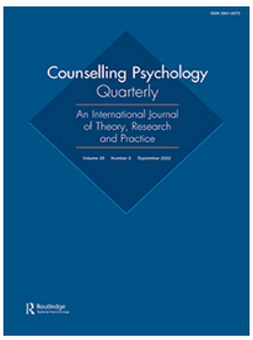

Routledge
Taylor & Francis Group

Counselling Psychology Quarterly

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/ccpq20

A qualitative exploration of student self-harm and experiences of support-seeking within a UK university setting

Laura Edwards-Bailey, Tina Cartwright, Nina Smyth & Jay-Marie Mackenzie

To cite this article: Laura Edwards-Bailey, Tina Cartwright, Nina Smyth & Jay-Marie Mackenzie (2022): A qualitative exploration of student self-harm and experiences of support-seeking within a UK university setting, Counselling Psychology Quarterly, DOI: 10.1080/09515070.2022.2146054

To link to this article: https://doi.org/10.1080/09515070.2022.2146054

Published online: 22 Nov 2022.

COUNSELLING PSYCHOLOGY QUARTERLY
https://doi.org/10.1080/09515070.2022.2146054

Routledge
Taylor & Francis Group

A qualitative exploration of student self-harm and experiences of support-seeking within a UK university setting

Laura Edwards-Bailey, Tina Cartwright, Nina Smyth and Jay-Marie Mackenzie

School of Social Sciences - Unit of Psychology, University of Westminster, London, UK

ARTICLE HISTORY Received 7 November 2021; Accepted 6 November 2022
KEYWORDS Self-Harm; University; Students; Support-Seeking; Thematic Analysis; Qualitative

Introduction

University is a key transition period for students, presenting unique demands such as increased independence, managing finances, and adjusting to new academic surroundings and ways of working (Taliaferro & Muehlenkamp, 2015). Additionally, many students move geographical locations and/or into new accommodations creating distance between 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, Summerfeldt, Hogan, & Majeski, 2004; Tosevski, Milovancevic, & Gajic, 2010). For some, this results in homesickness (Thurber & Walton, 2012) and psychological distress, with global estimates of one in four to one in five university students experiencing depression, anxiety, and high levels of stress (Beiter et al., 2015; Duffy et al., 2019).

In the United Kingdom (UK), rates of individuals attending university are growing (Department for Education, 2018; Universities UK, 2019). Alongside this, mental health difficulties amongst this group have increased fivefold in the last decade (Thorley, 2017) with a 450% (N = 21,105) rise in the number of students declaring a mental health condition (UCAS, 2021). Increasing psychological and mental distress can lead to reliance on unhealthy coping strategies such as Self-Harm (SH) (Stallman, 2020a), indicated by double the number of students versus non-students reporting SH (Swannell, Martin, Page, Hasking, & St John, 2014). Further, given the associated stigma and guilt surrounding SH, it is likely that these student reports are an underestimation (McManus & Gunnell, 2020; Walsh, 2012). Those who fail to receive support when experiencing mental health difficulties show poorer outcomes in academic achievement, employability, and relationships (Eisenberg et al., 2009; Wang et al., 2007). Therefore, university has been identified as a critical point for student support and psychological intervention (e.g. through counselling services) (Holm-Hadulla & Koutsoukou-Argyraki, 2015; Mental Health Foundation, 2016).

CONTACT Jay-Marie Mackenzie j.c.mackenzie@westminster.ac.uk

Defining self-harm

Various definitions of SH are proposed in the existing literature, creating difficulty in establishing a clear consensus on what constitutes SH. Non-suicidal self-injury (NSSI), often used in the United States (US), describes "the deliberate destruction of one's own bodily tissue in the absence of suicidal intent" (Bentley, Nock, & Barlow, 2014). In the UK, SH is commonly defined as "the intention to self-injure or self-poison regardless of motivation or suicidal intent" (Hawton et al., 2003).

Self-harm epidemiology

Over 80% of adults and young persons who engage in SH report psychiatric disorders, most frequently anxiety and depression (Hawton, Comabella, Haw, & Saunders, 2013). Further, 12 months following hospital attendance for SH, individuals are 30–100 times more likely than the general population to die by suicide (Cooper et al., 2005; Hawton et al., 2015, 2003; Hawton, Saunders, & O'Connor, 2012b) posing a major public health concern (Sharp & Theiler, 2018). Estimated lifetime prevalence of SH/NSSI amongst the general population varies across international studies, ranging from 4.3% to 38.6% (Brunner et al., 2014; Klonsky, 2011), and females are three times more likely than males to report an incident of lifetime SH (Madge et al., 2008). Cutting is the most frequently reported method of SH across genders (Madge et al., 2008); however, males are more likely to use hitting and burning in comparison to females (Klonsky, Victor, & Saffer, 2014). Research shows SH prevalence differs across demographic factors. Asian males report the lowest rates of SH compared to the highest rates amongst Black and Asian females (Al-Sharifi, Krynicki, & Upthegrove, 2015; Bhui, McKenzie, & Rasul, 2007). Suggestions as to what may contribute to these differing rates have been proposed, including SH definitions and differences in coping styles between groups. To improve preventative and supportive strategies for SH, understanding the meaning of SH/NSSI from the perspective of those with lived experience is crucial (Klonsky, 2007; Muehlenkamp, 2006).

SH most commonly initiates during the teenage years, with approximately 13–18% of individuals reporting at least one episode of SH/NSSI during adolescence (Evans & Hurrell, 2016; Swannell et al., 2014). Research focusing specifically on university students indicates varying rates of SH amongst this group. 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), and almost 60% (N = 224) reporting thoughts of SH during university in Jordan (Hamdan-Mansour et al., 2021). In contrast, a UK study by Hawton, Bergen, Mahadevan, Casey, and Simkin (2012a) found that occurrences of hospital presentations for SH were significantly lower amongst Oxford University students when compared to other young people over a 30-year period. In another UK study, 27% (N = 166) of a non-clinical student sample reported at least one lifetime incident of SH, whilst 9.7% (N = 60) engaged in SH during their time at university (Borrill, Fox, Flynn, & Roger, 2009). A series of open-ended questions exploring experiences of university support services were included, with findings highlighting the need for increased visibility and access to services, as well as the key role that academic staff play in providing support. However, 58% (N = 35) of respondents did not complete these questions limiting the generalisability of these findings. Students who SH are most frequently referred to

university counselling services following presentation at hospital compared to any other support service (Hawton et al., 2012a). Given that one-third to a half of those who SH fail to seek support due to fear of negative reactions (Rowe et al., 2014), and the high rates of poor mental health and SH amongst students, university support services play a critical role in SH intervention.

Functions and motivations of self-harm

SH/NSSI is often understood as a means of releasing unwanted negative emotions and/or self-punishment (Hambleton, Hanstock, Halpin, & Dempsey, 2020; Klonsky, 2007; Klonsky & Glenn, 2009) through a range of behaviours (e.g. cutting, burning, scratching). Coping mechanisms are behavioural and cognitive processes that are adopted to manage stressful events and situations (Evans, Hawton, & Rodham, 2005), and can be categorised into "healthy" (e.g. self-soothing and social support) versus "unhealthy" (e.g. self-criticism and SH) coping strategies based on the likelihood of negative outcomes (Stallman, 2020b). The Health Theory of Coping (Stallman, 2020a) proposes a coping continuum model, suggesting unhealthy coping (e.g. harmful behaviours such as binge drinking and SH) are typically observed when healthy mechanisms are unavailable or ineffective in reducing distress (Stallman, Beaudequin, Hermens, & Eisenberg, 2021). Further, the model recognises the influence of biological, psychological, and social factors on the ways in which individuals may alleviate stress (e.g. access to healthier coping mechanisms) (Stallman, 2020a). Therefore, to understand what aspects are influential in students adopting SH as a means of coping at university, recognition of specific contextual factors within this environment (e.g. living conditions, finances, workload, and relationships) is required.

Much of the research aimed at understanding SH 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 SH, including the importance of developmental and environmental factors such as separation, independence, and forming of an identity (Stänicke, Haavind, & Gullestad, 2018). Resultingly, suggestions to explore SH in specific time points and contexts may allow for a greater understanding of important phenomena that contribute to SH behaviours. Further exploration of how these factors may be relevant to student SH, including recognition of university as a time of change and transition, is required.

Study aims

The current study aimed to qualitatively investigate experiences of SH amongst UK university students across varying geographical and university locations by exploring students' own understanding and experience of managing SH at university, including triggers, maintenance factors, coping strategies, and support-seeking. 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 for this vulnerable group.

Methods

Study design

A qualitative semi-structured interview design was adopted. Qualitative interviews allow for the exploration of under-researched issues and hard-to-reach groups (Ritchie, Lewis, Nicholls, & Ormston, 2013), identifying the nuances and meanings of individual experiences in relation to a particular topic (Robertson et al., 2018), accommodating an interpretivist epistemological position (Braun & Clarke, 2006).

Researcher description

At the time of this study, *LEB* was a doctoral student at a London-based university in her mid-20s. *LEB* had experience working as an assistant psychologist in healthcare settings alongside children and young people experiencing mental health difficulties and SH. The remaining three members of the research team were employed as senior lecturers/readers in the fields of suicidology (*JM*, PhD) and health psychology (*TC* PhD; *NS*, PhD). The team consisted of experts in both qualitative (JM) and mixed-methods research (*TC and NS*). As university students/staff members, the research team had a direct connection to the university context. All members of the research team identified as White-British females.

Participants

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

Procedures

Ethics

Ethical Approval was granted from the Psychology Research and Knowledge Exchange Ethics Working Group at the University of Westminster(*ETH1617-0083*). The sample was recruited from a previous online survey conducted by the research team exploring student SH, including a range of validated measures and open-ended questions. Those who had experienced SH during university were invited to leave their contact details to partake in further research. SH was defined in the current study as "the intention to self-injure or self-poison, regardless of motivation or suicidal intent" (Hawton et al., 2003).

Table 1. 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

[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

Inclusion and exclusion criteria

Participants were aged 18 years or above. Given the sensitive nature of the interview topics within this research, the specific focus on SH, 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, Kawashima, Yonemoto, & Yamada, 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 SH during university.

Sampling

Initially, the research team 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). This sampling method aims 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 1). All participants held or were currently completing an undergraduate or higher degree.

Data collection

A semi-structured interview schedule was devised following the framework for qualitative interviews guide (Kallio, Pietilä, Johnson, & Kangasniemi, 2016), based on team discussions and consideration of previous research (Borrill et al., 2009; Hawton et al., 2012a), identifying gaps and utilising existing knowledge of the evidence-base. Questions were designed to be open to ensure participant-led findings. 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 SH (e.g. how participants define SH and initiation of SH), and specifically their experiences of SH at university (e.g. motivations/triggers and support-seeking) (see Table 2). Pacing and depth were determined by the appropriateness and interview flow, with *LEB* ensuring sensitivity to participants' emotional state throughout. Interviews occurred concurrently with transcription and data analysis. The total number of interviews was determined by data saturation, indicated by a lack of new codes developing during analysis (Guest, Bunce, & Johnson, 2006).

On average, interviews lasted 58 minutes (range 34–108 minutes) and took place via a variety of platforms: face-to-face (N = 4), skype (N = 5), telephone (N = 6), or instant messenger (N = 1) depending upon participant preference. Varying interview methods were used to promote an inclusive recruitment strategy across a wide geographical area (Meho, 2006) by encouraging those with access limitations to participate (e.g. time and location). Further, participants who may not feel comfortable discussing their experiences face-to-face had the opportunity to partake in a less anxiety-provoking setting (Mealer & Jones, 2014). Interviews about personal experiences, specifically SH, have been viewed as a positive and cathartic experience (Biddle et al., 2013). All verbal interviews were audio-recorded.

Participants' emotional state was measured before and after the interview using a Visual Analogue Scale (VAS). 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 SH and suicide-based research as a means of monitoring participant mood due to the emotive nature of these topics (Biddle et al., 2013). Therefore, the VAS enabled *LEB* alongside professional judgment, to monitor any participant distress resulting from taking part. 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. All participants were debriefed following interviews and offered a list of supportive resources (e.g. Samaritans).

Table 2. Semi-structured interview schedule.

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 SH • 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 SH at university?	• Thoughts/Feelings before & after the SH • Triggers • Did anyone else know how you were feeling/about the SH? • Location; Planned/Impulsive? • Was this your first time SH at University (if no – approx. how many times has this occurred during university) • How was this different/similar to SH prior to university? • Drugs/Alcohol?
(5) There may be many reasons why people SH. 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 SH prior to University? • Did this differ to motivations for SH on other occasions at university (if applicable) • Is this usually how you feel when you SH
(6) Can you explain why you used this specific method? (*If appropriate/not explored previously)	• Main method of SH? • Use of other methods? • Positive/negative expectations
(7) Thinking back to the hours, days or weeks BEFORE this incident of SH, 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 SH that we have discussed?	• Mood/health • Thoughts around SH • Self-care; support-seeking?
(9) How does this recent experience of SH compare with any previous experiences of SH/thoughts of SH – at university and prior.	• Mood/Motivations • Triggers/Location/Methods • Outcome/support-seeking • Injuries – have you ever sought medical attention for your SH? (If yes, was this during university?)
(10) (Depending on response to support/help-seeking); What encouraged you OR prevented you from seeking help for SH 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 SH (for yourself and others during university) • Desire to stop SH?
(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 SH? • 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)

Implementation of participant safety plans was not required by the interviewer on any occasion.

Data analysis

Interviews were transcribed verbatim to establish trustworthiness and credibility and analysed using reflexive Thematic Analysis (TA) (Braun & Clarke, 2006, 2021). TA was selected due to its flexibility and allowance for efficient exploration of the data. Further, this study did not intend to expand upon existing theory, instead focusing on understanding student experiences of SH during university. The ability to extend beyond the descriptive nature of participants' accounts, allowing for feelings, motivations, and meanings of their experiences to be considered, accommodates for the interpretive epistemological position (Braun & Clarke, 2006).

Interviews were conducted, transcribed, and initially coded by *LEB*, allowing for data familiarisation. Pseudonyms were given to participants, removing identifiable information to ensure anonymity. 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). To promote rigour and reflexivity a reflective log was kept by *LEB* after each interview offering insight into the interviewers' personal experience, and an opportunity to consider the context of each interview (Sullivan, Gibson, & Riley, 2012). Initial analysis was conducted on a case-by-case basis using line-by-line coding by *LEB*. Codes were used to identify and describe extracts of data that may be relevant to the research topic (e.g. "relationships in university") (Braun & Clarke, 2013).

To promote authenticity and credibility, *authors JM, TC and NS* coded a sample of transcripts (12.5%) and all authors met to discuss comparisons and discrepancies of codes, enabling a deeper understanding and generation of richer codes (Saldaña, 2015). Following this, *LEB* collapsed codes into emerging themes that were representative of patterns and meanings across the data set (Fereday & Muir-Cochrane, 2006). All authors then met to discuss and further develop themes 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" (e.g. 'A New Identity – The Impact of University on Self-Harm) (Braun & Clarke, 2006, p. 82). Coding and analysis occurred simultaneously considering previous steps before further advancement of themes. 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. The consolidated criteria for reporting qualitative research (COREQ) was adopted 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, Sainsbury, & Craig, 2007). Participant quotes representing each theme are presented throughout the results. Based on the scope of this paper, data that had no influence on university-specific experiences of SH have not been included.

Results

Data collected during interviews highlighted individual differences and similarities in the experiences of SH amongst university students. Whilst participants mainly focused on a university context, reflections on the way in which SH had been perceived and understood both within and outside of this setting were discussed across all interviews. As a result, three main themes were identified alongside six corresponding sub-themes (see Table 3). 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.

Theme one: Understanding self-harm

Theme one describes participants' experiences of how broader society views and perceives the concept of SH. A lack of understanding regards to reasons for engaging in SH, the contrast between "stereotypical" definitions of SH vs lived experiences, as well as their ability to openly talk about and visibly show their SH to different individuals, were prominent themes within participant accounts (see Table 3).

Sharing self-harm with others – misunderstanding vs acceptance

Several participants discussed experiences of sharing their SH with others, either through talking about their SH or showing visible signs such as scars. Throughout these reports,

Table 3. Summary of main overarching themes and sub-themes for interviews with students who self-harm.

Themes	Sub-themes	Example quote
Theme One: Understanding Self-Harm	Sharing Self-Harm with Others – Understanding vs Acceptance	"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"(Amelia).
	Misconceptions and Definitions of Self-Harm: Stereotypes vs Reality	"Most people only think of cutting when you mention SH" (Vicky).
Theme Two: A New Identity – The Impact of University on Self-Harm	Negative Impacts	"When I feel like it's too much pressure, or I don't understand an assignment or something . . . I compare myself to them and feel worthless and then, it's that downward spiral of bad thoughts, and that's where the SH comes in"(Elaine).
	Positive Impacts	"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" (Sophie).
Theme Three: Professional Help-Seeking at University – "A vague and confusing process"	Barriers	"What's the point, it takes so much energy to talk about SH and everything that's happened, it's not like six sessions is going to get me anywhere, I may as well just keep struggling through" (Tom).
	Student Support Needs	"It would be good if you could know what support uni offers before you actually get there, I think that would give reassurance that they prioritise and recognise the importance of their student's well-being" (Lucy).

most described friends and loved ones being confused and upset when they found out about the SH: "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 SH 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 SH is shameful and easier to hide to avoid judgment. 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 increased engagement in SH.

Based on comparable 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 SH, 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, participants occasionally reflected on feeling able to discuss their SH 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 told that SH is "just a phase". For others, particularly those studying for, or those who held, an undergraduate degree, the thought of telling anyone about their SH, particularly the emotional distress that they were experiencing, was difficult. This seemed to prompt reflection amongst several participants on the need for SH to be talked about more honestly:

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).

Motivations and definitions of self-harm: stereotypes vs reality

Several participants explored reactions to their SH, suggesting why SH may be difficult for friends and family members to discuss due to perceptions of the behaviour as "scary" and "challenging". Definitions of SH were felt to influence these viewpoints: "most people only think of cutting when you mention SH" (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 SH: "Actually, this is SH, 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 SH to define and characterise their behaviour, but this often led to the underlying motivation being missed or ignored. Resultingly many participants were responded to with unhelpful misconceptions about their SH behaviour

which were based on stereotypes linked to SH, leaving no room for them to share their true motivations and experiences. For example, with regards to suicidal ideations, most participants felt that SH was "very different" to suicidal thoughts or intentions, describing SH 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 . . . SH 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 SH contributed to negative stereotypes and misconceptions of SH. Sarah shared that during university she had watched a programme with her flatmates featuring a scene around SH. 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 "SH" 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 SH is complex, involving many behaviours and actions:

> It's (SH) 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 SH as well. I think maybe like, putting yourself in bad situations. I'd consider that SH too (Sam).

Theme one summary

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

Theme two: A new identity – the impact of university on self-harm

All participants explored the impact of their university experience upon their SH, with the majority describing university as a unique environment presenting new challenges and changes that 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 SH, others felt able to develop their identity and relationships which reduced their SH.

Negative impacts

SH 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 SH 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 SH. 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 SH 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 SH 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 SH due to feeling isolated.

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

> Definitely alcohol, without a shadow of a doubt. I would say that over fifty per cent of my SH 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 SH personally.

Participants who discussed their SH with friends, particularly those who also engaged in SH, 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 SH: "it was almost like, boastful, like how many times we'd SH 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.

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 SH.

For some, this reduction in SH 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 SH 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 SH 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 SH 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 SH 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".

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, SH. Achieving a sense of belongingness and stability was helpful; however, living with others who SH and feeling like an outsider based on ethnicity and individual characteristics increased engagement in SH. Similarly, academic studying and achievement offered some enhancing and purposeful experience; however, this poses a risk of comparison to others and feeling overwhelmed.

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 SH. Participants commonly reported barriers, particularly about how they had to share personal information in order to access services. Reflections on supportive resources for SH were explored, highlighting potential areas for improvement and development across university services.

Barriers The most common barriers to accessing professional support for SH 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 SH or was currently experiencing any suicidal ideations. She described this experience as "incredibly distressing", adding that a tick box for her SH felt "insensitive", minimising the emotional distress that she often experienced alongside SH. For Amelia, this way of asking about SH acted as a barrier to sending the referral as she felt the service "clearly didn't understand SH 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 SH 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 SH was something "even professionals didn't understand". This resulted in her feeling hopeless and embarrassed to talk about her SH 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 SH 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 SH, adding "what's the point, it takes so much energy to talk about SH 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". Limited availability of sessions was discussed by most participants, specifically

in relation to preventing support-seeking for SH, suggesting that limited sessions wouldn't allow them to feel "comfortable" enough to talk about their SH. Like Camilla, Roberto shared that he found SH 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 SH is the only thing I can rely on".

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 SH. The need for a space in which they did not feel judged, allowing exploration of all experiences related to SH, was suggested. For example, Vicky, who discussed in theme two that her SH 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 SH, 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 SH 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 SH, 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 SH.

Several participants suggested hearing from other students who experienced similar difficulties at university was a potential way to encourage people to talk about their SH 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 SH 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.

Theme three summary

This theme highlights the different stages to accessing student support for SH, 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 SH during university.

Discussion

To the best of our knowledge, this is the first study to explore experiences of SH and support-seeking specifically amongst UK university students. Whilst the function of SH as a means of coping remained fairly consistent across experiences before university, the impact of academic pressures, shame, isolation, and social demands were particularly influential in increased episodes and re-occurrence of SH 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 SH. A preventative rather than a reactive approach to SH 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 SH and transitional periods before, during, and after university.

The functions and motivations for SH described by participants in this study align with existing research among adolescents and students (Gratz, 2006; Guérin-Marion, Martin,

Deneault, Lafontaine, & Bureau, 2018; Hambleton et al., 2020). Participants detailed increased incidents of SH 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 SH in the trinity term amongst Oxford University students, coinciding with times of increased workload and exams (Hawton et al., 2012a). In the present study, SH 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 SH 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 SH 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, Hoye, & Nicholson, 2012), posing a potential means of improving university students' psychological health and consequently, reducing SH.

Participants offered contrasting views on how SH 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 SH 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 SH (Clement et al., 2015; Rosenrot & Lewis, 2020; Rowe et al., 2014). The current authors 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 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 authors recognise 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.

Consistent with qualitative findings amongst indigenous Australian students (Oliver, Grote, Rochecouste, & Dann, 2016), individuals in the present study felt that a greater understanding of SH amongst university personnel, including lecturers, personal tutors, and peers, would be beneficial. Evans et al. (2018) found that approximately half of the teaching staff in UK secondary schools had received training on SH, and only 22% rated this training as adequate. Whilst similar research has yet to be conducted amongst university staff, given the comments of students concerning a lack of understanding around SH, 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 SH. 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.

Both positive and negative influences of the university environment on SH engagement may be explained by existing models. The two-factor structure of SH (Klonsky, Glenn, Styer, Olino, & Washburn, 2015) emphasises the influence of interpersonal factors in reducing SH, including the importance of communicating emotional pain to those around us. Participants described the positive influence of new relationships and friendships on reducing SH, providing an opportunity to be themselves and motivation to engage in self-care for the sake of their friends and partners.

The Experiential Avoidance Model (EAM) (Chapman, Gratz, & Brown, 2006) suggests that emotional responses to certain environmental stimuli can lead to feelings of anger and shame, triggering episodes of SH. Students commonly described these feelings in the context of university SH, 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 SH 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 SH, 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, McCall, Savage, & Newton, 2019), offering alternative coping mechanisms during times of distress. These interventions have previously indicated effectiveness in reducing incidents of SH (Gelinas & Wright, 2013).

The Health Theory of Coping presents a continuum model, including unhealthy and healthy coping strategies (Stallman, 2020a). 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. SH) 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 SH 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, Burton, Xenos, & Elgar, 2013).

Limitations

This study offers a first-hand account of student experiences of SH during their time at a UK university, including students studying at multiple institutions and geographical locations. In doing so, a variety of media platforms were used for interviews which may have impacted data quality. At times, the instant messenger interview lacked depth of information; however, this platform was only used for one interview in the instance that the participant did not feel comfortable using other platforms, promoting inclusion. 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.

Further, 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 SH are at an increased risk of suicide (e.g. Hawton et al., 2015), the study findings may be limited to a homogeneous sample of SH. In addition, this study only included students at UK-based universities. Considering definitions of SH, as well as university structures and environments 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.

Implications

Understanding the experiences of students engaging in SH during university offers insight into the current barriers to accessing support, as well as key time periods and factors that may lead to increased SH 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 SH (e.g. through mentoring schemes and psychoeducation resources specific to SH 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.

Future research

These findings highlight key areas for researchers and universities to further explore on a wider scale. Given that several students discussed the potential benefits of speaking to course and subject staff, awareness of current provisions for training university staff around SH, 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 SH 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. 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 SH, including increased attendance at emergency departments, than those in urban settings (Hoffmann, Hall, Lorenz, & Berry, 2021). In contrast, UK-based studies show higher rates of SH 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 SH 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.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by the British Academy [SG163040].

Notes on contributors

Laura Edwards-Bailey is a Doctoral Researcher and Research Associate at the University of Westminster. Her research focuses on understanding context-specific Self-Harm and the experiences of those providing care and support for University students.

Tina Cartwright is a Reader at the University of Westminster and a Chartered Health Psychologist. Her research focuses on understanding people's experiences of living with long-term physical and mental health conditions and designing interventions to support health and wellbeing.

Nina Smyth is a Reader at the University of Westminster. Her research focuses on the impact of well-being and stress on health and illness, and the physiological pathways involved, and the design and evaluation of interventions to support health and wellbeing.

Jay-Marie Mackenzie is a Senior Lecturer at the University of Westminster. She specialises in research on understanding and preventing suicides in particular contexts or environments.

ORCID

Laura Edwards-Bailey http://orcid.org/0000-0002-2826-0678
Tina Cartwright http://orcid.org/0000-0003-3416-468X
Nina Smyth http://orcid.org/0000-0001-9047-6958
Jay-Marie Mackenzie http://orcid.org/0000-0002-0716-2155

References

Allison, M. A., Crane, L. A., Beaty, B. L., Davidson, A. J., Melinkovich, P., & Kempe, A. (2007). School-based health centers: Improving access and quality of care for low-income adolescents. *Pediatrics*, *120*(4), e887–e894.

Al-Sharifi, A., Krynicki, C. R., & Upthegrove, R. (2015). Self-harm and ethnicity: A systematic review. *International Journal of Social Psychiatry*, *61*(6), 600–612.

Beiter, R., Nash, R., McCrady, M., Rhoades, D., Linscomb, M., Clarahan, M., & Sammut, S. (2015). The prevalence and correlates of depression, anxiety, and stress in a sample of college students. *Journal of Affective Disorders*, *173*, 90–96. http://dx.doi.org/10.1016/j.jad.2014.10.054

Bentley, K. H., Nock, M. K., & Barlow, D. H. (2014). The four-function model of nonsuicidal self-injury: Key directions for future research. *Clinical Psychological Science*, *2*(5), 638–656.

Bhui, K., McKenzie, K., & Rasul, F. (2007). Rates, risk factors & methods of self-harm among minority ethnic groups in the UK: A systematic review. *BMC Public Health*, *7*(1), 1–14. https://doi.org/10.1186/1471-2458-7-336

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

Borrill, J., Fox, P., Flynn, M., & Roger, D. (2009). Students who self-harm: Coping style, rumination and alexithymia. *Counselling Psychology Quarterly*, *22*(4), 361–372.

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

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London, UK: SAGE Publications.

Braun, V., & Clarke, V. (2021). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, *21*(1), 37–47. https://doi.org/10.1002/capr.12360

Brewin, C. R. (2001). Cognitive and emotional reactions to traumatic events: Implications for short-term intervention. *Advances in Mind-Body Medicine*. https://doi.org/10.1054/ambm.2000.0308

Bronk, K. C. (2011). The role of purpose in life in healthy identity formation: A grounded model. *New Directions for Youth Development*, *2011*(132), 31–44.

Brown, P. (2016). *The invisible problem?: Improving students' mental health*. Oxford, UK: Higher Education Policy Institute.

Brown, K. M., Hoye, R., & Nicholson, M. (2012). Self-esteem, self-efficacy, and social connectedness as mediators of the relationship between volunteering and well-being. *Journal of Social Service Research*, *38*(4), 468–483.

Brunner, R., Kaess, M., Parzer, P., Fischer, G., Carli, V., Hoven, C. W., & Wasserman, D. (2014). Life-time prevalence and psychosocial correlates of adolescent direct self-injurious behavior: A comparative study of findings in 11 European countries. *Journal of Child Psychology and Psychiatry*, *55*(4), 337–348. https://doi.org/10.1111/jcpp.12166

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

Chester, A., Burton, L. J., Xenos, S., & Elgar, K. (2013). Peer mentoring: Supporting successful transition for first year undergraduate psychology students. *Australian Journal of Psychology*, *65*(1), 30–37.

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., … Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, *45*(1), 11–27. https://doi.org/10.1017/S0033291714000129

Cooper, J., Kapur, N., Webb, R., Lawlor, M., Guthrie, E., Mackway-Jones, K., & Appleby, L. (2005). Suicide after deliberate self-harm: A 4-year cohort study. *American Journal of Psychiatry*, *162*(2), 297–303.

Department for Education. (2018). *Participation Rates in Higher Education: Academic Years 2006/2007 – 2016/2017*. Retrieved April, 2019, from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/744087/Main_text_participation_rates_in_higher_education_2006_to_2017_.pdf

Duffy, A., Saunders, K. E., Malhi, G. S., Patten, S., Cipriani, A., McNevin, S. H., … Geddes, J. (2019). Mental health care for university students: A way forward? *The Lancet Psychiatry*, *6*(11), 885–887.

Duong, M. T., Bruns, E. J., Lee, K., Cox, S., Coifman, J., Mayworm, A., & Lyon, A. R. (2021). Rates of mental health service utilization by children and adolescents in schools and other common service settings: A systematic review and meta-analysis. *Administration and Policy in Mental Health and Mental Health Services Research*, *48*, 420–439. https://doi.org/10.1007/s10488-020-01080-9

Eisenberg, D., Golberstein, E., & Hunt, J. B. (2009). Mental health and academic success in college. *The BE Journal of Economic Analysis & Policy*, *9*(1).

Erikson, E. H. (1968). *Identity: Youth and crisis (No. 7)*. New York, NY: WW Norton & Company.

Erikson, E. H. (1994). *Identity and the life cycle*. New York, NY: WW Norton & Company.

Evans, E., Hawton, K., & Rodham, K. (2005). In what ways are adolescents who engage in self-harm or experience thoughts of self-harm different in terms of help-seeking, communication and coping strategies? *Journal of Adolescence*, *28*(4), 573–587.

Evans, R., & Hurrell, C. (2016). The role of schools in children and young people's self-harm and suicide: Systematic review and meta-ethnography of qualitative research. *BMC Public Health*, *16*(1), 1–16.

Evans, R., Parker, R., Russell, A. E., Mathews, F., Ford, T., Hewitt, G., … Janssens, A. (2018). Adolescent self-harm prevention and intervention in secondary schools: A survey of staff in England and Wales. *Child and Adolescent Mental Health*. https://doi.org/10.1111/camh.12308

Everstine, D. S., & Everstine, L. (1993). *The trauma response: Treatment for emotional injury*. New York, NY: WW Norton & Co.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, *5*(1), 80–92.

Gelinas, B. L., & Wright, K. D. (2013). The cessation of deliberate self-harm in a university sample: The reasons, barriers, and strategies involved. *Archives of Suicide Research*, *17*(4), 373–386.

Gratz, K. L. (2006). Risk factors for deliberate self-harm among female college students: The role and interaction of childhood maltreatment, emotional inexpressivity, and affect intensity/reactivity. *American Journal of Orthopsychiatry*, *76*(2), 238–250. https://doi.org/10.1037/0002-9432.76.2.238

Guérin-Marion, C., Martin, J., Deneault, A. A., Lafontaine, M. F., & Bureau, J. F. (2018). The functions and addictive features of non-suicidal self-injury: A confirmatory factor analysis of the Ottawa self-injury inventory in a university sample. *Psychiatry Research*, *264*, 316–321. https://doi.org/10.1016/j.psychres.2018.04.019

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

Hambleton, A. L., Hanstock, T. L., Halpin, S., & Dempsey, C. (2020). Initiation, meaning and cessation of self-harm: Australian adults' retrospective reflections and advice to adolescents who currently self-harm. *Counselling Psychology Quarterly*, 1–24. https://doi.org/10.1080/09515070.2020.1737509

Hamdan-Mansour, A. M., Alzayyat, A. A., Hamaideh, S. H., Rafaiah, M. Q. B., Al Jammal, O. L., & Hamdan-Mansour, L. A. (2021). Predictors of deliberate self-harm among university students. *International Journal of Mental Health and Addiction*, 1–13. https://doi.org/10.1007/s11469-021-00561-8

Harriss, L., & Hawton, K. (2011). Deliberate self-harm in rural and urban regions: A comparative study of prevalence and patient characteristics. *Social Science & Medicine*, *73*(2), 274–281.

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

Hawton, K., Bergen, H., Mahadevan, S., Casey, D., & Simkin, S. (2012a). Suicide and deliberate self-harm in Oxford University students over a 30-year period. *Social Psychiatry and Psychiatric Epidemiology*, *47*(1), 43–51.

Hawton, K., Comabella, C. C., Haw, C., & Saunders, K. (2013). Risk factors for suicide in individuals with depression: A systematic review. *Journal of Affective Disorders*, *147*(1–3), 17–28.

Hawton, K., Hall, S., Simkin, S., Bale, L., Bond, A., Codd, S., & Stewart, A. (2003). Deliberate self-harm in adolescents: A study of characteristics and trends in Oxford, 1990-2000. *Journal of Child Psychology and Psychiatry*, *44*(8), 1191–1198. https://doi.org/10.1111/1469-7610.00200

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

Hoffmann, J. A., Hall, M., Lorenz, D., & Berry, J. G. (2021). Emergency department visits for suicidal ideation and self-harm in rural and urban youths. *The Journal of Pediatrics*, *238*, 282–289.

Holm-Hadulla, R. M., & Koutsoukou-Argyraki, A. (2015). Mental health of students in a globalized world: Prevalence of complaints and disorders, methods and effectivity of counselling, structure of mental health services for students. *Mental Health & Prevention*, *3*(1–2), 1–4. https://doi.org/10.1016/j.mhp.2015.04.003

Inagaki, M., Kawashima, Y., Yonemoto, N., & Yamada, M. (2019). Active contact and follow-up interventions to prevent repeat suicide attempts during high-risk periods among patients admitted to emergency departments for suicidal behavior: A systematic review and meta-analysis. *BMC Psychiatry*, *19*(1), 1–11.

Kallio, H., Pietilä, A. M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: Developing a framework for a qualitative semi-structured interview guide. *Journal of Advanced Nursing*, *72*(12), 2954–2965. https://doi.org/10.1111/jan.13031

Kapur, N., Cooper, J., King-Hele, S., Webb, R., Lawlor, M., Rodway, C., & Appleby, L. (2006). The repetition of suicidal behavior: A multicenter cohort study. *Journal of Clinical Psychiatry*, *67*(10), 1599–1609.

Klonsky, E. D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review*, *27*(2), 226–239.

Klonsky, E. D. (2011). Non-suicidal self-injury in United States adults: Prevalence, sociodemographics, topography and functions. *Psychological Medicine*, *41*(9), 1981–1986.

Klonsky, E. D., & Glenn, C. R. (2009). Assessing the functions of non-suicidal self-injury: Psychometric properties of the Inventory of Statements About Self-injury (ISAS). *Journal of Psychopathology and Behavioral Assessment*, *31*(3), 215–219. https://dx.doi.org/10.1007%2Fs10862-008-9107-z

Klonsky, E. D., Glenn, C. R., Styer, D. M., Olino, T. M., & Washburn, J. J. (2015). The functions of nonsuicidal self-injury: Converging evidence for a two-factor structure. *Child and Adolescent Psychiatry and Mental Health*, *9*(1), 1–9.

Klonsky, E. D., Victor, S. E., & Saffer, B. Y. (2014). Nonsuicidal self-injury: What we know, and what we need to know. *The Canadian Journal of Psychiatry*, *59*(11), 565–568.

Madge, N., Hewitt, A., Hawton, K., Wilde, E. J. D., Corcoran, P., Fekete, S., . . . Ystgaard, M. (2008). Deliberate self-harm within an international community sample of young people: Comparative findings from the Child & Adolescent Self-harm in Europe (CASE) Study.

Journal of Child Psychology and Psychiatry, *49*(6), 667–677. https://doi.org/10.1111/j.1469-7610.2008.01879.x

Marshall, M. N. (1996). Sampling for qualitative research. *Family Practice*, *13*(6), 522–526.

McManus, S., & Gunnell, D. (2020). Trends in mental health, non-suicidal self-harm and suicide attempts in 16–24-year old students and non-students in England, 2000–2014. *Social Psychiatry and Psychiatric Epidemiology*, *55*(1), 125–128. https://doi.org/10.1007/s00127-019-01797-5

Mealer, M., & Jones, J. (2014). Methodological and ethical issues related to qualitative telephone interviews on sensitive topics. *Nurse Researcher*, *21*(4), 32–37.

Meho, L. I. (2006). E-mail interviewing in qualitative research: A methodological discussion. *Journal of the American Society for Information Science and Technology*, *57*(10), 1284–1295. https://doi.org/10.1002/asi.20416

Mental Health Foundation. (2016). Better mental health for all: A public health approach to mental health improvement. Retrieved August 15th, 2021, from https://www.mentalhealth.org.uk/publications/better-mental-health-all-public-health-approach-mental-health-improvement

Muehlenkamp, J. J. (2006). Empirically supported treatments and general therapy guidelines for non-suicidal self-injury. *Journal of Mental Health Counseling*, *28*(2), 166–185.

Oliver, R., Grote, E., Rochecouste, J., & Dann, T. (2016). Indigenous student perspectives on support and impediments at university. *The Australian Journal of Indigenous Education*, *45*(1), 23–35. https://doi.org/10.1017/jie.2015.16

Parker, J. D., Summerfeldt, L. J., Hogan, M. J., & Majeski, S. A. (2004). Emotional intelligence and academic success: Examining the transition from high school to university. *Personality and Individual Differences*, *36*(1), 163–172.

Patton, M. Q. (2002). Two decades of developments in qualitative inquiry: A personal, experiential perspective. *Qualitative Social Work*, *1*(3), 261–283.

Patton, M. Q. (2014). *Qualitative research & evaluation methods: Integrating theory and practice*. Thousand Oaks, CA: SAGE publications.

Renn, K. A., & Bilodeau, B. (2005). Queer student leaders: An exploratory case study of identity development and LGBT student involvement at a Midwestern research university. *Journal of Gay & Lesbian Issues in Education*, *2*(4), 49–71.

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (Eds.). (2013). *Qualitative research practice: A guide for social science students and researchers* (2nd ed.). London, UK: SAGE publications.

Robertson, A. E., Stanfield, A. C., Watt, J., Barry, F., Day, M., Cormack, M., & Melville, C. (2018). The experience and impact of anxiety in autistic adults: A thematic analysis. *Research in Autism Spectrum Disorders*, *46*, 8–18.

Roche, A. M. (1991). Making better use of qualitative research: Illustrations from medical education research. *Health Education Journal*, *50*(3), 131–137.

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

Rossouw, T. I., & Fonagy, P. (2012). Mentalization-based treatment for self-harm in adolescents: A randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, *51*(12), 1304–1313.

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

Saldaña, J. (2015). *The coding manual for qualitative researchers (3rd ed.)*. London, UK: SAGE publications.

Sharp, J., & Theiler, S. (2018). A review of psychological distress among university students: Pervasiveness, implications and potential points of intervention. *International Journal for the Advancement of Counselling*, *40*(3), 193–212.

Sivertsen, B., Hysing, M., Knapstad, M., Harvey, A. G., Reneflot, A., Lønning, K. J., & O'Connor, R. C. (2019). Suicide attempts and non-suicidal self-harm among university students: Prevalence study. *BJPsych Open*, 5(2. https://doi.org/10.1192/bjo.2019.4

Stallman, H. M. (2020a). Health theory of coping. *Australian Psychologist*, *55*(4), 295–306.

Stallman, H. M. (2020b). Suicide following hospitalisation: Systemic treatment failure needs to be the focus rather than risk factors. *The Lancet Psychiatry*, *7*(4), 303.

Stallman, H. M., Beaudequin, D., Hermens, D. F., & Eisenberg, D. (2021). Modelling the relationship between healthy and unhealthy coping strategies to understand overwhelming distress: A Bayesian network approach. *Journal of Affective Disorders Reports*, *3*, 100054.

Stänicke, L. I., Haavind, H., & Gullestad, S. E. (2018). How do young people understand their own self-harm? A meta-synthesis of adolescents' subjective experience of self-harm. *Adolescent Research Review*, 1–19. https://doi.org/10.1007/s40894-018-0080-9

Stoliker, B. E., & Lafreniere, K. D. (2015). The influence of perceived stress, loneliness, and learning burnout on university students' educational experience. *College Student Journal*, *49*(1), 146–160.

Sullivan, C., Gibson, S., & Riley, S. C. (Eds.). (2012). *Doing your qualitative psychology project*. London, UK: SAGE publications.

Swannell, S. V., Martin, G. E., Page, A., Hasking, P., & St John, N. J. (2014). Prevalence of nonsuicidal self-injury in nonclinical samples: Systematic review, meta-analysis and meta-regression. *Suicide and Life-Threatening Behavior*, *44*(3), 273–303. https://doi.org/10.1111/sltb.12070

Taliaferro, L. A., & Muehlenkamp, J. J. (2015). Risk factors associated with self-injurious behavior among a national sample of undergraduate college students. *Journal of American College Health*, *63*(1), 40–48.

Thorley, C. (2017, September 4th). *Not by degrees: Improving student mental health in the UK's universities*. IPPR: London, UK. http://www.ippr.org/publications/not-by-degrees

Thurber, C. A., & Walton, E. A. (2012). Homesickness and adjustment in university students. *Journal of American College Health*, *60*(5), 415–419.

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357.

Tosevski, D. L., Milovancevic, M. P., & Gajic, S. D. (2010). Personality and psychopathology of university students. *Current Opinion in Psychiatry*, *23*(1), 48–52.

UCAS. (2021). *Starting the conversation: UCAS report of student mental health*. https://www.ucas.com/file/513961/download?token=wAaKRniC

Universities UK. (2019). *Higher Education in Facts and Figures*. https://www.universitiesuk.ac.uk/sites/default/files/field/downloads/2021-08/higher-education-facts-and-figures-2019.pdf

Walsh, B. W. (2012). *Treating self-injury: A practical guide*. New York, NY: Guilford Press.

Wang, P. S., Simon, G. E., Avorn, J., Azocar, F., Ludman, E. J., McCulloch, J., … Kessler, R. C. (2007). Telephone screening, outreach, and care management for depressed workers and impact on clinical and work productivity outcomes: A randomized controlled trial. *Jama*, *298*(12), 1401–1411.

Willig, C. (2013). *Introducing qualitative research in psychology*. London: McGraw-Hill Education (UK).

Yardley, P., McCall, A., Savage, A., & Newton, R. (2019). Effectiveness of a brief intervention aimed at increasing distress tolerance for individuals in crisis or at risk of self-harm. *Australasian Psychiatry*, *27*(6), 565–568.