - Work
2. Tell me about your experience of providing support for student SH…	- Individual/Multiple people? - Initiation; before or during university? - Commonality of self-harm at university (if relevant) - Disclosure/discovery of self-harm; voluntary? - Patterns?; Triggers? - How did you feel?; immediately after and on reflection? - What did you do? - What does providing support look like?
3. What is your understanding of the term 'self-harm'? (read Hawton et al	- Methods - Definitions/language; helpful/unhelpful? - Perceptions of self-harm

(2003) definition to participants following initial response).	- Self-harm/Suicide
4. There may be many reasons why people self-harm - what is your understanding? (if not explored in Q3)	- Motivation on that day - What contributes to student self-harm specifically?
5. Thoughts about the impact of caring for an individual/s who self-harm?	- Positive/Negative? - Associations/thoughts; has this changed? - Impact on personal life/relationships? - Impact on well-being/mental health? - Anything you wish you'd have known/done differently?
6. Do/Did you feel as though you have/had enough knowledge of self-harm to provide support?	- Able to understand/empathise? - Has knowledge changed over time; how? - Awareness of resources available around self-harm/for carers?
7. Have you needed your own support during this time?	- If sought help; experience of this (helpful/unhelpful). If no, any reason?

	- Contacted support organisations/university services for own support? - (Professionals); any support in the workplace?; helpful? - Barriers/facilitators to seeking help as a carer (specifically self-harm/university setting?)
8. Anything that health organisations/workplaces/universities could do to support people who are supporting those engaging in self-harm? Ending – questions and VAS	- Improvements? - Knowledge/awareness of organisations/support for carers?

Appendix G: Dempsey et al. (2016) Essential Elements in Qualitative Interviewing Framework

Elements	Considerations	Action
Preparation, Planning & Implementing an Interview Schedule	Preparation is vital. Select the correct research methodology and data collection tool/s to acquire data from participants. Develop an interview schedule and have a thorough knowledge of this interview schedule. Use the interview schedule flexibly as a guide to facilitate meaningful discussion between the researcher and participant.	Liaise with research supervisor or research team to decide which research methodology best addresses the study's research question, aims and objectives. Develop an interview schedule with predetermined questions focusing on the study's research question and aims. Conduct pilot interviews to troubleshoot issues with interview schedule questions. Pilot interviews will aid skillful and effective questioning.
Accessing Vulnerable Groups	Consider issues with accessing gatekeepers of vulnerable groups and negotiating access to participants. Participants require sufficient information to make an informed decision to participate. Consider how participants may contact researchers to self-select to participate in a research study (text message, telephone call, or return postal consent form).	Meet gatekeepers in person to facilitate relationship building, develop trust, allow questions to be asked and clarification to be sought. Explain to gatekeepers the perceived benefits of taking part in research. Provide detailed study information to potential participants and contact names and numbers if they wish to partake in the research. Consider utilizing social media to recruit participants.
Time & Location of Interviews	Flexibility on the part of the researcher.	Conduct interviews at a time and location which is suitable for the participant.
Rapport & Relationship Building	Consider how to deal with distress and emotions. Care is required for the participant and researcher. Interviews may be therapeutic for participants. Relationship development which is mutually trusting and positive facilitates discussing sensitive topics.	Effective listening is required. Support structures may be required to deal with distress. Rapport development and a trusting relationship are key to facilitating discussion of sensitive topics.

Therapeutic Interviewing	Know your interview questions so that your schedule is a guide, allowing free flow of conversation. Develop skills in empathic listening and being comfortable with interview silences. Consider how you will deal with distressed participants. Location of the interview is key to allow for free flowing discussion. Consider the need for refreshments and tissues during interviews.	Thorough knowledge of interview questions is required for free flowing conversation between researcher and participant. Avail of qualitative interviewing training. Develop a distress protocol. Source a quiet, private interview location free from interruptions. Provide water and tissues to participants to promote comfort.
Concluding Interviews	Closing of relationship after data has been collected. Ensure positive closures for the participant and the researcher. Reflexivity is required to consider values, beliefs, perceptions which may influence the research process.	Debriefing with participant after interview has ended. Provide contact numbers of support services as required. Meet with supervisor or research team to discuss the interview process.

Appendix H: Study 1 Thematic Map

Self-Harm qual questionnaire data Themes/Key Findings

For those with experience of support – types received and effectiveness

- CBT
  - Helpful – emotion regulation, behaviour reduction, alternative strategies
  - Unhelpful – can manipulate focus
- Counselling
  - Unhelpful
- Group Therapy/Peer support
  - Helpful – identification
  - Unhelpful – awkward, uncomfortable
- Medication
  - Helpful – reduced SH
  - Unhelpful – Sedating, Increase SH, No difference
- CAMHS
  - Unhelpful – childlike
- EMDR – unhelpful
- Teachers
- Mindfulness
- ACT
- Multiple therapies
  - Marginally helpful, did not stop SH
  - Therapy did not focus on SH – ignored/undisclosed
  - Challenging
  - Unwanted
  - Helpful ST – not LT – too brief

Barriers to seeking support

- Apprehension
  - Afraid, worried, ashamed, nervous, burden, judgement, embarrassment
- Ability to manage alone
  - SH not seen as a problem – never asked for support
- Previous negative experiences of support/services
  - Unexpected outcomes, uncomfortable, too severe or not severe enough, fear
- Cost
- Timing
  - Not ready to discuss, not ready for family to know
- Uncertain of where to seek support

Apps/Internet Measures Accessed

- 7 Cups of tea
- Headspace
- Nightline
- Calm Harm
- Samaritans
- Childline
- Kooth
- Big White Wall
- Social Media
  - Tumblr
  - Whatsapp
- Grassroots
- Getselfhelp
- Mind
- Moodgym
- Online forums
  - Reddit
  - Selfharm.pics
  - KatiMorton.com

Experience/Consideration of Apps – Advantages

- Helpful – relaxing, calming, grounding, less anxiety-provoking, safe space
- Accessibility – immediate support, distraction, 24 hours, convenient – no set appointment
- Anonymity – no judgement, honesty, less stigma, no shame, easier to open up
- Specific/Tailored to needs
- Cheaper – less resources, good stepping stone

Experience/Consideration of Apps – Disadvantages

- Cost
- Isolation – no feedback, no one's perspective, no response, unrelatable, unable to intervene when high-risk, info not shared with family/friends/professionals
- Impersonal – generic, too broad, creates another barrier, no human contact
- Doesn't stop SH – root of problems not explored
- Trigger – new methods, escalated mood, competitiveness, supporting other
- Unprofessional
- Motivation – easy to avoid, no commitment
- Data protection/Trust – worry around sharing of information, data breaches, don't know who is reading it – can't see individuals.
- Less effective – no face to face contact
- Technology – need to be familiar with using, encourages time online

Appendix I: Study 2 Thematic Map

Defining Self-Harm/Views and Perceptions of SH

- Differences in participants view of SH
- Many asked me to define SH, asked did it include certain behaviours (e.g. eating disorders/food restriction)
- Participants mentioned a lot about the idea of SH as an addiction
- Distinction between SH and suicide/ideation

Function of SH

- Coping Mechanism – Release
- Emotions – anger
- Allow feeling
- Control – stress

Intervention/App

1. Difficulty in verbalising feelings
2. Allows you to record thoughts/feelings 24/7
3. Self-help tips not found to be useful
4. Speaking to previous individuals with experience of SH – online messaging/mentor system? (Same person every time?)
5. Ashamed – keep it to themselves/remain private – secure platform to prevent shame
6. Preventative – may be more useful in initial stages
7. Don't feel you have to do what the app tells you – difficulty with engagement/loyalty
8. Video chat – good way to build up to eventual face to face contacts

Self-Harm Interview Themes/Key Findings

SH Characteristics

1. Methods/Type of SH – ease of access
2. Location of body of harm
3. Location – place where SH took place - bedroom
4. Timing – evening, alone, (physiological explanation?)
5. Severity
6. Triggers – Parental separation/conflict

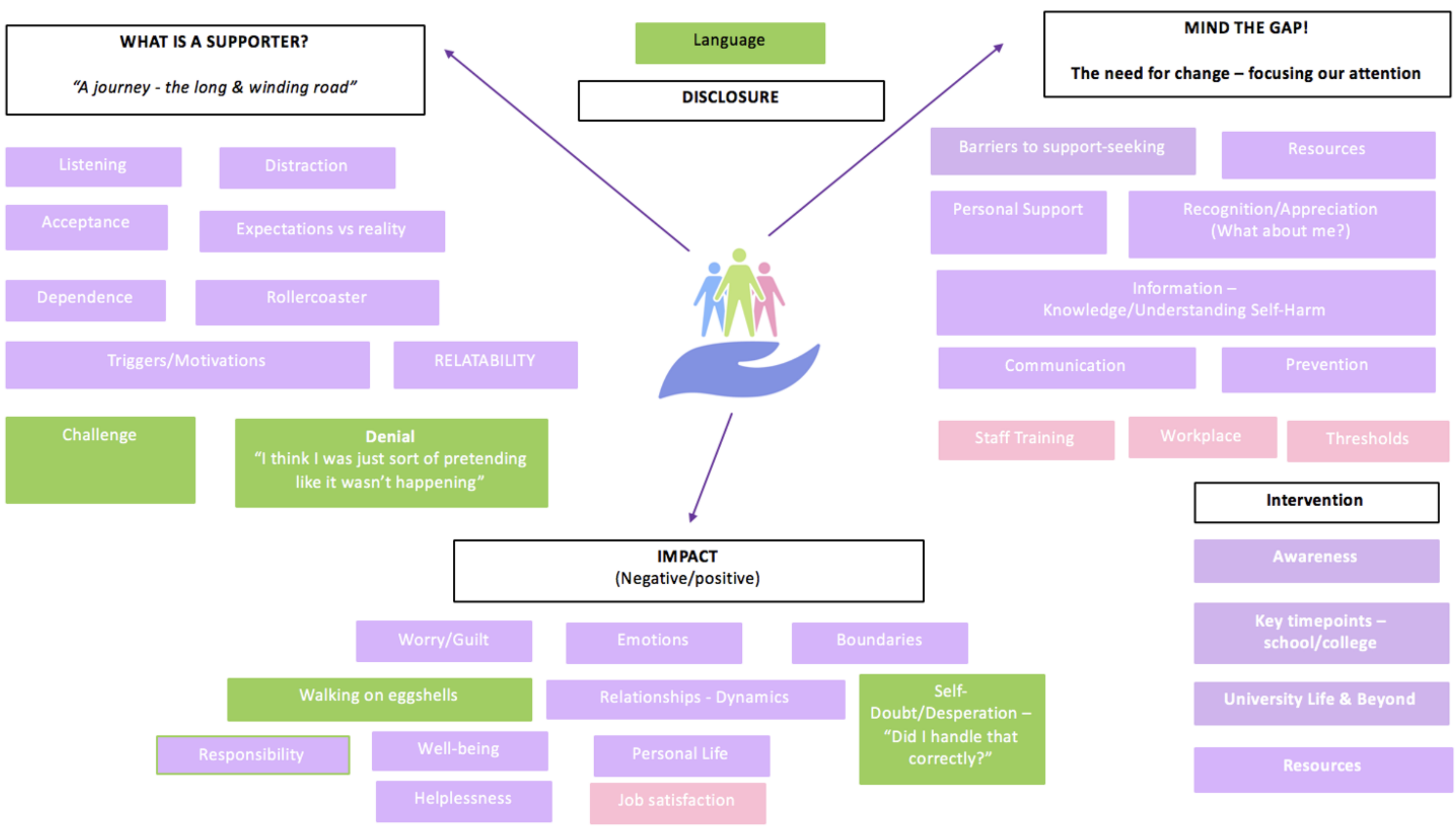
Support

1. University Support – Pros and Cons – Important to know who will be seeing the info and where it will be shared
2. General Support – Pros and Cons – laughed at, not taken seriously – Peer support helpful
3. Barriers to help seeking – shame and stigma
4. Friends/Family – importance of reactions to disclosure and role as support mechanism
    a. Bad reactions – parents blaming themselves – made SH worse
    b. Lack of understanding about SH – shame - made reaction to disclosure worse – minimising
    c. Loving relationship – feeling cared for – helped stop SH (never felt this from anyone)
5. Apps – pros/cons

SH and University

1. Effects of university on SH – better or worse?
    - Uni/Work offering a distraction
    - Alcohol consumption increasing – caused SH to increase
    - Stress of Uni/work – deadlines, not understanding the work, work load
    - Grades/Comparing yourself to others
    - Difficulty concentrating
    - Loneliness
    - No one to check on you – freedom to SH without people noticing
    - Still exists but different triggers
2. Support at university is there but isn't helpful – there because it has to be; services are disjointed/fragmented; limited sessions and availability; lack of response
3. Support needs to be more open and transparent – clear pathway between services. Department staff to be more involved – more personal. Transition.

Appendix J: Study 3 Thematic Map



Map Notes

What is a supporter – (JOURNEY THROUGH THE UNKNOWN)

- Constant journey – highs & lows – ongoing development
- Professionals – constantly developing and learning over time; experience very important when working specifically with self-harm
- Lay – listening, helping them get support, talking, offering a distraction, creating a safe space
- Constant challenge of expectations vs reality – awareness of your limitations as a support (what can and can't you do). Importance of boundaries:
  - Between supporter/individual
  - Within supporters life
  - Professional boundaries
  - What is right for you vs what is right for them (Selfless vs selfish)
- Challenge of a new role – disclosure, not knowing how to react, talking about SH, approaching the topic – "learning a new language"
- Requires Skill Set

Impact of providing support

- Negative:
  - Highly emotive
  - Negative impacts on well-being; feelings of self-doubt/desperation (lay supporters & younger professionals)
  - Feeling lost/isolated
  - Guilt/Worry – about patients, about decisions, did I do the right thing?
  - Overwhelming responsibility; out of depth; burden
  - Negative impact on relationships – no longer friends, not speaking to family member for some time
  - Sensitivity about SH – negative impact of hearing people joke & use hurtful language
  - Isolation – not present when with other people, constantly thinking & worrying about them
- SH/SUPPORTER – impact on own SH; for some made them stop as made them realise the external impact and how it wasn't helpful, for others – relationship was very co-dependent, challenge of being emotionally available (even more difficult for this group as also going through the same thing – or for others, it being easier due to the fact that they felt able to relate & understanding)
- Positive
  - Felt trusted & privileged that the individual was able to tell me/share this with me
  - Caring for someone else helped me care better for myself

Mind The Gap! (or Prevention)

- Gaps in lots of areas & failing lots of groups/individuals – need to focus our attention (Barriers to support-seeking - through a supporters eye)
  - Resources – not enough resources available to individuals & those supporting them, universities not using staff who are qualified, universities not offering training to staff members which could help prevent further escalation, well-being/counsellors not supported by therapists; impacts on relatability & understanding
  - Thresholds – students needing support are 'falling through the gaps' – too severe for university services, but not meeting thresholds for community services; impact of this? (falls to friends & family, or the individual is left and negative thoughts/beliefs are reinforced)
  - Communication and positive working relationships is key between services in order to bridge this gap and ensure that these individuals get the support that they need
  - Intervention – earlier & consistent intervention needed – TRANSITION
    - Schools/College
    - Before University, during & after
    - Intervention for supporters
  - Personal Support
    - Workplace
    - Resources for supporters
    - Recognition/appreciation - validation to the role – who is able to support me?

Appendix K: Theme Development - Study 2 Student Interviews

Basic Codes/Categories	**Sub-themes:**	**Main/Global Themes:**
University stressors – academic pressures, comparison between other students, deadlines, exams, isolation, work level, freedom, adjustment, second language, university culture – drinking. Quotes: "When I feel like it's too much pressure, or if I don't understand an assignment or something or when I feel like, you know because you are there with so many other students, I compare myself to them and then I feel worthless and then, it's like that downward spiral of bad thoughts." *"I mean, it's always there, but I find when I like get close to exam periods or when loads of work is due, it gets worse"* *"Yeah, there was a lot of change around then. Adapting to a new environment, that was probably one of the reasons why my mood was so low. And then I started self-harming." (*Commenting on moving to University)* *"Yeah, the most stressful ones. So I would say exams, even the process of writing stresses me out because I'm a good writer in Portuguese but sometimes academically writing in English is a bit frustrating because it puts extra stress. The language, writing in a*	University Triggers	**1. Understanding the role of self-harm within higher education** (This theme highlights the data around self-harm within University. It was felt that the triggers and experiences should be presented as a separate theme to support-seeking within University in order to highlight the role of self-harm and the impact of the University environment directly on self-harm as opposed to support-seeking)

second language is definitely a stress and self-harm trigger and pusher for sure. More than for example, the stress for deadlines, because I have no problem with deadlines. I meet the deadlines. So the stress is about writing up in a second language, that's what's stressful…. I absolutely think that for international students it's a total other level of challenge to be honest with you. We come from extremely different backgrounds, we don't have the a levels, we don't have the language, you know, it's a whole new thing." *"There is a lot of pressure on students from both themselves and others to do well, when you add life, work, illness into all that pressure it makes them very vulnerable to mental illness and self-harm as well as dropping out if they can't cope or get support to keep going. Being a student is a full time and very stressful job in comparison."* *"Definitely. I do take drugs recreationally but never found that they would increase my risk of doing it, but definitely alcohol, without a shadow of the doubt. I would say that over fifty percent of my self-harm has involved alcohol…..You know, you get to University and all this binge-drinking is really encouraged. So yeah, that had quite an impact on my self-harm personally."* *"My self-harm is mainly to do with workload, it's quite overwhelming at the moment."* *"Yeah, so I managed to stop altogether about a year before I went to university, but then when I went to university it got worse than it had ever been…. I think it*		

was a lot about the stress of university but also because I moved out to go to university and lived by myself. And I think moving out gave me a lot more freedom to kind of engage in that sort of behaviour." *Yeah, it was when I first arrived at university, you know in a new university environment, away from home and just feeling disjointed from friends and new friends around me, you know feeling disorientated, living in a room and being quite self-contained. I remember have cutlery around me and just looking at myself in the the mirror there and just feeling a sense of self-loathing, so I took a little carving knife and cut my face.*		
Enjoyment of studies, fulfilment, distraction, belonging, purpose, identification, relationships, friendships, comfortable, balance "*I think - and this may sound stupid - but also being cared about, really cared about by someone, even loved, had a hugely restorative effect at university. Especially as I'd never really felt it before. So it was like, I don't need to hurt myself anymore, because I don't deserve it. Other people care if I hurt, and by hurting me, I also hurt them"* *"I just feel better since I have been here and I feel the qualities I have developed here have made me, me."* *"Like here, I have more friends and it's like we can all talk openly, it's like seeking therapy and I finally feel like I belong. University has given me that definitely.*	University Protective factors	

"I think sometimes when you are studying it can help give you a balance and acts as a distraction I think" *"It's like, with studying, it's better than doing nothing at all, because if you're doing nothing then you just think too much, so yeah, it's been a positive distraction for me."*		
Lack of communication; lack of understanding of the role of different services; students not aware of how to seek support, there because it has to be, lack of response to referrals and enquiries, impact, disclosure of sensitive information, online forms, concerns over information and sharing, escalation, technology, expectations, credibility, validation, recognition, resignation, effectiveness of support, type of support, variety, consistency, limitation of sessions, relatability, acceptance, supportive, non-judgemental Quotes:	Barriers to support-seeking Providing effective support for students	**2. Student support – "A vague and confusing process"** (This theme highlights the common perception of a lot of support being available (i.e. present) but that it's effectiveness in many situations is questionable. The need for communication between services,

Yeah, I was just really worried that they would sort of escalate things because of what was going on, I didn't really want anything to be taken out of my control *I approached them beforehand with my history, you know just to say this is what happened beforehand, I'm hoping everything will be ok now but just to make you aware. I gave them all my information from my GP and stuff like that, however, when I did need that support, it wasn't done very well. It took a very long time, it wasn't until like the end of my course that I actually got the support that I needed, and there were like some exam adjustment that they were putting in place for me, and then on the day of it didn't happen which wasn't helpful at all in that situation and I was quite disappointed.* *It would just be nice to maybe have a very direct flow chart of questions, you know "what's the issue" yes, no, this would be the best person for you to contact. Instead it's just some vague descriptions on the University website and emails, which again I find really unsettling. To disclose such personal information via email and not knowing who is on the other end.* *The help I have had from the university counselling services have only really been in the last six months. The previous two times that I was referred to it, I didn't get a response, I got taken off the waiting list and at one point, got straight up abandoned* *The first time that I went to the counselling service I had made an appointment, and the person that I made an appointment with didn't show up. And they didn't let me*		developments to services and forms of support. Also the idea that support services are there but that many referrals and sessions have been cancelled or ignored and the impact of this).

know that they weren't showing up, and the state of mind that I was in at that time, I took that as I wasn't important enough to get help and that I didn't deserve the help, and therefore I will never ask for it again. *In the most recent time it a professional who referred me. And I got so much more attention from being referred by my GP than I ever did when I tried to seek help out myself. I think it's absolutely not right. I think that it shouldn't take a GP for you to get help, because a lot of people can find involving a doctor far too overwhelming. I don't think it's right at all.* *They don't have a particularly good counselling service. It's not their fault and I haven't accessed it yet but I know that they can only offer six sessions, which I know is quite common in these types of services but I think if they could offer more than that, or even just not say that it's going to be limited and do it more on a case to case basis or something, that would be a lot nicer, I think that's my main concern.* *I feel like what the university does is talk about these things because they should. They make it known and advertise it and talk about it, but that's really it. Like if you go on the website it tells you were to go, but it feels more like something they have to do rather than them trying to make it a supportive service.* *I think if you started university and suddenly needed support, I'm not sure that it would work out that well, I think it would really depend upon the University and the individual.*		

I think I'd prefer support from my subject, because the university is really big and you have all these different places to go to, but they never really sit together. *Personally I feel like it's important that it's face-to-face and that there's actually another person there, like I have tried using apps but I never found it very helpful.* *I think that people who have gone through it talking to you, like having a talk in front of an audience for example, talking about their experience, I think would have helped, or might help people now* *The year I just done, I wouldn't have been able to do without the support I got from the lecturers on my course and in particular one. I also got support to do my assessments separate which helped take the anxiety and pressure off.* *Peer group support, I didn't feel judged, because you know there is a lot of stigma around self-harm, and I felt like I couldn't speak about it and it's so taboo, but I felt supported to talk about it there. You know, I'm not saying that self-harming was like encouraged, but it was very much supportive and non-judgemental.* *Self-harm is just a coping mechanism and if universities had the right support such as lecturers being trained, separate study and exam accommodation for students who need it, counsellors in the universities readily available for students. It would make a massive difference.*		

Yeah, I think it someone would have given me the opportunity to go and speak to someone in college or university, I think it would have made a huge difference because as soon as I started speaking to the doctor and the therapist, you know you really start to realise what's going on in your head. The cognitive behavioural therapy helps you realise the way you respond to situations and if I'd have had that in college and university it would have made the world of difference…. I would say that there was very little to no support available at the university. You get a lot of support for things like learning difficulties but the mental side of it, there was none. *I think it is a trust thing, because you are worried that if it was one of your lecturers and you go and tell them something, they might then go and sit in the staff room and they might say oh I spoke to this student and they said such and such, you know, like that kind of thing, so yeah, I think I'd prefer to speak to someone who you're not associated with*		
Shame/Stigma, Fear, Understanding, Awareness of SH, The nature of SH, definitions, terminology, functions of SH, perceptions of SH, stereotypes, complexity, triggers, coping mechanism, release, dissociation, addiction, time of day, isolation, openness, SH/Suicide, impulsiveness, self-esteem, culture Quotes:	Knowledge/Awareness Perceptions - Definitions and Views of Self-Harm	

I think it's still a very sensitive subject that people are too scared to talk about. I think it would help students more if people spoke about it normally and not scared by it because that makes it all the more hard to admit to anyone if you're doing it. It needs to be spoke about more openly in my opinion. *More awareness of the real reasons people do it because most of the time people go straight to suicide but in most cases that's far from the reason why anyone does it.* *It satisfies the urge, but then I don't know, I find it quite satisfying to feel the pain, it's almost part of the addiction. It's not just an addiction to the behaviour but to the pain as well. Which seems daft, but.* It's just any way, any way in which you are hurting yourself, so like restricting food is going to affect you, like you are going to be weak and tried. Scratching yourself, the same thing, and then, I know people like they pull out their hair on purpose, I've never done that, but, that's self-harm as well. I think maybe like, putting yourself in bad situations. I'd consider that self-harm as well. *I felt find of disgusted and I just wanted to like release the feeling so that I wouldn't feel it anymore* *I had quite a lot of experiences really. You know when I was backpacking there were a lot of Chinese and Japanese tourists and a lot of different cultures, I think they hadn't really heard about it and didn't know about it and it hadn't ever come up in their life before, so I*		**3. Understanding the unknown - Seeing beyond the behaviour** (The purpose of this theme was that a lot of students and participants explored the idea that they constantly felt like a lot of things associated with self-harm are not understood – for example people see the behaviour but don't see what's underneath, as well as their views of what should be classed as SH).

think they were genuinely curious and sort of like "what the hell?" *Yeah definitely, sometimes when myself and my partner have been away and I won't know anyone, I don't mind showing the scars because I don't know anyone and it doesn't matter, but if there is anyone around who does know me I think I would feel very embarrassed. You know it's so private and I think some people are so insensitive. You know I'm more than happy if someone wants to take me to the side and talk about it and if that can help others, but making jokes about it and talking about it within a group I find really insensitive.* *Maybe it is that the primary forms of information are quite clinical, and I think most people will associate self-harm with silly things like being mad, or institutionalised. You know it is a serious thing but all they see it as is something serious but if you sort of give it a more patient and compassionate approach, that can be a lot more helpful.* *I was working in Leeds in a very nasty area of Leeds with a lot of people who were from deprived areas and things, and one of my managers said that I needed to cover up my scars as I couldn't be seen as weak, we are better than them kind of attitude, and that just made me sick to my core and I left the course after that, because I couldn't go into a job with that attitude, you know, not only that we are higher and better than them, but an environment where self-harm is something weak and should be hidden*		

Appendix L: Theme Development - Study 3 Supporter Interviews

Basic Codes/Categories	Sub-themes/Categories/Narrowing	Main Themes
Holding information, relatability, characteristics, strengths, weaknesses, qualifications, background, identity, listening, emotional support, recovery, distraction, experience, indirect support, limitations to what they can offer, abilities, talking, empathy, check-ins, prevention, risk management, assessments, signposting, support-seeking, information gathering, parental role, caring, basic needs, therapy, counselling, liaising, safety, dynamics, shifts in dynamics, advocating, hospital visits, insight, deeper understanding, responsibility, insecurity, progression, sympathy, compassion.	Skill Set Qualifications/personal characteristics Identification Sample quotes: *"I've always had that role with a lot of people, like I'm the person that people talk to about stuff. So she would tell me about it, and I guess it was mainly just about*	What is the role of a supporter?

	listening, rather than actually like doing anything." *"There is only so much you can do for someone if you aren't like a professional counsellor when they are in that state."* *"...even driving around for half an hour, forty minutes, and just chatting about crap is actually really helpful for her. And like coming home she was saying how she felt so much better..."*	
Worry, guilt, boundaries, powerless, helpless, separation, blurred lines, doubt, lack of coping skills, burden, not feeling qualified enough to give information, challenging, intensity, family, friends, personal life, negative, disengagement in own hobbies, one directional, own needs, disengagement, flatmates, battle, balance, uncertainty, flexibility, priorities, part of the job, heart-breaking, scared, sick leave, impact on other relationships, morale, anger, frustration, self-care, well-being, isolation, loneliness, emotional	One-directional Benefits vs Negatives Boundaries Relationships/Personal Life Emotional availability /impact	Impact of providing support

availability, cut-off, shame, minimal impact, cathartic, rollercoaster, relatability, enmeshed, breaking down of relationships, broken friendships, withdrawal, step-back.	Sample quotes: *"..I mean, really, really challenging. I had some time off sick at Christmas because I was just done. I just couldn't safely see any one. I couldn't sleep, I couldn't eat, I was just exhausted.."* *"Sometimes when you're dealing with crisis situations, you can't leave at 5pm, and actually you get home at 8pm, and you've missed dinner with your girlfriends or something…that's quite an intense way to work. I would say undoubtedly it has an impact personally…It's tiring, it's emotionally draining, which means that when I get to the end of the day and go*	

	home, I'm not always as emotionally available as I would like to be to my family." *"..there's that immense feeling of guilt that I can't do more. And there have been times when I've wanted to leave the house in order to like to spend time with some other friends who are my support...but I always feel guilty if I know that my friend back at home isn't well, it makes me feel like a bad person if they're by themselves."* *"So I worry and I care, but I don't sort of bring it home with me, except very occasionally where I see someone highly risky.."* *"..I suppose, supporting my sister was quite a challenging time. I mean, I would*	

	do my best to listen and give her strength. But when she would, like, say about the negative thoughts coming into her head, that would make me quite distraught. And I felt like I wasn't doing enough to clear these thoughts from her. So I suppose, it made me question my own mental health as well." *"To a point. It's very weird because you'll both be on your own roller coasters. Like one will be down and wanting to self-harm and the other will be up and feeling better...So it's like you both try to sort yourself out a bit, and then you're down and you're like, well a few days ago you were saying the exact same thing that I'm now saying and feeling. Like the reasons that they are using to try and get you out of it, you've used on them, but when it's you that's down you just can't see it. And*	

	it's like, that kind of paradox between who you were and who you are, and who they were and who they are."	
Sharing, disclosure, knowledge, understanding, development, resources, access, availability, direction, targeted interventions/support, positive experience, effective support, information, platforms, protected time, safe space, supervision, multiple perspectives, relatability, regularity, brainstorming, linking in, sharing, collaboration, networking, tailored, universal, broad range, self-harm awareness, self-care, own support, guidance, helpful strategies, warning signs, helplines, services	Measures taken to get more knowledge Role of self-care Gaps in resources for supporters Support for self/Self-care Supporters needs Lay supporters – mainly in relation to coping strategies, having someone to also hold the information/speak to would be helpful Professional supporters – mainly in relation to having work breaks, being able to keep updated with research & new	Needs of those providing support, what helps? What are the gaps?

	resources to use with patients, having wellbeing days at work Sample quotes: *"I definitely did not have enough knowledge at all. I just kind of knew what any normal adult would know. You automatically think that when someone is cutting themselves that they are trying to end their life. Not really having an in-depth understanding of what self-harm actually is and what causes it. I think if people do know about it, that would help people supporting, and also help people say if they are doing it and need help at that age."* *"I always think that knowledge is power, and I think if people understand why someone is self-harming, that's really important…. I think if supporters understand it more, that will be their*	

	lightbulb moment, and that will give them a better understanding of what that individual is experiencing. And then support them in the appropriate way. I think especially in the student body, you have friends supporting friends who are self-harming and it's impacting upon them, and then the student themselves isn't accessing support." …"It's *silly things like, knowing when to take someone to the hospital, you know, that kind of thing is really important, because sometimes that isn't appropriate, but sometimes it is. Like I've heard stories of people whose mums have like found out that they cut themselves and have taken them to A&E, when it wasn't appropriate to do so. But also cases whereby people definitely needed to go, so I think that's really important to provide more*	

	information on. I also think like, how to support someone, like you know accepting that it won't necessarily just go away." *"We often try to find time in our diary to try and read through a new paper, but we never ever do it, because it just doesn't happen. We always say we must read that paper, but years later we still haven't. So I think time as a group would be really helpful to have that space. I remember once myself and my colleague had the chance to attend a conference and we learnt so much, it was absolutely amazing….we just brainstormed about the service and what the service would look like and our roles and it was just amazing. So it was really helpful to have that time away, and meeting people from other Universities and other professionals. I think everyone should at least go to one conference a year,*	

	if not two, you know once every six months, to just kind of regenerate and refresh, and the inspiration that can give you is really important for the role."	
Student issues, minimising, relatability, understanding, stress, workload, deadlines, belonging, fitting-in, vulnerable groups, alcohol, drinking, drugs, adjustment, transition, unknown, new environments, key time points, university journey, peaks, exam-periods, university life, university culture, expectations, high standards, pressure, peer-pressure, coursework, deadlines, patterns, re sits, intervention, caring for friends, concern for friends, supporting other students.	Student Issues/Student Needs University life/setting Expectations vs reality University demands/deadlines *"..there are definitely peak times, so like in September we will get a lot of registration forms for example, like when students first*	University Demands/Student Needs

	arrive here we do a lot of initial assessments. Kind of coming up to Christmas time and the end of terms is always quite busy, exam times, so January and then May time, and then resits in July. So you do kind of notice some patterns to things and there are times when we know to expect it to be busier than usual." *"I think the changes and adjustments are a big part of it, but I think a big part of it as well is kind of this expectation, or pressure, or whatever it is, that you'll come to University and you'll meet your best friends for life in the first few days and you'll have a fantastic time and go out every night and you'll do this, and you'll do that, and everything's wonderful. I think for a lot of people if they don't like going out all the time, or if they aren't necessarily best friends with the people in*	

	their flat, or if they don't get on with them or they just don't click with them, I think a lot of people then worry that they aren't living up to this University dream kind of thing. Even if people don't like going out and drinking and partying, they feel that they ought to be, so I think there really is that peer-pressure there." *"Sometimes we will get students who come to us directly with concerns about a friend. And whether that's because they're coming to us about supporting their friend, or for supporting themselves, yeah, it's definitely a feature that we notice people talking about supporting their friends and being there for them."*	
University self-harm, University triggering self-harm, re-engagement, pressure, common, ability to recognise, definitions of SH, perceptions of harmful behaviours,	SH amongst students University triggers/maintenance Definitions/Perceptions; understanding SH	Student SH; supporters perspective on how it presents at University/why

frequency, regularity, detection, language, definitions, suicide,	*Note; overlap with above, but some nuances/differences here in terms of potential re-engagement of SH at University, it remaining dormant and then being triggered, students not recognising certain actions as SH; overlap with definitions of SH and perceptions of SH. Need to intervene/education prior to Uni and at University. *…"so I'll say, "oh you know, do you engage in any sort of self-harm", and they'll say no, and then they'll go to say that they take cocaine and Xanax and drink ten bottles of wine a week….so then you are engaging in self-harm."* *"Yeah, it's common. It comes up a lot. I mean most, for me with my kind of clinical head on, I'd say about 75% of the students that I see are engaging in self-harm of some form. Now, to the person on the street, their view of self-harm is cutting, and that's not my view of that. As you know, it's a plethora of different things. So*	

	yes, lots of lots of students are engaged in some form of self-harm." ..."*I think at the start, I was not really understanding because it was quite difficult and I think I was just sort of pretending like it wasn't happening. But with time, I understood why she was doing it, or at least some of the reasons."*	
Supporters perspective, access, referrals, multiple avenues, pathways, well-being service, counselling service, triage, mental health team, communication, liaising, thresholds, lost in the system, streamlining, community services, GPs, overwhelming, criticism, session constraints, timepoints, placement, inaccessible, consistency, standardised, institutional recognition, management, re-structure, risk, commissioning, regularity, before University, priorities, university staff, lecturers, knowledge, reminders, online, face-to-face, urgent, drop-ins, challenges, visibility, clarity, disconnected, training, gaps, improvement, funding, resources.	University Support Referral pathways/service access Mind the Gap! Sample quotes: *"They can get to see us via a number of ways. So we have an online referral form that comes into student well-being services and we have a counselling team and a mental health team and they would get triaged...another avenue is that we run a daily mental health drop-in, so they can come to that. Or a doctor may ring us up*	Service provisions in higher education Improvements to University support

	and say they've seen one of our students, or a parent might ring us up, friends might come in, so there's many ways in which people can come to us." *"I think it can put you off (talking about not knowing where to go from support and having to ask multiple people). Because you're having to tell all these people your problems and what support you need. You feel like you're being judged because you're asking for the help. So then you don't want to reach out because you don't want to have to deal with all those steps to getting eventually to the support."* *"It is a wide category of students who feel that they can't really speak to anyone else, such as friends or family, for various reasons. And they develop a warmer relationship with one of their lecturers, and that will be the first person they go to. Most lecturers know that it's best to hold*	

	the student initially, and then signpost to support services. But in some cases we had some inappropriate responses and that really shut the student down….some of them don't know how to deal with that and they then panic, which just exacerbates the problem." *"I think that there are definitely times when their risk is too high for us to carry as a service, then we would then refer on to the NHS crisis teams or recovery teams. But that wouldn't mean that we would necessarily discharge that student. So we may work in conjunction with the community team, so yeah, it wouldn't be exclusive from one or another really."* *…"I think a lot of places will say this, there's a gap in services for people who self-harm. So there are students who are not meeting the threshold for NHS services, they are too risky for the GP and*	

	IAPT, and so there's this gap in the middle and they're kind of lost, you know, there's only so much we can do." *"I think a massive part of it is the stigma towards going to your well-being service…. I think from other students. Like at Uni, it was a different part of the building, so for someone going in there, it's very obvious where they are going and what they are doing, and that can just feel really open. And I think, especially for me, with self-harm it's all about being closed. So the thought of others knowing about it and being aware of my pain makes your feel really vulnerable at a time when you really don't want to feel vulnerable."*	

Appendix M: COnsolidated criteria for REporting Qualitative research (COREQ) (Tong et al., 2007)

Topic	Item No.	Guide Questions/Description
Domain 1: Research team and reflexivity		
Personal characteristics		
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?
Credentials	2	What were the researcher's credentials? E.g. PhD, MD
Occupation	3	What was their occupation at the time of the study?
Gender	4	Was the researcher male or female?
Experience and training	5	What experience or training did the researcher have?
Relationship with participants		
Relationship established	6	Was a relationship established prior to study commencement?
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic
Domain 2: Study design		
Theoretical framework		
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis
Participant selection		
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email
Sample size	12	How many participants were in the study?
Non-participation	13	How many people refused to participate or dropped out? Reasons?
Setting		
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace
Presence of non-participants	15	Was anyone else present besides the participants and researchers?
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date
Data collection		
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?
Field notes	20	Were field notes made during and/or after the inter view or focus group?
Duration	21	What was the duration of the inter views or focus group?
Data saturation	22	Was data saturation discussed?
Transcripts returned	23	Were transcripts returned to participants for comment and/or

Topic	Item No.	Guide Questions/Description
		correction?
Domain 3: analysis and findings		
Data analysis		
Number of data coders	24	How many data coders coded the data?
Description of the coding tree	25	Did authors provide a description of the coding tree?
Derivation of themes	26	Were themes identified in advance or derived from the data?
Software	27	What software, if applicable, was used to manage the data?
Participant checking	28	Did participants provide feedback on the findings?
Reporting		
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number
Data and findings consistent	30	Was there consistency between the data presented and the findings?
Clarity of major themes	31	Were major themes clearly presented in the findings?
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?

Appendix N: Ethical Approval for the Current Thesis

Dear Laura

I am writing to inform you that your application was considered by the Psychology Ethics Committee.

The proposal was approved with conditions.

Yours,

Laura Boubert

Psychology Ethics Committee

I am advised by the Committee to remind you of the following points:

Your responsibility to notify the Research Ethics Committee immediately of any information received by you, or of which you become aware, which would cast doubt upon, or alter, any information contained in the original application, or a later amendment, submitted to the Research Ethics Committee and/or which would raise questions about the safety and/or continued conduct of the research.

The need to comply with the Data Protection Act 1998.

The need to comply, throughout the conduct of the study, with good research practice standards.

The need to refer proposed amendments to the protocol to the Research Ethics Committee for further review and to obtain Research Ethics Committee approval thereto prior to implementation (except only in cases of emergency when the welfare of the subject is paramount).

The desirability of including full details of the consent form in an appendix to your research, and of addressing specifically ethical issues in your methodological discussion.

The requirement to furnish the Research Ethics Committee with details of the conclusion and outcome of the project, and to inform the Research Ethics Committee should the research be discontinued. The Committee would prefer a concise summary of the conclusion and outcome of the project, which would fit no more than one side of A4 paper, please.

Dear Laura

Project: *Understanding the needs of those supporting students who self-harm: What can we do to help?*

Ethics Application number: ETH1718-2337

I am writing to inform you that your response to conditions was considered by the University Research Ethics Committee Acting Chair on 14 September 2018.

The proposal was approved.

- you may still require an insurance cover note for any off-site research (currently you have received the insurance cover policy note). If your protocol changes to include off-site research please provide an 'amendment to protocol' via the VRE along with a copy of insurance cover note (can be requested from Procurement Team).

Kind regards

Huzma

Huzma Kelly

University Research Ethics Committee

I am advised by the Committee to remind you of the following points:

Your responsibility to notify the Research Ethics Committee immediately of any information received by you, or of which you become aware, which would cast doubt upon, or alter, any information contained in the original application, or a later amendment, submitted to the Research Ethics Committee and/or which would raise questions about the safety and/or continued conduct of the research.

The need to comply with the Data Protection Act 2018 and General Data Protection Regulation (GDPR) 2018.

The need to comply, throughout the conduct of the study, with good research practice standards.

The need to refer proposed amendments to the protocol to the Research Ethics Committee for further review and to obtain Research Ethics Committee approval thereto prior to implementation (except only in cases of emergency when the welfare of the subject is paramount).

The desirability of including full details of the consent form in an appendix to your research, and of addressing specifically ethical issues in your methodological discussion.

You are authorised to present this University of Westminster Ethics Committee letter of approval to outside bodies, e.g. NHS Research Ethics Committees, in support of any application for further research clearance.

The requirement to furnish the Research Ethics Committee with details of the conclusion and outcome of the project, and to inform the Research Ethics Committee should the research be discontinued. The Committee would prefer a concise summary of the conclusion and outcome of the project, which would fit no more than one side of A4 paper, please.

UNIVERSITY OF
FORWARD
THINKING
WESTMINSTER

Project title: Doctoral research project

Application ID: ETH1819-0638

Date: 05 Feb 2019

Dear Laura

I am writing to inform you that your minor amendments to protocol was considered by the Psychology Ethics Committee. Given that you are seeking to recruit from the general population, and that the minor amendments requested do not concern a vulnerable group (for whom ethical approval has already been given at University Level) I am happy to approve this small amendment by Chair's Action at Psychology Level.

The proposal was approved.

Yours,

Prof. Coral Dando

Psychology Ethics Committee

I am advised by the Committee to remind you of the following points:

Your responsibility to notify the Research Ethics Committee immediately of any information received by you, or of which you become aware, which would cast doubt upon, or alter, any information contained in the original application, or a later amendment, submitted to the Research Ethics Committee and/or which would raise questions about the safety and/or continued conduct of the research.

The need to comply with the Data Protection Act 2018 and General Data Protection Regulation (GDPR) 2018.

The need to comply, throughout the conduct of the study, with good research practice standards.

The need to refer proposed amendments to the protocol to the Research Ethics Committee for further review and to obtain Research Ethics Committee approval thereto prior to implementation (except only in cases of emergency when the welfare of the subject is paramount).

The desirability of including full details of the consent form in an appendix to your research, and of addressing specifically ethical issues in your methodological discussion.

The requirement to furnish the Research Ethics Committee with details of the conclusion and outcome of the project, and to inform the Research Ethics Committee should the research be discontinued. The Committee would prefer a concise summary of the conclusion and outcome of the project, which would fit no more than one side of A4 paper, please.

Appendix O: Participant Information Sheets (Study 1 - 3)

Study 1 Participant Information Sheet – Questionnaire Version I

Investigating self-harming behaviours amongst university students

This study has been approved by the University of Westminster University Research Ethics Committee

Researchers: Jay-Marie Mackenzie, Laura Culshaw, Jo Borril and Tina Cartwright

Participant Information Sheet

We are very pleased to invite you to take part in a research study that is being conducted by the University of Westminster. This information sheet explains why the research is being conducted and what it will involve. Once you have read the information you are welcome to get in touch with the researchers if there is anything that is not clear, or if you would like more information (contact details below). You can take as much time as you like to think about taking part.

What is the purpose of the study?

The aim of this study is to explore people's experiences of self-harm during their time at university, and what support or information would be helpful for those who have experienced self-harm, either directly or indirectly. We hope that it will help to reduce and prevent self-harm, as well as providing support to those who may be supporting somebody who self-harms (or has done so previously).

As part of the research we would like to hear from a range of people about their experiences, including those who have had thoughts of self-harm but not acted on these thoughts, those who have, or are currently, supporting someone who self-harms and those who have actively self-harmed.

What will happen if I take part?

This phase of the study is being conducted online. As part of this study you will be asked a variety of questions about your own personal experiences of self-harm, including questions related to your thoughts and behaviours, as it is important for us to understand your reflections on these past experiences. Previous research suggests that most people have no difficulty answering these types of questions, and are pleased to be able to provide this information. However it is possible that some questions could be difficult or potentially upsetting for you, in which case we would not want you to answer them. Before deciding to take part in this study, please consider carefully whether you are likely to find anything distressing and let us know if this is the case. Given the sensitive nature of the study, we would advise against taking part in the research if you have attempted suicide and/or have had thoughts of ending your life within the last 6 months.

If you do decide to take part, you will be asked about your experiences of self-harm, including questions around your thoughts and behaviours. These questions will focus mainly on helping us to understand what people think about specific self-harm methods, what factors may influence these thoughts and decisions, the support available to those self-harming at university, and what could be done to improve this support.

The questionnaire should take no more than 15-25 minutes to complete.

At the end of the questionnaire, you will be asked to register your interest in taking part in the next phase of this research. If you agree to this, you will be asked to provide contact information (e.g. phone number, email etc) so that a member of the research team is able to contact you with regards to taking part in further study. As it may be possible to link this contact information with participant identity, responses given in this study may no longer be anonymous to the research team. However, any data published from the survey will remain anonymous.

Please note:

- Your participation in this research is entirely voluntary.
- You have the right to withdraw at any time without giving a reason.
- Wherever practicable, withdrawal from the research will not affect any treatment and/or services that you receive.
- You have the right to ask for your data to be withdrawn as long as this is practical, and for personal information to be destroyed.
- You do not have to answer particular questions either on questionnaires or in interviews if you do not wish to do so.
- Your responses will normally be made anonymous, unless indicated above to the contrary. All responses will be confidential and will only be viewed by members of the research team. [NOTE: it may not be possible to maintain confidentiality in certain circumstances, e.g. where issues of child safety have been identified. You should seek clarification from the researcher and/or their supervisor if you are concerned about this].
- No individuals should be identifiable from any collated data, written report of the research, or any publications arising from it.
- All computer data files will be encrypted and password protected. The researcher will keep files in a secure place and will comply with the requirements of the Data Protection Act 1998.
- All hard copy documents, e.g. consent forms, completed questionnaires, etc. will be kept securely and in a locked cupboard, wherever possible on University premises. Documents may be scanned and stored electronically. This may be done to enable secure transmission of data to the university's secure computer systems.

- Please notify the researcher immediately if any adverse symptoms arise during or after the research.
- If you wish you, can receive information on the results of the research. Please indicate on the consent form if you would like to receive this information.
- The researcher can be contacted during and after participation by email (w1609297@my.westminster.ac.uk)
- If you have a complaint about this research project you can contact the project supervisor, Jay-Marie Mackenzie by e-mail (J.C.Mackenzie@westminster.ac.uk)

What will happen to the results of this research study?

We will produce a summary of the results for the websites that have supported this research by posting this questionnaire. The results of this study may also be published in academic journals. You will not be personally identified in any report or publication resulting from this study.

Who has reviewed this study?

All research that involves human participants has to be reviewed and approved by an Ethics Committee before it can begin. The University of Westminster Ethics Committee has approved this project.

Contacts for further information

Thank you for taking the time to read this information. If you have any further questions about the study, please don't hesitate to contact us via email or postal address shown below:

Laura Culshaw
Department of Psychology
University of Westminster
115 New Cavendish Street,
London
W1W 6UW
Email: w1609297@my.westminster.ac.uk

Supervisor: Dr Jay-Marie Mackenzie
J.C.Mackenzie@westminster.ac.uk, 020 7911 5000 (ext: 64710)

FURTHER SUPPORT

If you feel that you are in need of immediate support, please contact Samaritans (116 123) or NHS Choices

(http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/NHS-111.aspx) on 111 (both are available 24 hours a day, 365 days a year, and are free). Alternatively, please go to, or call, your nearest Accident and Emergency (A&E) department and tell the staff how you are feeling.

Please click here for a more comprehensive list of support organisations

You can also download a copy of this participant information by clicking here

Study 1 Participant Information Sheet – Questionnaire Version II

Exploring University Student Emotions and Perceptions of Support

This study has been approved by the University of Westminster University Research Ethics Committee
Researchers: Jay-Marie Mackenzie, Laura Culshaw, Nina Smyth and Tina Cartwright

Participant Information Sheet

The research team would like to thank you greatly for taking the time to visit our questionnaire. We very much hope to increase the understanding of student health during university life as well as perceptions of support. Our aim is to use this information to inform the development of effective support available to students, families and friends.

Participant Information Page

We are very pleased to invite you to take part in a research study that is being conducted by the University of Westminster. This information sheet explains why the research is being conducted and what it will involve. Once you have read the information you are welcome to get in touch with the researchers if there is anything that is not clear, or if you would like more information (contact details below). You can take as much time as you like to think about taking part.

What is the purpose of the study?
The aim of this study is to explore individual emotions and thinking styles during their time at university, as well as students understanding and experience of support networks. We hope that it will help to gain a greater understanding of the level of support available to students, the emotions attached with university life and perceived effectiveness of university based support.

What will happen if I take part?
This phase of the study is being conducted online. As part of this study you will be asked a variety of questions exploring your social relationships and experience of support seeking, including questions related to your thoughts, emotions and behaviours, as it is important for us to understand your reflections on these past and/or current experiences. Further, where applicable, questions exploring self-harm and your experiences of these behaviours will be featured. Previous research suggests that most people have no difficulty answering these types of questions, and are pleased to be able to provide this information. All results will remain anonymous.

However it is possible that some questions could be difficult or potentially upsetting for you, in which case we would not want you to answer them. Before deciding to take part in this study, please consider carefully whether you are likely to find anything distressing and let us know if this is the case. Given the sensitive nature of the study, we would advise against taking part in the research if you have attempted suicide and/or have had thoughts of ending your life within the last 6 months.

If you do decide to take part, questions will focus mainly on helping us to understand student emotions, what factors may influence thoughts and decisions, the support available to those at university, and what could be done to improve this support.

The questionnaire should take no more than 10-15 minutes to complete.

At the end of the questionnaire, you may be invited to take part in the next phase of this research and/or the opportunity to enter a voucher draw. Names are not requested for taking part in this survey, but if you would like to take part in further research or enter the draw, you will be asked to provide some contact information (e.g. phone number, email etc) so that a member of the research team is able to contact you.

As it may be possible to link this contact information with participant identity, responses given in this study may no longer be anonymous to the research team. However, any data published from the survey will remain anonymous.

What will happen to the results of this research study?
Results may be presented on the websites of the charities/organisations that have supported the research. The results of this study may also be published in academic journals. You will not be personally identified in any report or publication resulting from this study, all results will be anonymous.

Who has reviewed this study?
All research that involves human participants has to be reviewed and approved by an Ethics Committee before it can begin. The University of Westminster Ethics Committee has approved this project.

Contacts for further information
Thank you for taking the time to read this information. If you have any further questions about the study, please don't hesitate to contact us via email or postal address shown below:

Laura Culshaw
Department of Psychology
University of Westminster
115 New Cavendish Street,
London
W1W 6UW
Email: L.Culshaw@westminster.ac.uk

Dr Jay-Marie Mackenzie
J.C.Mackenzie@westminster.ac.uk, 020 7911 5000 (ext: 64710)

Dr Nina Smyth
N.Smyth@westminster.ac.uk, 020 7911 5000 (ext: 64425)

Dr Tina Cartwright
T.Cartwright@westminster.ac.uk, 020 7911 5000 (ext: 69067)

FURTHER SUPPORT

If you feel that you are in need of immediate support, please contact Samaritans (116 123) or NHS Choices (https://www.nhs.uk/using-the-nhs/nhs-services/urgent-and-emergency-care/nhs-111/) on 111 (both are available 24 hours a day, 365 days a year, and are free).

Alternatively, please go to, or call, your nearest Accident and Emergency (A&E) department and tell the staff how you are feeling.

Support organisations:

https://www.samaritans.org/

https://www.nightline.ac.uk/

http://www.mind.org.uk/

http://www.harmless.org.uk/

Participant Information Sheet – Interviews (Studies 2 & 3)

Understanding Student Self-Harm: What can we do to help?

This study has been approved by the University of Westminster University Research Ethics Committee

Researchers: Jay-Marie Mackenzie, Laura Culshaw, Nina Smyth and Tina Cartwright

Participant Information Sheet (Interviews)

We are very pleased to invite you to take part in a research study that is being conducted by the University of Westminster. This information sheet explains why the research is being conducted and what it will involve. Once you have read the information you are welcome to ask the researchers if there is anything that is not clear or if you would like further information. You are also welcome to get in touch with the researchers before and/or after taking part if there is anything that is not clear, or if you would like more information (contact details below). You can take as much time as you like to think about taking part.

What is the purpose of the study?

The aim of this study is to explore people's experiences of self-harm during their time at university, and what support or information would be helpful for those who have experienced self-harm, either directly or indirectly. We hope that it will help to reduce and prevent self-harm, as well as providing support to those who may be supporting somebody who self-harms (or has done so previously).

As part of the research we would like to hear from a range of people about their experiences, including those who have had thoughts of self-harm but not acted on these thoughts, those who have, or are currently, supporting someone who self-harms and those who have actively self-harmed.

What will happen if I take part?

You are now taking part in interview phase of this research after indicating in phase 1 that you would be interested in taking part in the next stage of this study. Unlike phase one of this study, which was conducted online, this phase of the study involves a one-to-one interview that will be conducted either via telephone, skype or face-to-face. For interviews conducted face-to-face, you will have the opportunity to choose/negotiate a location for the interview with the researcher. For example, a quiet room within the university of Westminster or a quiet place within a public area (e.g. café) may be used. During the interview you will be asked a few questions about your own personal experiences of supporting someone through self-harm, including questions related to your thoughts and behaviours, as it is important for us to

understand your reflections on these past experiences. Previous research suggests that most people have no difficulty answering these types of questions, and are pleased to be able to provide this information. However it is possible that some questions could be difficult or potentially upsetting for you, in which case we would not want you to answer them. Before deciding to take part in this study, please consider carefully whether you are likely to find anything distressing and let us know if this is the case. Given the sensitive nature of the study, we would advise against taking part in the research if you have attempted suicide and/or have had thoughts of ending your life within the last 6 months.

If you do decide to take part, you will be asked about your experiences of self-harm, including questions around your thoughts and behaviours and your role, if relevant, as a supporter. These questions will focus mainly on helping us to understand what people think about specific self-harm methods, what factors may influence these thoughts and decisions, the support available to those providing support to students who self-harm, and what could be done to improve this support.

The interview should take approximately 45-60 minutes to complete.

Whilst the interviewer will know your identity at the time of interview, all data after this point will be anonymised for the purpose of analysis. The interview will be recorded so that we are able to later transcribe (that is, write down) for the researcher to study. Once the interview recording has been transcribed, the recording will be permanently deleted. After the interview, your name, and any further identifiable information will be removed so that no one is able to identify that it is you who is talking/taking part.

Please note:

- Your participation in this research is entirely voluntary.
- You have the right to withdraw at any time without giving a reason.
- Wherever practicable, withdrawal from the research will not affect any treatment and/or services that you receive.
- You have the right to ask for your data to be withdrawn as long as this is practical, and for personal information to be destroyed.
- You do not have to answer particular questions either on questionnaires or in interviews if you do not wish to do so.
- Your responses will normally be made anonymous, unless indicated above to the contrary. All responses will be confidential and will only be viewed by members of the research team. [NOTE: it may not be possible to maintain confidentiality in certain circumstances, e.g. where

issues of child safety have been identified. You should seek clarification from the researcher and/or their supervisor if you are concerned about this].

- No individuals should be identifiable from any collated data, written report of the research, or any publications arising from it.
- All computer data files will be encrypted and password protected. The researcher will keep files in a secure place and will comply with the requirements of the General Data Protection Regulations (GDPR) 2018.
- All hard copy documents, e.g. consent forms, completed questionnaires, etc. will be kept securely and in a locked cupboard, wherever possible on University premises. Documents may be scanned and stored electronically. This may be done to enable secure transmission of data to the university's secure computer systems.
- Please notify the researcher immediately if any adverse symptoms arise during or after the research.
- If you wish you, can receive information on the results of the research. Please indicate on the consent form if you would like to receive this information.
- The researcher can be contacted during and after participation by email (L.Culshaw@westminster.ac.uk)
- If you have a complaint about this research project you can contact the project supervisor, Jay-Marie Mackenzie by e-mail (J.C.Mackenzie@westminster.ac.uk)

What will happen to the results of this research study?

The results of this study may be published in academic journals. You will not be personally identified in any report or publication resulting from this study.

Who has reviewed this study?

All research that involves human participants has to be reviewed and approved by an Ethics Committee before it can begin. The University of Westminster Ethics Committee has approved this project.

Contacts for further information

Thank you for taking the time to read this information. If you have any further questions about the study, please don't hesitate to contact us via email or postal address shown below:

Laura Culshaw
Department of Psychology
University of Westminster
115 New Cavendish Street,
London
W1W 6UW
Email: L.Culshaw@westminster.ac.uk

Dr Nina Smyth
N.Smyth@westminster.ac.uk, 020 7911 5000 (ext; 64425)
Dr Jay-Marie Mackenzie
J.C.Mackenzie@westminster.ac.uk, 020 7911 5000 (ext: 64710)
Dr Tina Cartwright
T.Cartwright@westminster.ac.uk, 020 7911 5000 (ext; 69067)

FURTHER SUPPORT

If you feel that you are in need of immediate support, please contact Samaritans (116 123) or NHS Choices (http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/NHS-111.aspx) on 111 (both are available 24 hours a day, 365 days a year, and are free). Alternatively, please go to, or call, your nearest Accident and Emergency (A&E) department and tell the staff how you are feeling.

Support organisations:

https://www.selfharm.co.uk/

https://www.nightline.ac.uk/

http://www.mind.org.uk/

http://www.harmless.org.uk/

Appendix P: Participant Consent Forms (Studies 1-3)

Study 1 Consent Form – Questionnaire Version I

CONSENT FORM

Title of Study: Investigating self-harming behaviours amongst university students

Lead researcher: Laura Culshaw

I have been given the Participation Information Sheet and/or had its contents explained to me.	Yes	❒	No	❒
I have had an opportunity to ask any questions and I am satisfied with the answers given.	Yes	❒	No	❒
I understand I have a right to withdraw from the research at any time and I do not have to provide a reason.	Yes	❒	No	❒
I understand that if I withdraw from the research any data included in the results will be removed if that is practicable (I understand that once I submit my responses on the questionnaire and once anonymised data has been collated into other datasets it may not be possible to remove that data).	Yes	❒	No	❒
I consent to the storage and processing of my personal information for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with the Data Protection Act 1998*	Yes	❒	No	❒
I would like to receive information relating to the results from this study.	Yes	❒	No	❒
I wish to receive a copy of this Consent form.	Yes	❒	No	❒
I confirm I am willing to be a participant in the above research study.	Yes	❒	No	❒
I note the data collected may be retained in an archive and I am happy for my data to be reused as part of future research activities. I note my data will be fully anonymised (if applicable).	Yes	❒	No	❒

Participant's Name: ______________________________

Date: ________________

This consent page will be stored separately from any data you provide so that your responses remain anonymous.

**This consent form was altered following the introduction of the General Data Protection Regulations (GDPR) 2018. Study 1 initially launched in 2017 prior to this change.*

Study 1 Consent Form – Questionnaire Version II

CONSENT FORM

Title of Study: Exploring University Student Emotions and Perceptions of Support

Lead researcher: Laura Culshaw

I have been given the Participation Information Sheet and/or had its contents explained to me.	Yes	❐	No	❐
I have had an opportunity to ask any questions and I am satisfied with the answers given.	Yes	❐	No	❐
I understand I have a right to withdraw from the research at any time and I do not have to provide a reason.	Yes	❐	No	❐
I understand that if I withdraw from the research any data included in the results will be removed if that is practicable (I understand that once I submit my responses on the questionnaire and once anonymised data has been collated into other datasets it may not be possible to remove that data).	Yes	❐	No	❐
I consent to the storage and processing of my personal information for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with the General Data Protection Regulations (GDPR) 2018.	Yes	❐	No	❐
I would like to receive information relating to the results from this study.	Yes	❐	No	❐
I wish to receive a copy of this Consent form.	Yes	❐	No	❐
I confirm I am willing to be a participant in the above research study.	Yes	❐	No	❐
I note the data collected may be retained in an archive and I am happy for my data to be reused as part of future research activities. I note my data will be fully anonymised (if applicable).	Yes	❐	No	❐

Participant's Name: ______________________________

Date: ________________

This consent page will be stored separately from any data you provide so that your responses remain anonymous.

Study 2 & 3 Interview Consent Form

CONSENT FORM

Title of Study: Understanding student self-harm: what can we do to help? (Interviews)

Researcher: Laura Culshaw
Supervisors: Dr Jay-Marie Mackenzie, Dr Tina Cartwright and Dr Nina Smyth

I have been given the Participation Information Sheet and/or had its contents explained to me.	Yes	❒	No	❒
I have had an opportunity to ask any questions and I am satisfied with the answers given.	Yes	❒	No	❒
I understand I have a right to withdraw from the research at any time and I do not have to provide a reason.	Yes	❒	No	❒
I understand that if I withdraw from the research any data included in the results will be removed if that is practicable (I understand that once I submit my responses on the questionnaire and once anonymised data has been collated into other datasets it may not be possible to remove that data).	Yes	❒	No	❒
I consent to the storage and processing of my personal information for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with General Data Protection Regulations (GDPR) 2018.	Yes	❒	No	❒
Understood that my participation will be audio recorded and I am aware of and consent to the transcribing of these recordings by the research team after the interview.	Yes	❒	No	❒
I would like to receive information relating to the results from this study.	Yes	❒	No	❒
I wish to receive a copy of this Consent form.	Yes	❒	No	❒
I confirm I am willing to be a participant in the above research study.	Yes	❒	No	❒
I note the data collected may be retained in an archive and I am happy for my data to be reused as part of future research activities. I note my data will be fully anonymised (if applicable).	Yes	❒	No	❒

Participant's Name: ___________________________

Signature: ___________________________ **Date:** _______________

This consent form will be stored separately from any data you provide so that your responses remain anonymous.

____

I confirm I have provided a copy of the Participant Information Sheet approved by the Research Ethics Committee to the participant and fully explained its contents. I have given the participant an opportunity to ask questions, which have been answered.

Researcher's Name: ___________________________

Signature: ___________________________ **Date:** _______________

If you have any queries in relation to this research, please do not hesitate to contact a member of the research team on the contact details below;

Laura Culshaw
L.Culshaw@westminster.ac.uk

Dr Jay-Marie Mackenzie
J.C.Mackenzie@westminster.ac.uk, 020 7911 5000 (ext: 64710)

Dr Tina Cartwright
T.Cartwright@westminster.ac.uk, 020 7911 5000 (ext: 69067)

Dr Nina Smyth
N.Smyth@westminster.ac.uk, 020 7911 5000 (ext: 64425)

Appendix Q: Study 1 Online Questionnaire Debrief Page/End of Survey

End of Survey

Thank you for taking the time to complete this questionnaire. As mentioned at the start of the survey, this questionnaire has been designed as the first phase in our research. For the second phase, we are hoping to conduct interviews with participants.

If you would be interested in taking part in the next phase of the research, **please leave your preferred method of contact in the box provided** (e.g. phone number, email etc). Your contact details will be kept confidential and will only be shared with the research team. Providing your contact details at this stage does not mean that you are in anyway obliged to take part in phase 2, you can withdraw from the research at any time. If you are contacted by a researcher, they will provide you with more details on what would be involved in phase 2 and you will be given chance to ask questions and see if further participation would be in your best interest.

Based on the time taken to conduct interviews, and the information that we are hoping to gather in phase 2, you may not be contacted to take part even if you leave your contact details. We would like to emphasise that we are very grateful to anyone who is willing to be contacted to take part in further research.

If you have any further questions about the study, please don't hesitate to contact us on the contact details below:

Lead Researcher: Laura Culshaw
Email: L.Culshaw@westminster.ac.uk

Supervisor: Dr Jay-Marie Mackenzie
Email: J.C.Mackenzie@westminster.ac.uk

As part of the next phase of this research, we are hoping to conduct one-on-one interviews with a sample of individuals who have completed this questionnaire. Interviews will be offered face-to-face, via skype or via telephone and the method of interview will be entirely your choice. If you would be happy for a researcher to contact you about taking part in an interview, please leave your contact information in the box provided:

We are grateful for any feedback you may have on your experience of completing this questionnaire. Please comment in the box below:

Contacts for further information
Thank you for taking the time to complete this questionnaire. If you have any further questions about the study, please don't hesitate to contact us via email or postal address shown below:

Laura Culshaw
Department of Psychology
University of Westminster
115 New Cavendish Street,
London
W1W 6UW
Email: w1609297@my.westminster.ac.uk

Supervisor: DrJay-Marie Mackenzie
Email: J.C.Mackenzie@westminster.ac.uk

FURTHER SUPPORT

If you feel that you are in need of immediate support, please contact Samaritans (116 123) or NHS Choices (http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/NHS-111.aspx) **on 111 (both are available 24 hours a day, 365 days a year, and are free).**

Alternatively, please go to, or call, your nearest Accident and Emergency (A&E) department and tell the staff how you are feeling.

Below is a list of support organisations that can provide support including information and low cost counselling options:

Organisation	Support	Contacts
Samaritans	24-hour service providing confidential emotional support to anyone in crisis	Helpline: 116 123 Website: www.samaritans.org
Mind	Charity about mental health and related topics.	Helpline: 0300 123 3393 Text: 86463 Website: www.mind.org.uk
National Self-harm network	UK based charitable support group. Includes forums and resources.	Website: http://www.nshn.co.uk/
Nightline	Confidential listening, support and practical information service for students in London and Open University. **Please note this service only runs during term-time (see website for specific dates)*	Phone: 0207 631 0101 Website: http://nightline.org.uk/ Email: listening@nightline.org.uk
HOPELineUK	Specialist telephone helpline to prevent young suicide	Helpline: 0800 068 41 41 Text: 07786 209 697 Email: pat@papyrus-uk.org Website: www.papyrus-uk.org

Appendix R: Participant Personalised Safety Plans (Study 2 and 3)

Personalised Safety Plan

[TO BE COMPLETED WITH RESEARCH PARTICIPANTS. ONE COPY TO BE KEPT BY THE RESEARCHER; ONE COPY FOR THE PARTICIPANT]

Researcher: Laura Culshaw
Supervisors: Dr Jay-Marie Mackenzie, Dr Nina Smyth, Dr Tina Cartwright

Most people find it helpful to talk about their experiences but this can also be upsetting. Please let your researcher know if you are feeling uncomfortable and would like to stop or suspend your participation in the interview. You do not have to answer anything you do not feel comfortable answering, and are free to stop participation in the interview at any point.

Given the sensitive nature of the study, we would advise against taking part in the research if you are currently experiencing strong thoughts of suicide, or have attempted suicide within the past 6 months.

Please note that if someone in the interview tells us that they are currently experiencing serious thoughts of suicide we are duty bound to inform someone, to ensure their own safety. However, we would tell them that this will happen and would not mention anything else from the interview. Please let us know who we may contact should we have some serious concerns over your safety. This may be your GP, a key worker, and/or a trusted family member or friend.

Name of person or persons to contact:
Email(s):
Telephone number(s):

What happens if I become distressed after the interview?
Please contact Laura Culshaw by email L.Culshaw@westminster.ac.uk if you have any concerns post participation in the interview.

If you are thinking about harming yourself or attempting suicide, or feeling overwhelmed, please seek help from your GP, a key worker, or family and friends. If you feel that you are in need of immediate support, please contact Samaritans (08457 90 90 90) or NHS Choices (http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/NHS-111.aspx) on 111 (both are available 24 hours a day, 365 days a year. Calls to 111 are free). Alternatively, please go to, or call, your nearest accident and emergency (A&E) department and tell the staff how you are feeling.

Below is a list of support organisations that can provide support including information and low cost counselling options.

Organisation	**Support**	**Contacts**
Samaritans	24-hour service providing confidential emotional support to anyone in crisis	Helpline: 116 123 Website: www.samaritans.org
Mind	Charity about mental health and related topics.	Helpline: 0300 123 3393 Text: 86463 Website: www.mind.org.uk
National Self-harm network	UK based charitable support group. Includes forums and resources.	Website: http://www.nshn.co.uk/
Nightline	Confidential listening, support and practical information service for students in London and Open University. **Please note this service only runs during term-time (see website for specific dates)*	Phone: 0207 631 0101 Website: http://nightline.org.uk/ Email: listening@nightline.org.uk
HOPELineUK	Specialist telephone helpline to prevent young suicide	Helpline: 0800 068 41 41 Text: 07786 209 697 Email: pat@papyrus-uk.org Website: www.papyrus-uk.org

If you have any queries in relation to this research, please do not hesitate to contact a member of the research team on the contact details below;

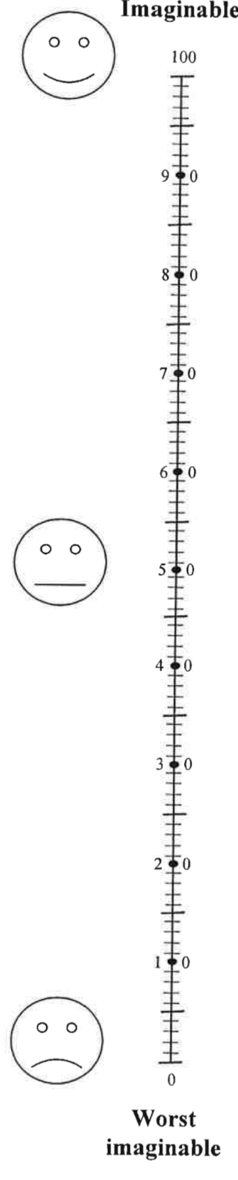
Laura Culshaw
L.Culshaw@westminster.ac.uk
Dr Nina Smyth
N.Smyth@westminster.ac.uk, 020 7911 5000 (ext: 64425)
Dr Jay-Marie Mackenzie
J.C.Mackenzie@westminster.ac.uk, 020 7911 5000 (ext: 64710)
Dr Tina Cartwright
T.Cartwright@westminster.ac.uk, 020 7911 5000 (ext: 69067)

Appendix S: Visual Analogue Scale (VAS)

To help people say how happy or upset they feel, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how you feel at the moment. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your emotional state is now.

Your own emotional state at the moment



1

Appendix T: Study 1 Poster Adverts

Study Advert for Questionnaire Version I

Study Advert for Questionnaire Version II

Understanding Student Emotions and Perceptions of Support

University of Westminster

This research project aims to explore student emotions and thinking styles during University, as well as experiences of support networks.

We would like to hear from any student currently studying, or those who have previously studied, at a U.K. University.

As a thank-you for taking part, you can choose to be entered into a prize draw for the chance to win a £50 voucher.

.

If you would like to share your experiences, please consider taking part in a brief anonymous online survey (please copy and paste into your browser):

bit.ly/2UWSUNR

If you have any further questions, or would like any further information, please email Laura Culshaw:

L.Culshaw@westminster.ac.uk

Online Study - Student Emotions bit.ly/2UWSUNR

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Appendix U: Extracts from the Researchers Reflexivity Journal

Study 2 Interviews – Reflective Extracts for Interview 1 and 16

Participant 1 – Skype Video Interview

This was my first interview and I was feeling a little nervous/apprehensive as I didn't know what to expect. I guess I wasn't sure how well received the questions would be and how easy the conversation would flow. I found the participant easy to talk to, at time they were quite quiet and didn't add much to what I said, but there were times when they shared some really personal and insightful stories and thoughts into their life and their self-harming behaviour. The participant discussed the issue of defining self-harm and I tried to deal with this by asking them their view in order to think about the first time they had thoughts of and carried out harmful behaviours. I felt the interview flowed well and I felt it was well received by the participant. At times, I feel I could have picked up on more of what the participant had said instead of worrying about covering all the questions/finishing within a specific time frame. I also feel like I kept trying to fill in brief pauses and kept trying to clarify myself further. I think it would be best to sit with the question and give the participant time to digest and then ask for further clarification themselves if they feel this is necessary. There were also times when the signal went and on reflection it's difficult to hear what the participant was saying, I felt apprehensive asking the participant to repeat themselves and need to ensure I do this in future in order to ensure that I am fully understanding and hearing what they are saying.

Participant 16 - Face-to-Face interview.

It has been some time since my last face-to-face interview and it was interesting to note how it felt different to completing interviews on the telephone and skype. I felt that I was able to concentrate more on the moment and the individuals experiences and tried not to concern myself with making sure I had asked every question – instead I tried to focus on their experiences and ask them to reflect and build on these in relation to the topics and emerging themes that have been discussed with previous participants. It was interesting to hear about the view of mental health and self-harm within her culture and how her experiences in England and at an English university had helped a lot with her development and understanding of her self-harm and anxieties.

Study 3 Interviews – Reflective Extracts for Interview 1 and 24

Participant 1 – Telephone Interview

This was the first interview that I had conducted with a supporter. I found the interview very interesting, and they gave a lot of information without me asking too many questions. They brought up some really interesting points and I felt I was able to follow these up effectively. At times, I felt like I may have missed one or two points that I would have liked to follow-up however I felt it was important not to interrupt the participant during their flow. I found it interesting to be on the other side of my work to date, hearing about the experiences and perspectives of a parent and how they experienced guilt and uncertainty around self-harm.

Participant 24 - Telephone interview

My initial feeling after finishing this interview was that I feel very privileged that individuals who don't know me are willing to share such personal information. I really enjoyed this interview and found the participant very easy to speak to, and as though the interview flowed very well without little input from myself, and with the participants experiences very much leading the interview. On a personal level this one was very interesting for me, as the participant described supporting their family and specifically their mother with mental health difficulties, and I found a lot of her thoughts and feelings resonating with my own experiences. I think it is important here to recognise this and be especially careful when interpreting and analysing this interview.

Appendix V: Study 3 Poster Advert

Providing support for Student Self-Harm

Call for Participants

Have you ever supported a student engaging in self-harm during their time at University?

Would you be willing to share your thoughts and experiences by taking part in an anonymous interview?

This research project aims to explore the experiences of those who have provided support for any individual engaging in self-harm during their time at University.

This may be professionally, as a friend, parent, or in any other capacity.

The idea of this interview is to develop our understanding of your role as a supporter, why students may self-harm, as well as exploring current support provisions.

Interviews can take place via face-to-face, skype, or telephone, depending upon preference.

You will be offered £15 worth of vouchers for your time.

If you would be willing to share your experiences, or would like any further information, please contact Laura Culshaw:

L.Culshaw@westminster.ac.uk

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Appendix W: Guidance to Providing Effective Support for Self-Harm amongst University Students: A Student Perspective (Leaflet)

Guidance to providing effective support for
self-harm amongst University students:
A Student's perspective

What is the HUSSH Project?

The HUSSH project was a research study aimed at understanding self-harm amongst University students. Individuals from across the United Kingdom with experience of self-harm during University were invited to participate in an online questionnaire. A variety of measures and open-ended survey questions were used to explore views and perceptions around self-harm, including methods, definitions and the usefulness of support and interventions currently available. Further, participants who were happy to be contacted for further phases were invited to take part in one-to-one interviews with a member of the research team.

The findings revealed key areas that students feel support could be developed and where potential improvement and advancements are required.

What is the purpose of this leaflet?

This leaflet provides an overview of our findings. Key stages were identified by students at which they felt intervention and/or support would be helpful. This leaflet provides suggestions on how Universities may be able to provide support at key stages, including before, during and after attending University. Whilst some institutions may be addressing some, or all, of these points, it became clear from speaking with students that this differs greatly between universities. Based on the voice of students, this leaflet has been designed to provide standardised and tailored ideas for supporting University students who self-harm.

BEFORE UNIVERSITY

Before attending University, students consider many different institutions. Once selected, applications will be made to the University and if successful, offers to students will be made. Once provisional offer requirements are met, students will now have an identified University which they will be preparing to attend and commence their studies at.

We asked:

What can be done before arriving at University to help you feel supported?

They Said:

1. **Accessibility** – Universities should review the information that they have available for prospective students, ensuring that the supportive resources available to students once attending the University are transparent at this stage. Universities could collect feedback on this from students in order to ensure that they are meeting their needs and requirements.
2. **Information** – on how to access University services before starting courses should be made available e.g. sending out leaflets, advertisement on University websites, student prospectus, emails and/or offer and acceptance letters.
3. **Contacts** – Opportunity for prospective students to contact University personnel and enquire about support with the potential to set up support for when arriving at University.

DURING UNIVERSITY

Students described the process of arriving at University and how this can be quite daunting. They are often attending inductions and welcome events, and meeting lots of new people and settling into a new environment during this time.

We asked:

What can be done during this stage of University to help you feel supported?

They said:

1. Visibility – All supporting staff and University personnel to be identifiable – e.g. badges, t-shirts.
2. Promotion and Presence – Freshers events and specific well-being hubs/events to be used to promote services and conversations amongst the study body.
3. Encouragement – Stories, talks and experiences of those who have accessed support or experienced difficulties to be shared.

After this period of arriving and settling in, students reflected on how this was a fundamental time in requiring support. This was often related to work pressures and deadlines, or just needing someone to talk to about general well-being and University life. At this time, students may feel that they need to access the services advertised to them earlier on. This will often be a time of receiving referrals and assessing the needs of students for counselling and well-being services.

We asked:

What can be done during this time at University when you feel you may need to access support?

They said:

1. Differing approaches – Students suggested that different approaches needed to be used to cover the variety of difficulties that they were experiencing. Specifically, learning support/options for those who may find aspects of University triggering – e.g. offering time out cards from lectures and flexible assessment procedures, such as alternatives to oral presentations (e.g. pre-recorded videos or podcasts).
2. Communication – Prompt responses and validation of referrals is vital. Cancellations and appointment changes need to be clearly communicated to students. Further, communication between services requires improvement. Many felt that this was not done and had impacted on their future support-seeking and for some, increased their self-harm.
3. Interventions – Need for a clear support pathway and management of expectations. Whilst number of sessions available may be limited, this should be approached sensitively with validation of feelings. Students reflected on the impact of feeling not worthy of support due to being told they could only be seen for a set number of session on several occasions.
4. Tailored and Specific Support for self-harm – Leaflets and information should be specific to self-harm and recognised in isolation as well as alongside other mental health difficulties. Students felt this was not met, and that self-harm is a topic that Universities provide limited, if any, information on. Due to this, students didn't feel comfortable in disclosing and discussing self-harm, even during therapy.

DURING/AFTER UNIVERSITY

Once support has been accessed, assessments and appropriate approaches to support will be agreed. At this stage, services will be providing on-going support to students who self-harm. Students reflected on the support sessions during University, the ending of support, as well as leaving University and the importance of transition out of the University environment.

We asked:

What can be done during this time of receiving support and endings to help you feel supported?

They said:

1. **Exploration** – Self-harm should be safely explored and support should be tailored to the student's specific difficulties.
2. **Alternative support** – Options of other support services/methods outside of sessions and on ending of University support should be explored, for example, external organisations and services, app-based support etc. Further, the creation of 'safe' spaces and 'chill out/time out' zones at University. Students felt this would help them in the future and in-between sessions.
3. **Endings** – Allow for potential difficulties that may occur after ending support sessions from University services to be addressed during treatment/sessions (e.g. the need for future support). Skills and Information for approaching conversations around self-harm with family members/friends/peers and University personnel would be helpful to explore. Students felt that the option of follow-up and/or check-in sessions after ending sessions would be reassuring and comforting.
4. **Smooth transition** – Students expressed that the ending of University can be a particularly stressful and worrisome time. At this stage, smooth transitions in which students feel supported are vital. Care/Safety plans (e.g. including advice on where they can go for further support and who they can get support from when leaving University) that students are able to take away would be helpful in preventing feelings of isolation and abandonment at this crucial period.

If you have any further questions about the content of this leaflet or our research – please feel free to contact the research team (L.Culshaw@westminster.ac.uk or j.c.mackenzie@westminster.ac.uk)

Developed by The HUSSH Research Team (Culshaw, L., Cartwright, T., Smyth, N., & Mackenzie., J. (2019), University of Westminster.

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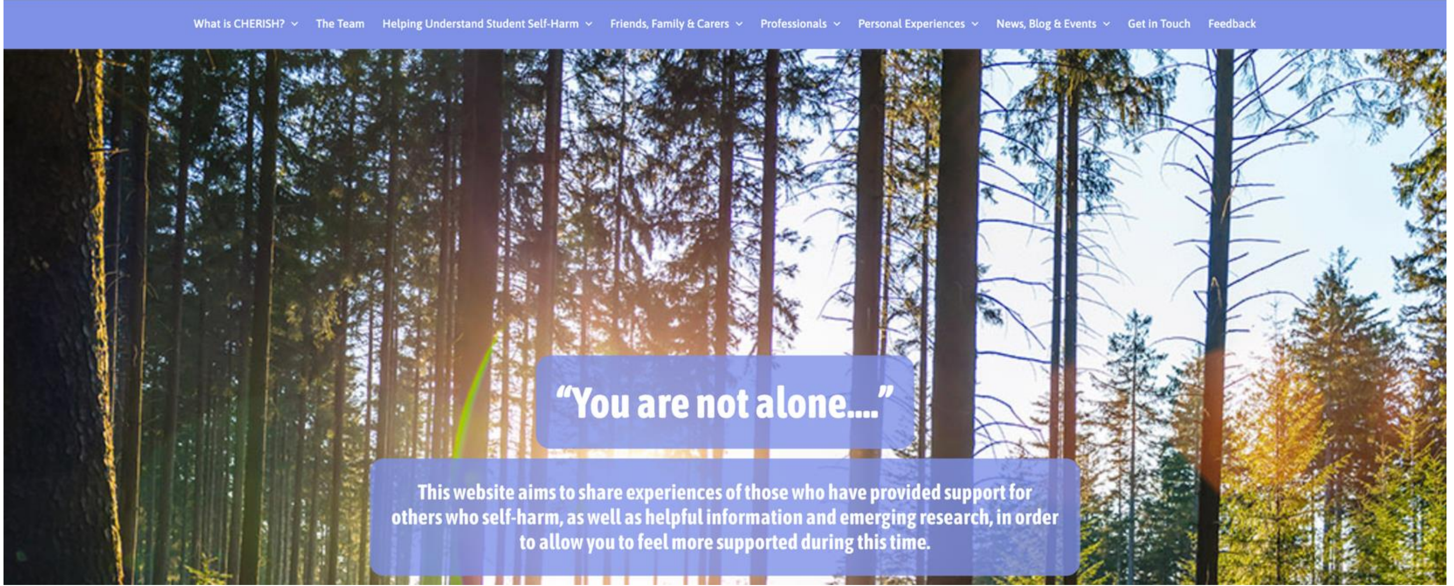
Appendix X: CHERISH Website Homepage Screenshot



www.cherishsupport.co.uk

Appendix Y: CHERISH - Caring for Student Self-Harm Video

https://www.youtube.com/watch?v=jD44N88U4XY

Appendix Z: CHERISH Carers Event June 2022 Artwork: Supporting the Supporters