How do individuals who self-identify as having Borderline Personality Disorder [BPD] symptomatology perceive interventions to prevent self-harm?

A thesis submitted to the University of Manchester for the degree of Doctor of Counselling Psychology (DCounsPsych) in the Faculty of Humanities.

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<tbody>
<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
</tr>
<tr>
<td>BPD</td>
<td>Borderline Personality Disorder</td>
</tr>
<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HCP</td>
<td>Health Care Professional</td>
</tr>
<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
</tr>
<tr>
<td>MMHSCT</td>
<td>Manchester Mental Health and Social Care Trust</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
</tr>
<tr>
<td>PIPS</td>
<td>Perceptions of Interventions to Prevent Self-harm</td>
</tr>
<tr>
<td>QoL</td>
<td>Quality of Life</td>
</tr>
<tr>
<td>RCT</td>
<td>Randomised Controlled Trial</td>
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<tr>
<td>SAFA</td>
<td>Self-harm Awareness For All</td>
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<tr>
<td>SD</td>
<td>Standard Deviation</td>
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<tr>
<td>SHI</td>
<td>Self-Harm Inventory</td>
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How do individuals who self-identify as having Borderline Personality Disorder [BPD] symptomatology perceive interventions to prevent self-harm?

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May 5 2016

Abstract

Background: Individuals with Borderline Personality Disorder [BPD] symptomatology have high rates of self-harm (50-80%). Limited information exists on the most appropriate interventions to prevent recurrent self-harm in this population. Recent reviews on BPD interventions have suggested more research needs to be conducted looking at how individuals experience interventions with the aim of identifying the effective components of interventions. Objectives: The aim of the present study was to examine how individuals with BPD symptomatology experience interventions to prevent self-harm using a qualitative methodology. Methodology: Twelve individuals with BPD symptomatology and past or current self-harm were recruited through therapeutic services, and took part in a semi-structured interview. The interviews were analysed using a grounded theory approach. Findings: The grounded theory identified a core category, an alternative path to self-harm, and two sub-categories, established beliefs and causal factors, and the time course of self-harm. The results were presented using a process model which was indicative of the participants’ experiences of interventions. Conclusions: The findings suggest individuals with BPD symptomatology perceive interventions as helping to reduce self-harm when interventions are long-term, consistent, and instant, and the intervention’s outcome matches the purpose for the self-harm. The use of interventions appears to be context dependent, specifically being affected by the individual’s level of emotional tension, and their cognitive processing during the decision to seek help. For long-term self-harm prevention, multiple interventions are required, and individuals need to be actively maintaining and evaluating these alternative strategies. It is suggested adoption of such a holistic approach could be one avenue for developing collaborative and effective self-harm interventions in clinical practice.
Declaration

This declaration states that no portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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Most importantly, I would like to thank the participants who took part in the research without whom this work could not have taken place.

“What the caterpillar conceives as the end of the world, the butterfly sees as life’s beginning.”

- Richard Bach
Chapter 1

Introduction

Chapter Introduction

This introductory chapter outlines the context surrounding the research, by presenting an overview of the background to Borderline Personality Disorder [BPD] and self-harm, and the current study’s position on these concepts, during which the key terms used in the research are defined. This is followed by the rationale for the work through consideration of the current clinical guidance for recurrent self-harm, and why counselling psychology could provide a novel perspective on this research area. The chapter ends with an overview of the structure of the thesis to guide readers.

Borderline Personality Disorder [BPD]

History, epidemiology and prevalence.

The term ‘borderline’ was first used by Stern (1938) to describe individuals who did not fit into psychotic or neurotic presentations and who seemed to not respond to psychotherapy. Kernberg was the first to write extensively on borderline presentation describing borderline as a particular pattern of personality organisation (Kernberg, 1967). He outlined many of the BPD features still relevant today to define an individual with BPD, such as lack of anxiety tolerance and impulse control, difficulty differentiating between self and nonself, idealisation, and devaluation of others. Following Kernberg’s work, Gunderson and Singer (1975) outlined the major characteristics of BPD which heavily influenced the BPD diagnostic criteria first introduced in the Diagnostic and Statistical Manual [DSM-III] (American Psychiatric Association [APA], 1980). Since DSM-III BPD diagnostic criteria has changed little in subsequent revisions up to the present day. The DSM-5 (APA, 2013) situates
BPD within Cluster B of personality disorder symptoms characterised by dramatic or irrational behaviour (See Appendix AA for DSM-5 criteria), and defines BPD as ‘a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning in early adulthood’.

The causes of BPD are not fully known, however it is accepted by many that a biopsychosocial model is likely to be most informative given the pervasive, heterogeneous, and developmental nature of the disorder (Cicchetti, 2014). Cicchetti (2014) proposes ‘equifinality’ in the development of BPD, meaning a number of pathways, rather than a single trajectory, can lead to BPD, with genetic vulnerability and developmental experiences moderating outcomes. It is beyond the scope of this thesis to consider the theories on the causes of BPD, but many theories have been suggested (Kernberg, 1975). For an overview of the main theories, including attachment theory, emotional dysregulation, mentalization-based deficit theory, stress-diathesis model, and PTSD, see Bateman and Fonagy (2004).

The manifestation of behaviours typically associated with individuals with a diagnosis of BPD include great difficulty in regulating emotions, unstable relationship patterns, mood swings, feelings of emptiness and chaotic lifestyles (Gunderson, 1984). 69-80% of those diagnosed with BPD attempt suicide or engage in self-harm, and completed suicide occurs in up to 10% of those diagnosed (Gunderson, 1984; Zanarini et al., 2008). It has been described as the most lethal of psychiatric disorders, with suicide rates 50 times higher than the general population (Soloff, Lynch, & Kelly, 2002).

Research suggests patients with a diagnosis of BPD are high-level users of health-care for social, psychiatric, ambulance, and emergency department services (Chiesa, Fonagy, Holmes, Drahoram, & Harrison-Hall, 2002; Paris, 2002). The median prevalence of BPD in
the Western population is reported to be 1.6% (Torgersen, 2009), however the prevalence of BPD in healthcare systems is much higher, with the prevalence of individuals with BPD in services increasing corresponding to more intensive care environments, out-patient prevalence rates range from 8 - 11%, inpatient prevalence rates range from 14 - 20%, and forensic services prevalence rates range from 60 – 80% (Bateman & Fonagy, 2004). BPD was considered by many to be a chronic condition unresponsive to treatment, however recent evidence indicates the severity of BPD symptoms decreases dramatically over time. Research indicates under 50% of patients meeting criteria for BPD still do so six years later (Davidson, Tyrer, Norrie, Palmer, & Tyrer, 2010), and after ten years this drops to 26% (Zanarini, Frankenburg, Reich, & Fitzmaurice, 2012).

**The present study’s stance towards BPD: BPD and interpersonal symptomatology.**

The participants in this study include individuals who either consider themselves to have BPD, or experience difficulties in their relationships with others, and have a history of recurrent self-harm. No attempt was made to diagnose or classify individuals using DSM criteria. Recruiting participants based on them strictly meeting the current DSM criteria makes little sense when the specific criteria changes over time and there is a likely move towards a dimensional approach in the future (see literature review for further discussion and critique of BPD diagnosis). It could be argued that by not ensuring individuals met diagnostic criteria there will be greater variability among participants. However, as Critchfield, Levy, and Clarkin (2007) point out, because there are nine criteria for BPD, of which only five need to be present to make the diagnosis, 256 different combinations of criteria for a BPD diagnosis exist. It is possible for two individuals who receive the diagnosis to share only one of the criteria, therefore the heterogeneity even within those with a diagnosis is wide. Nevertheless,
there is some consensus the core deficit is an emotional instability resulting in a pattern of unstable relationships and self-harm (Clarkin, 2006; Gunderson, 2009). Given the above, for the purposes of this study individuals were recruited on this basis, as this is likely to continue to be the core deficit present across revisions and approaches.

Furthermore, Horn, Johnstone, and Brooke (2007) note that given the significant connotations associated with a BPD diagnosis, clinicians need to be aware and sensitive to the impact of a BPD label and focus on aspects helpful to the service user. In this research during initial discussions with recruiting services, some managers and clinicians felt uncomfortable with using a diagnostic label, but described individuals who had interpersonal difficulties and chronic self-harm who they felt would add a valuable perspective to the understanding of self-harm interventions in the context of the present study. Therefore the present study took the position it was not necessary or ethically appropriate to diagnose any participant with BPD, and instead sought to recruit individuals who identified with the term. Further discussion and explanation of why the term BPD symptomatology is used in this research is found in the literature review chapter.

Self-harm

This study explores the perspectives of individuals with BPD symptomatology who have history of recurrent self-harm. For the purposes of this research the term ‘self-harm’ from Skegg (2005) was adopted which defines self-harm as any self-motivated act which results in psychological or physical harm to self, regardless of the intent. Research indicates individuals with BPD symptomatology frequently engage in reported self-harm (Linehan, 1993). The APA (2001) noted from all psychiatric disorders, a BPD diagnosis is the psychiatric criteria most frequently and closely associated with self-harm, with one study
reporting people with BPD diagnoses are 16 times more likely to engage in self-harm and suicidal behaviours than those with depression (Kelly, Soloff, Lynch, Haas, & Mann, 2000). Furthermore, some of the training literature for Health Care Professionals [HCPs] links discussions of self-harm almost exclusively with BPD (Townsend, 2014). For the purposes of this study, a HCP is an individual who provides, preventive, curative, promotional, or rehabilitative health care services in a systematic way to people, families, or communities (WHO, 2010). This strong association between BPD and self-harm has been reported by the individuals themselves. Black, Murray, and Thornicroft (2014) found all participants with BPD discussed self-harm and suicide, suggesting these are predominant concerns. This tendency of individuals with BPD to engage in self-harm has been linked to negative attitudes from HCPs (McAllister, Creedy, Moyle, & Farrugia, 2002), and is one of the impetuses for the current study, as the next section considers in more detail.

**Rationale for the Work**

This section outlines the rationale for the work from research and clinical perspectives, and also why counselling psychology is well placed to study this topic. Personal motivations for the present study can be found in the reflexive section in the discussion chapter.

Numerous researchers report individuals with BPD experience significant stigma relating to their self-harm (Horn et al., 2007; Nehls, 1999), and it has been suggested this stigma leads to the individual feeling worthless and perpetuating further self-harm (Becker, 1997; Liebman & Burnette, 2013). Researchers investigating this stigma have proposed it occurs because others surrounding the individual with BPD feel helpless and unable to prevent the behaviour (Cleary, Siegfried, & Walter, 2002; McCarthy, Carter, & Greneyer, 2013).
Limited information with supporting research evidence is available advising on appropriate interventions to prevent reoccurrence of self-harm (NICE, 2011). The National Institute for Health and Care Excellence [NICE] guidelines for self-harm, which provides advice and quality standards to improve and inform health and social care in the United Kingdom, advise where service users are likely to repeatedly self injure, clinical staff, service users, and carers may wish to discuss appropriate alternative coping strategies, using suitable material available from voluntary organisations (NICE, 2011). However no further suggestions or detailed recommendations are given. There are no specific guidelines to prevent or reduce recurrent self-harm in individuals with BPD (NICE, 2009). A review of the current interventions to prevent self-harm in BPD concluded there is a lack of effective treatments and more research is needed to understand current interventions and develop new ones (Bateman, Gunderson, & Mulder, 2015). The present study aims to meet some of these objectives by investigating current interventions.

Existing research looking at the effectiveness of interventions is conducted predominately from medicalised, quantitative perspectives. These approaches potentially neglect or trivialise non-majority responses, resulting in an incomplete understanding of the complex experience of using an intervention. Estroff, Patrick, Zimmer, and Lachicotte (1997) urged researchers and clinicians to embrace the wide range of responses to psychiatric interventions. The present study therefore purposefully implements this ethos through investigating individuals with BPD symptomatology’s perceptions of interventions to prevent self-harm using a qualitative methodology.
Why counselling psychology philosophy is suited to the research topic.

A counselling psychology perspective is well placed to undertake research examining individuals’ perceptions of interventions, incorporating principles of ethics in action, a valuing of subjective experience and a holistic perspective to psychological well-being. These have guided and underpinned the research throughout and are elaborated upon below.

Cooper (2009) refers to counselling psychology as ethics in action whereby psychologists should not just hold humanistic values, researching areas poorly understood and subject to stigma, but any new knowledge gained should be used to enact change. The researcher’s personal motivations for this study is not in maintaining a diagnostic or medicalised approach to BPD and self-harm. The motivation for this research lies in exploring repetitive self-damaging actions which are poorly understood in research and clinical environments, and by which further understanding may improve services in this area.

Counselling psychology philosophy centres on valuing the subjective experience of an individual, and supporting their agency and capacity to make their own decisions (Douglas, Woolfe, Strawbridge, Kasket, & Galbraith, 2016). This aligns with guidelines for BPD treatment which list the development of autonomy and the promotion of choice as key priorities for treatment, following a person-centred care approach (Helleman, Goossens, Kaasenbrood, & Achterberg, 2014). Guidelines strongly recommend patients are actively involved in finding solutions for their difficulties, and are encouraged and helped to consider different treatment options and life choices. Thus research on interventions generated from the perspectives of individuals themselves, promotes personal autonomy, potentially leading to identification of obstacles and solutions for change. In accordance with valuing individuals who are the subject of research viewpoints foremost, the review of the literature presents
research from the perspective of the individual primarily, with a secondary focus on quantitative and theoretical accounts.

Counselling psychology has a humanistic value base and aims to take a holistic perspective to phenomena (Douglas et al., 2016), which is in agreement with previous qualitative research on interventions, in which participants have identified the importance of looking at causes and surrounding factors influencing self-harm, and not just treat the behaviour (Nehls, 1999; Svenaeus, 2000). In order for counselling psychologists and other HCPs to provide assistance there needs to be an understanding of the phenomenology of an intervention. For example, Gunderson (2009) suggests without taking into account how an individual feels inherently bad, it is hard to understand self-harm as an act of punishment. Therefore a broader view than just the experiences of interventions is needed, encompassing an individual’s reasons for self-harm, desired outcomes, and how this is mediated over time. A successful intervention might not result in complete cessation of self-harm, but in living a worthwhile existence defined by the individual themselves.

In conclusion, there is a need for further research from the perspectives of individuals with BPD symptomatology, examining interventions to prevent self-harm in order to improve existing interventions or aid the development of new ones. By conducting qualitative research with individuals who have experienced interventions, incorporating counselling psychology principles, it is possible to get a new perspective on the field with the potential to influence treatments in the future.

**Structure of the Thesis.**

The thesis is constructed of six chapters, introduction, literature review, methodology, findings, discussion, and conclusions. The introduction provides the context in which the work
is situated and the rationale for the research. The literature review presents an overview of the existing literature in this area, in conjunction with limitations and gaps in research knowledge suggesting the need for the present study. The research question which the thesis seeks to address is introduced. In the methodology chapter the research design is discussed through consideration of epistemology and ontology. The methods of data collection, generation, and analysis are outlined, alongside a summary of the participant’s demographics. In the findings chapter the analysis using grounded theory methodology is presented. The discussion reflects upon these findings, considering how they are situated within the existing literature and the clinical and wider implications. This is followed by the limitations of the thesis, avenues for further research, and personal reflections. The conclusion details a final summary of the research.
Chapter Introduction

This chapter outlines the research landscape relevant to the present study. It is not intended to be an exhaustive account of the literature but to present an overview of the main arguments in this area. Literature was chosen on the basis of its relevance to the research question. Priority was given to the latest research, seminal work, and systematic reviews of specific areas, such as self-harm. Details of the specific inclusion and exclusion criteria used in each section of this chapter can be found at Appendix AB.

The chapter begins with a critical discussion of BPD diagnosis and details the position of the present study. Explanations for self-harm in BPD are considered through insider perspectives, and the interaction between seeking help and future self-harm is discussed. The current interventions for BPD to reduce self-harm are examined through research investigating their effectiveness and the perceptions of individuals with BPD. The final part of this chapter presents findings from recovery literature as this augments a broader understanding of the overall process of interventions and the resultant change process. The chapter concludes with a reflection on the rationale for the current study and the research question.

BPD

The introduction defined the characteristics and features commonly associated with BPD. This section begins by taking a critical psychology perspective to the diagnostic approach, through the adoption of a counselling psychology philosophy valuing the subjective and unique elements of an individual’s experience (Douglas et al., 2016). This is followed by a consideration of how individuals report having a BPD diagnosis and their perceptions of
their difficulties, before finally outlining how the present study situates itself within the BPD diagnostic debate.

**Problems with a BPD diagnostic approach.**

Personality disorders are claimed to be one of the most controversial, confusing and abstract ideas within psychology and psychiatry (Bateman & Fonagy, 2004) and there have been frequent attempts to discard the concept altogether. Approaching this topic from a critical and counselling psychology perspective highlights some of these controversies. A critical psychology perspective typically includes a systematic examination of psychological practice, and in particular looking at how some experiences and practices are privileged above others, and a consideration of the cultural and historical influences informing dominant discourses (Parker, 1999). A full consideration of the controversies and difficulties with the term BPD from a critical psychology perspective is beyond the remit of this research, and is the subject of many critical articles and books (Becker, 1997; Livesley, 2001; Parnas, 1994; Skodol, Morey, Bender, & Oldham, 2013; Tyrer, 1999). This section outlines three of the pertinent issues relevant to the current study.

**The physical construct of personality disorders.**

Some researchers suggest BPD does not represent an actual physical construct. Pilgrim (2002) argues personality disorders are not a reflection of underlying reality but are a by-product of our professional discourse. He suggested personality disorder diagnoses are used by HCPs to define a diverse group of patients who do not fit elsewhere. Horn et al. (2007) agrees with this view pointing out the concept of BPD is generally based on clinical descriptions which imply an underlying unifying disorder, but in fact no research has been able to support this. Similarly, Becker (1997) and Manning (2000) propose BPD is a social
construction arising as a consequence of the struggle for independence predominant in western culture, suggesting it has become the ‘new hysteria’ and is a fashionable diagnosis representing oppression. These critical approaches raise valid concerns opposing the majority view of BPD whereby it is seen as a medical illness and therefore can be theoretically treated as such.

**Heterogeneity among individuals with BPD diagnoses.**

Even if the predominant medical and psychological viewpoint of BPD as a construct representing a cluster of physical symptoms is accepted, rather than a social construction, it can be difficult to define its parameters. Personality disorders have been criticised over the lack of specificity, with people often meeting the criteria for more than one personality disorder (Snowden & Kane, 2003). Approximately twenty-five percent of people diagnosed with BPD also meet the criteria for anti-social personality disorder (Zanarini et al., 1998). Furthermore, different classification systems are used for diagnosis. In the United Kingdom diagnosis tends to be made using International Classification of Diseases [ICD] systems (WHO, 1992) rather than DSM criteria. DSM criteria being generally used for research purposes. The ICD system does not recognise BPD, and instead uses the term emotionally unstable personality disorder, borderline type, which is thought to be equivalent (WHO, 1992).

The different approaches mean the same individual could be given different diagnoses dependent on the criteria and service used, which creates a confusing picture for clinicians and patients. As a result, there have been calls for a revision in approach. Frances and Nardo (2013) and Tyrer, Reed, and Crawford (2015) have raised concerns regarding existing multiple diagnostic systems, that use a checklist approach and propose changes to future
classification. The latest version of the DSM acknowledges these changes, and introduces a dimensional approach to reflect patterns of behaviour on a continuum rather than a trait disorder per se, in a section focusing on emerging measures and models (APA, 2013). Many practitioners and researchers have advocated for this change of direction (Skodol et al., 2013; Tyrer & Garralda, 2005). In this approach diagnosis would be made according to the severity of impairment in self and interpersonal functioning (APA, 2013).

**Stigma associated with BPD diagnosis.**

Social and personal consequences associated with diagnosis are widely acknowledged, and people labelled as mentally ill face many consequences in relation to stigma, social isolation, and discrimination (Snowden & Kane, 2003). Individuals can internalise views of themselves as disempowered and devalued which affect the course of their distress (Knight, Wykes, & Hayward, 2003). Hayne (2003) highlights the power that exists in medical language, and as a result diagnosis using medical terminology can be taken as an absolute and irrefutable fact.

Borderline personality disorder as a diagnosis has been associated with negative attitudes, arguably to a greater degree than other mental health disorders (Pandya, 2014), due to HCPs feeling overwhelmed, stressed, and under-skilled when working with this client group (Cleary et al., 2002). Research has consistently identified HCPs view individuals with a diagnosis of BPD as in control of their behaviour and ‘bad’ rather than ‘mad’, labelling them as ‘irrational’, ‘difficult to treat’ and ‘manipulative’, and displaying less empathy towards these individuals (Gallop, Lancee, & Garfinkel, 1989; Markham & Trower, 2003). Pilgrim (2001) states people diagnosed with personality disorder face the worst of both worlds as they are ‘treated as if they are deserving of care and traditional paternalism but they are actually
scorned and disliked’. Horn et al. (2007) found when individuals with a BPD diagnosis internalise judgemental and rejecting behaviours by HCPs, they feel rejected and worthless which leads them to reject and challenge services, setting up a cycle where services perceive them as difficult. Therefore understandably some HCPs are reluctant to use BPD diagnoses with their patients, fearing they will be subjecting them to the stigma associated with the label and activating difficult dynamics with services. With all of the contention surrounding the term BPD, it is easy to overlook this research is mainly conducted from the perspectives of HCPs and academics, rather than the individuals themselves. The next section considers the individual's perspectives on a diagnosis and the lived experience of BPD.

**Perspectives of individuals on BPD.**

The first study interviewing people with a diagnosis of BPD was published by Miller (1994), who obtained life history narratives from ten individuals over the course of one year. Using grounded theory, Miller (1994) found three categories captured the experiences of the individuals; despair, estrangement and inadequacy. The authors noted this experience was markedly different from descriptions of BPD in clinical literature. Individuals viewed themselves as having a chronic dissatisfaction with life, rather than difficulties in identity disturbance or instability of mood (clinical characteristics). This view is supported by a later study, in which Castillo (2000) found people’s experiences of BPD were distinctly different from clinical descriptions, 86% of service users with a personality disorder diagnosis described their difficulties in terms of depression, anxiety or both. The researchers concluded further research from the individual’s point of view needs to be conducted as it adds another dimension to the difficulties experienced by individuals with BPD. However, Miller’s (1994) study could be criticised for potentially reflecting universal aspects of the human condition
rather than BPD specific features. For example, to some extent all participants with long-term health difficulties will probably experience a degree of despair. A later study focused on the unique elements of living with a diagnosis of BPD (Nehls, 1999). Thirty females described their experience of having a BPD diagnosis as living with a label, having self-destructive behaviour which is perceived by others as manipulation, and having limited access to care. Nehls (1999) found participants did not deny the existence of their diagnosis but deplored the associated stigma and stereotypes. Thus, while controversy exists within professional discourses about whether BPD exists and the defining criteria, this debate does not seem to concern the individuals themselves.

Horn et al. (2007) looked at how people experienced being given a diagnosis of BPD by HCPs. They found people experienced positive and negative aspects in relation to this. For example, individuals saw the diagnosis as rejection and confirmation they were different to other people, but also conversely knowledge of their condition was seen as power, in which the diagnosis provided a focus and gave individuals a sense of control, generating feelings of hope and the possibility of change. More recently, Black et al. (2014) looked at the phenomenology of BPD interviewing nine individuals with a diagnosis of BPD, and conceptualised their experiences in terms of internal and external dynamics. Internal dynamics consisted of dramatic and confusing perceptual states, whereby individuals tried to cope by seeking help from others or self-harming. External dynamics concerned their relationships to others. They described their illness as having a negative impact on close others, and hence tried to protect others by hiding their suffering. This research suggests individuals themselves recognise their difficulties in terms of self-destructive behaviour and difficulties in their interpersonal relationships, which aligns to some extent with the clinical criteria.
In synopsis, there are several contrasting perspectives on BPD diagnosis. There is an active critical discourse towards BPD diagnosis in the literature, but a predominant medical perspective in healthcare settings. The qualitative literature indicates individuals with BPD perceive themselves having difficulties and the BPD diagnosis is viewed ambivalently. The position of the current study is summarised below.

**The present study stance to BPD terminology.**

Given the valid criticisms of a diagnostic approach it might be considered strange that the present study groups together individuals under a label of BPD symptomatology rather than individuals who have chronic self-harm. This study uses BPD terminology because there is a professional discourse around BPD. The term is used frequently by HCPs and research shows HCPs view individuals they consider to have BPD to be difficult to treat (Aviram, Hellerstein, Gerson, & Stanley, 2004). In addition, there have been suggested benefits from having a BPD diagnosis, Horn et al. (2007) found individuals with BPD found a label helpful when it led to further support. A label felt like something firm to grasp by which they could separate themselves from their problems and start to conceive of them differently. Moreover, Hall (1997) separates the objection to diagnosis from what diagnosis leads to, meaning it is not the diagnosis that is the problem, it is the way in which this information is used. The aim of the present study was to gather the perspectives of some of these identified individuals, in the hope this would generate useful knowledge for HCPs and the individuals themselves. Therefore it felt important to use the discourse present in healthcare settings to converse in this sphere, while acknowledging the concept is not without significant flaws and associated stigma. Couture and Penn (2003) reviewed literature on stigma, and found the most appropriate strategy to dispel negative beliefs about mental illness is to place people in direct
contact with the stigmatised group. Similarly, Nehls (1999) comments that to learn from a person with mental health problems, rather than research them remotely, acts to challenge the reification and stigmatization of any classification system.

The present study takes the position it is only through a better understanding of the meaning of BPD as lived that advancements will be made. Through this process we can build care practices focused on helping people build their lives based on who they are, how their difficulties are changing the ways they define themselves, and what their lives mean. This research aims to try and enact these values through engaging the perspectives of individuals with BPD within a discourse understandable to HCPs.

**Summary of BPD.**

This section has considered some of the difficulties and controversies surrounding BPD and the views of individuals on their diagnosis. The stance of the present research towards these issues has been outlined. The next section will focus more closely on one of the behaviours associated with BPD, self-harm.

**Self-harm**

This section considers what constitutes self-harm and some of the difficulties faced by researchers defining the term. Explanations for self-harm are presented using research from the perspectives of individuals with BPD. The latter part of the self-harm section explores HCPs perceptions of self-harm, gaps in current literature, and how the current study aims to further the current knowledge.

**Prevalence of self-harm.**

Research has found it difficult to quantify accurate prevalence rates of self-harm, possibly due to the secrecy surrounding the behaviour, with rates estimated from 4.3% to 35%
(Briere & Gil, 1998; Gratz, 2001). However, Bird and Faulkner (2000) suggest rates are likely to be largely underestimated, stating many incidents of self-harm are treated by the person in private and will not reach the attention of services. 120,000 people are admitted annually as inpatients to hospitals in England and Wales with self-inflicted harm (Brooke & Horn, 2010), and between 25% and 50% of those attending hospital for self-harm have a history of repeated episodes (Lilley et al., 2008). In addition, individuals who engage in self-harm are at heightened risk of suicide.

There is some indication rates of self-injurious behaviour are increasing in adult populations (Hawton, Zahl, & Weatherall, 2003). However reasons for the increase are unknown. There is little evidence factors such as race, culture, and ethnicity have a significant impact on self-harm (Babiker & Arnold, 1997; Hjelmeland et al., 2002), except following migration (Hjelmeland et al., 2002). There is no evidence self-harm happens in females more than males, however there is a perception of self-harm as more of a female behaviour (Taylor, 2003). It has been suggested this may result in a reluctance of men to present to services and a lack of services catering for both sexes (Stegg, 2005).

**Definitions and characteristics of self-harm.**

**Definition of self-harm.**

Many definitions have been put forward to encompass self-harm, Muehlenkamp (2005) identified 33 separate definitions in the literature, such as non-suicidal self-injury (Glenn & Klonsky, 2011), self-mutilation (Ross & Heath, 2002), self-wounding (Tantam & Whittaker, 1992), self-injurious behaviour (Herpertz, 1995), parasuicide (Hjelmeland et al., 2002) and deliberate self-harm (Hawton, Fagg, Simkin, Bale, & Bond, 2000).
For the purposes of this research the term ‘self-harm’ from Skegg (2005) is used which defines self-harm as any self-motivated act which results in psychological or physical harm to self regardless of the intent. The definition of self-harm adopted for the present study does not exclude suicide attempts. Although it is noted that a number of researchers refer to self-harm and suicide as separate phenomena (Edmondson, Brennan, & House, 2016; Maddock, Carter, Murrell, Lewin, & Conrad, 2010). However, researchers have highlighted the difficulty distinguishing between suicidal and non-suicidal intent, especially in the BPD population, pointing out sometimes individuals state clearly there was no intention of suicide, nevertheless individuals’ self-harm is so serious there is a high chance they could have died. At other times there is a stated intention to die, however the behaviour is unlikely to have resulted in death and help was sought (Kapur, Cooper, O’Connor, & Hawton, 2013; Messer & Fremouw, 2008). Brooke and Horn (2010) found in a qualitative study of people with BPD, which explored meanings of overdoses, there was a clear juxtaposition between the stated intention of overdosing, all participants expressed wanting to die, and the act itself, highly visible, non-fatal means and help-seeking. The authors suggest this may represent the ambivalence related to suicidal intent. Perseius, Ekdahl, Åsberg, and Samuelsson (2005) provide a rationale for this ambivalence suggesting there could be an unconscious differentiation between an immediate plan to die and being comfortable with death. By this explanation, individuals rationalise suicide by being comforted by the possibility of death, frantically longing for it and being full of self-hatred, but not necessarily committed to the act itself. Due to this ambivalence reported by previous studies and difficulties discerning intent, this study does not differentiate between suicidal and non-suicidal intent.
Self-harm behaviours.

Self-harm in the present study includes behaviours typically associated with self-harm such as cutting, overdosing, and burning but also behaviours less associated with self-harm but nevertheless cause harm to self, such as skipping medication, abusing laxatives, or excessive consumption of alcohol (for a full list of behaviours considered self-harm in the present study see the methodology chapter). A broad criteria has been applied because the literature is divided in terms of whether specific behaviours should be included or excluded. For example, some studies exclude mild-to-moderate tissue damage leading to visible, direct, bodily injury (most often cutting) defined as self-injury (McAllister, 2003), from other forms of self-harm as it has been suggested cutting is a way of averting suicide as a form of self-help, or is an addiction (Skegg, 2005). However, other research argues behaviours cannot be categorised in this manner, pointing out the same individuals who engage in cutting, also take overdoses or attempt suicide (Lilley et al., 2008). Owens et al. (2015) found a sizeable proportion of individuals will change method of self-harm in consecutive episodes. The evidence does not clearly suggest individuals can be classified by method of self-harm, or that different behaviours represent distinct processes. Moreover, individuals’ self-harm is not always habitual or predictive, therefore separating or excluding individuals based on particular behaviour patterns removes the experiences of people who do not neatly fit into clinical boxes but potentially are more representative of reality. Middleton and Butler (1998) include behaviours such as excessive smoking, starvation, unprotected sex with multiple partners, sado-masochism, reckless driving, self-neglect of hygiene, and provoking of violence on a spectrum of self-harm. Skegg (2005) states including behaviours less traditionally associated with self-harm, such as exercising to hurt oneself, or not taking prescribed medication can illuminate the subtleties of self-harm and help to portray self-harm as a continuum rather than
a disorder. This study takes a similar position, therefore studies referencing self-harm in this literature review include all forms of self-harm, excluding cultural self-harm elaborated upon below.

**Cultural self-harm.**

From a counselling psychology perspective which values cultural influences and diversity within individuals (Douglas et al., 2016), it is important to note harming the self is not always considered pathological, for example, body piercing and tattooing are common among certain cultural subgroups (Clarke & Whittaker, 1998). Favazza (1996) has written extensively on cultural meanings of self-harm suggesting self-harm symbolises beauty and purity in African tribes, membership of subculture in biker communities and the punk movement, and rites of passage in indigenous cultures. Clarke and Whittaker (1998) contend what society deems acceptable or repulsive changes over time, for example blood-letting was once mainstream, and practices such as tattooing and body piercing were once subversive. Therefore there is an acknowledgement to some extent that there is a temporal aspect affecting how self-harm is viewed in society presently, and this acceptability of self-harm will fluctuate over time. However, cultural self-harm practices are less relevant to the present study. Self-harm in this research refers to self-harm linked to psychological distress.

**How individuals view their self-harm.**

In accordance with counselling psychology ethos this section gives an overview of the literature examining individuals’ views of their self-harm through a consideration of their explanations for self-harm, how they conceptualise the process of self-harm, and the mind-set when self-harm occurs, rather than theoretical perspectives. Due to size constraints of this
thesis it is not possible to outline all the relevant theories in this area (see Appendix AC for an overview of how the main psychological theories in this area conceptualise self-harm).

*Individuals’ explanations for their self-harm.*

How individuals with BPD view their self-harm varies upon the person, the particular incident and even the view of a particular incident can change over time. To illustrate, reported explanations for self-harm from research conducted immediately after the event, can be compared to perspectives gathered some time later. Research conducted directly after an overdose examining an individual’s intentions found the most commonly reported purposes were to gain relief from a terrible state of mind, to die, to seek help, to influence someone, not being able to think of any alternative, and losing control of themselves, and not knowing why they did it (Schnyder, Valach, Bichsel, & Michel, 1999). Most individuals reported more than one intention. Individuals reflecting on their need to self-harm, sometime after the event, have described a number of different motivations. Holm and Severinsson (2010) studied women with BPD and reasons for their self-harm. The women described their self-harm as a conflict between a desire for self-sacrifice, and being relieved of responsibility, with a fear of intimacy and intrusion. Similarly, other researchers report the main reason for suicidal and self-harm in BPD is to be relieved of distressing emotions and to leave others better off (Brown, Comtois, & Linehan, 2002; Paris, 2002). This is supported by Lindgren, Wilstrand, Gilje, and Olofsson (2004) who suggest that self-harm is a way of dealing with difficult psychiatric pain, and is a coping strategy (Solomon & Farrand, 1996), and a survival strategy (Pembroke, 1998). Favazza (1996) first postulated by physically inflicting harm, emotional pain becomes more manageable. Holm, Berg, and Severinsson (2009) found women with BPD described suicidal behaviour represents a struggle to obtain a new meaning of life through change, forgiveness,
and reconciliation. Other reported reasons for self-harm in BPD include self-punishment (Morris, Simpson, Sampson, & Beesley, 2015), a means of relief from extreme emotions, to feel more alive (Barr et al., 2010), a means of external self-soothing (Gallop, 2002), facilitating mood elevation, relief from negative feelings (Kemperman, Russ, & Shearin, 1997), and restores a feeling of balance (Brooke & Horn, 2010). Moreover, research found different forms of self-harm can have different purposes, Rodham, Hawton, and Evans (2004) found that the most common reason for self-poisoning was to escape, whereas Briere and Gil (1998) found cutting was as a result of depression.

Three highly cited reviews examining explanations for self-harm comprising over 150 studies identified eight negative broad reasons for self-harm; managing distress or affect regulation, interpersonal influence, punishment, managing dissociation, sensation-seeking, averting suicide, expressing and coping with sexuality, and maintaining or exploring boundaries. As well as two positive explanations, which were the enjoyment of the act of self-harm and finding it comforting and protective against others, and self-harm as a means of defining the self by way of personal expression or validation (Edmondson et al., 2016; Klonsky, 2007; Suyemoto, 1998).

This body of research gives an insight into why individuals self-harm but less insight into the internal processes occurring, which result in self-harm. These processes are considered next.

Process leading to self-harm.

Looking at the preceding factors which lead to self-harm, Chance, Bakeman, Kaslow, Farber, and Burge-Callaway (2000) found individuals with a diagnosis of BPD, who were hospitalised following an overdose, described a relational pattern whereby they find others to
be rejecting, which led them to feel depressed and alone prior to overdosing. However, this study did not identify why individuals who felt depressed and alone decided to overdose, as opposed to other more adaptive strategies such as seeking help directly. The process of self-harm in BPD was explored in a later study, Brooke and Horn (2010) looked at how four women with BPD perceived acts of self-harm, that had both suicidal and non-suicidal intent. They found both proximal and distal factors were stated by the women as responsible for their self-harm. Distal factors which were reported included incidents such as childhood abuse and loss, and proximal factors covered a range of overlapping factors on an inter to intra-personal continuum illustrated diagrammatically below (see Figure 1).

Figure 1. Interpersonal to intrapersonal continuum (Brooke & Horn, 2010)

The authors suggested factors were related, such that interpersonal difficulties created initial distress, leading to an internalised process of escalation of negative thoughts and feelings, however distal factors such as prior abuse and loss prevented more adaptive help-seeking, and thus resulted in self-harm. Self-harm was seen as a way of managing distress by
regaining emotional control, and was both impulsive and planned. It was described initially as a private experience, which gave individuals ownership of themselves and represented a form of self-help. However as the situation creating distress remained unresolved, individuals progressed to more serious acts of self-harm. They described struggling to know how to attract support and receiving secondary gains from self-harm such as receiving care from others. There was a strong desire to escape from their current situation, but on exploration this was to end their suffering and communicate their distress to others, rather than to end their life, and there was ambivalence around dying. Brooke and Horn’s (2010) study provides useful knowledge by highlighting the processes leading to self-harm, however is little focus on moment-to-moment experiencing, which will be explored further in the next section.

**Mind-set when self-harm occurs.**

There is little research exploring the mind-set in which self-harm occurs. Black et al. (2014) described perceptual changes directly before self-harm, resulting in individuals entering an altered state or zone involving a loss of control and concentrated on harm. They found some individuals depicted self-harm as a reflex or semi-conscious act, leading to shock later at what happened. Others reported a long build-up and preoccupation with self-harm. Many individuals were able to harm themselves without feeling any pain until after the event. Participants described seeing their blood focused them, reassuring them of their existence. Death was viewed as a resolution of distressing feelings, but there was a conflict between wanting to live and wanting to die, suggesting an explanation for failed suicide attempts and low-level overdoses. Seen from this perspective whereby self-harm seems to temporarily resolve emotional pain for the time that individuals are engaged in the behaviour, it seems understandable individuals with BPD with recurrent difficulties keep repeating self-harm.
However this creates tension when individuals come into contact with HCPs aiming to reduce high-risk behaviours. The next section presents an overview of the research examining how HCPs perceive working with BPD and self-harm, highlighting the need for future research addressing these issues, and providing the focus for the present study.

**HCPs perspectives on self-harm in BPD.**

There is a large amount of literature on self-harm in medical, nursing, and psychological domains, therefore it might be assumed HCPs have a solid understanding of the nature of self-harm and are confident in their ability to respond. However, research suggests HCPs struggle with providing help for self-harm. Skegg (2005) reported despite self-harm being a common clinical problem, it remains poorly understood and arouses ambivalent feelings in HCPs. Shaw (2002) argues self-harm is seen by many HCPs as a treatment resistant behaviour reporting individuals frequent disengage from services. McAllister et al. (2002) conducted a large survey of Australian nurses’ responses to patients who self-harm, and concluded there is a need for continuing professional development activities to address negative attitudes and provide practical strategies to inform clinical practice.

A number of reasons for negative attitudes by HCPs have been suggested. Self-harm has been identified as causing high levels of anxiety for HCPs since acts of self-harm can lead to severe injuries and accidental death (Paris, 2012; Zila & Kiselica, 2001). Researchers report staff feel frustrated, under skilled, and incompetent due to being unable to prevent self-destructive behaviour by people with BPD (Cleary et al., 2002; McCarthy et al., 2013; Wilstrand, Lindgren, Gilje, & Olofsson, 2007). Furthermore, HCPs have reported individuals with BPD who are chronically self-harming require more care than other patients (James & Cowman, 2007). Cleary et al. (2002) found 84% of nurses surveyed indicated working with
individuals with BPD was harder than any other patient group. NICE (2009) commented a lack of specialist services means overwhelmed community mental health teams find it difficult to meet the needs of those with BPDs.

Moreover, the frequency of self-harm and the manner in which help is sought in patients with BPD, has led to the belief by HCPs that self-harm is wilful, deliberate and under the patient’s control. Studies have reported HCPs view patients’ self-harm as a form of manipulation, and evidence suggests HCPs treat patients who have had a serious suicide attempt better than patients who have less severe self-harm (Anderson, 1997; Platt & Salter, 1987). However from the patients’ perspective, Nehls (1999) found individuals described how it felt illogical and unfair to be viewed as manipulative, as often self-harm was a direct not ‘sneaky’ way of receiving services, or they self-harmed without informing anyone. Individuals with BPD explained how self-harm was warranted because the activities were grounded in the experience of living with emotional pain. By taking emotional pain and turning it into physical pain it was easier to handle. Participants explained they felt HCPs were more focussed on preventing self-harm than what was causing it. They described when self-harm is perceived as manipulative, the underlying reasons are overlooked, and the cycle of self-harm continues. Similarly, Liebman and Burnette (2013) suggest HCPs attitudes impact on individuals’ future self-harm. They found as a result of feeling under skilled and anxious HCPs respond in punishing unhelpful ways towards service users, reinforcing their destructive behaviours. This is supported by Becker (1997) who commented on the complex interplay and reciprocal relationship between self-harm and HCPs perpetuating difficulties. This can be summarised as individuals self-harm to reassert control over themselves when feeling powerless, when HCPs come into contact with an individual who has self-harmed the HCP
feels helpless and powerless. As a result HCPs use diagnosis and labelling to help them feel more in control, but in doing so, the individual can be reduced to the diagnosis, consequently feeling powerless again and activating the need to self-harm in order to feel in control and the cycle is maintained. Despite these difficulties there is evidence showing some HCPs find this area of work interesting and engaging (Bergman & Eckerdal, 2000; Bowers, 2002), and through drawing on the support of colleagues and being realistic about the pace of change, some HCPs establish therapeutic relationships leading to positive outcomes with patients (Bowen, 2013). A number of studies recommend more training is needed to improve service provision (Cleary et al., 2002; Markham & Trower, 2003; McGrath & Dowling, 2012), and advise HCPs examine their attitudes and beliefs surrounding self-harm and BPD, to engage in meaningful therapeutic dialogue (Birch, Cole, Hunt, Edwards, & Reaney, 2011; Castillo, Allen, & Coxhead, 2001; Fallon, 2003).

In conclusion, the clinical literature suggests individuals with BPD who self-harm feel subject to negatives attitudes from HCPs, which prevent them seeking help more constructively and continuing to self-harm, HCPs feel unable to prevent behaviour and become overwhelmed leading to further negative attitudes towards their patients. In order to break the cycle, the present study proposes a better understanding of the current interventions is needed to identify new approaches or better existing ones.

**Interventions to Prevent Self-harm**

The previous section considered research on explanations for self-harm from individuals with BPD, and presented evidence suggesting further study in this area is needed to improve service provision. This section will consider the existing interventions and their
effectiveness, alongside individuals’ perspectives on interventions and recovery, to give an overview of the research field identifying the need for the present study.

**Existing interventions.**

A systematic review of the literature identified 29 studies implementing an intervention targeted at reducing self-harm in outpatients with BPD (Noble, 2015). The interventions were categorised into four types, psychotherapy, hospitalization, medication, and collaboration with HCPs. The majority of interventions consisted of psychotherapy (24 studies, see Table 1 below for the list of therapeutic approaches), three studies used a combination of hospitalization and intensive psychotherapy to reduce self-harm (Berrino et al., 2011; Birch et al., 2011; Gratz, Lacroce, & Gunderson, 2006), one study administered medication (Sonne, Rubey, Brady, Malcolm, & Morris, 1996), and one study took a collaborative approach between HCPs and patients (Borschmann et al., 2013). Due to the scope of this thesis, it is not possible to give a detailed account of each type of intervention and the theory by which it reduces self-harm (see Appendix AD for summary descriptions of common interventions), an overview of the effectiveness of interventions and their common features is discussed in the next section.
Table 1. Identified therapeutic interventions aiming to reduce self-harm in BPD (Noble, 2015)

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<tr>
<th>Therapeutic approach</th>
<th>Research</th>
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<tr>
<td></td>
<td>Stevenson, Meares, &amp; D'Angelo (2005)</td>
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<td>Bedics, Atkins, Comtois, &amp; Linehan (2012)</td>
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<td>McMain, Guimond, Streiner, Cardish, &amp; Links (2012)</td>
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<td>Neacsiu, Rizvi, &amp; Linehan (2010)</td>
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<td>Pasieczny &amp; Connor (2011)</td>
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<td>Pistorello, Fruzzetti, MacLane, Gallop, &amp; Iverson (2012)</td>
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<td>Turner (2000)</td>
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<td>Verheul et al. (2003)</td>
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<td>Gratz &amp; Gunderson (2006)</td>
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<td></td>
<td>Gratz &amp; Tull (2011)</td>
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<tr>
<td>Mentalization Based Therapy [MBT]</td>
<td>Bales et al. (2012)</td>
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<tr>
<td></td>
<td>Bateman &amp; Fonagy (1999)</td>
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<tr>
<td>Transference Focussed Psychotherapy [TFP]</td>
<td>Clarkin et al. (2001)</td>
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</table>
Effectiveness and common features of interventions.

A meta-analysis of 16 studies investigating interventions for self-harm found DBT had a moderate positive effect (0.56) compared to treatment as usual, but did not find any evidence to support DBT over and above other therapies targeting BPD such as MBT, or TFP (Kliem, Kröger, & Kosfelder, 2010). Similarly, Noble (2015) found comparing all forms of interventions, MBT had the largest effect on reducing self-harm (Bateman & Fonagy, 2004; Berrino et al., 2011), but not greatly more than other therapeutic approaches. Of note, within DBT studies, Turner (2000) showed large intervention effects on self-harm, however there were considerable differences in effect sizes among studies implementing similar interventions. It is not known why these differences occurred, and Scheel (2000) pointed out further research is needed to explore specifically which components in interventions are effective. Weinberg, Ronningstam, Goldblatt, Schechter, and Malsberger (2011) reviewed the literature aiming to identify the common features of effective interventions. The researchers found effective therapeutic interventions have a clear treatment framework promoting change, focus on the therapeutic relationship, take an exploratory stance where the therapist takes an active role, and close attention is paid to emotions. Paris (2010) stated effective treatments to prevent self-harm often involve longer term therapy.

A lack of qualitative intervention literature.

The studies noted above which have investigated interventions assessed the reduction in self-harm through questionnaires, semi-structured interviews, and medical records, often combining multiple data sources (Noble, 2015). Therefore it was possible to quantify the overall effectiveness of the interventions, but it is unknown how these interventions were experienced by the participants, for example, which parts did they find helpful? Which parts
were ineffectual or actually made self-harm worse? Did the intervention sometimes work and other times not work? Did the effectiveness of the intervention change over time? It is important to bear in mind none of the interventions were 100% effective, and effect sizes are calculated based on group averages within which there will be great variation among experiences. This is evidenced by drop-out rates and large variability in outcome measures among studies (Bateman et al., 2015). Andresen, Caputi, and Oades (2010) point out clinical outcome measures focussing on symptomatic improvement rarely capture an individual’s experiences and expectations of interventions. A review carried out by Bateman et al. (2015) points out there is a lack of effective treatments for BPD and more research is needed to understand current interventions and develop new ones. Qualitative methods offer an under-researched idiographic perspective of the intervention process. The next section outlines the existing literature from this qualitative area.

**How individuals experience interventions.**

There is very limited literature studying individuals’ experiences of interventions. A systematic review (Noble, 2015) identified three studies examining qualitative experiences of interventions (Helleman et al., 2014; Langley & Klopper, 2005; Lindgren et al., 2004). These studies give different viewpoints to the research area. Helleman et al. (2014) gave a practical account of the tangible aspects of brief hospital admissions which individuals found helpful, whereas Lindgren et al. (2004) considered the positive and negative aspects of interactions with others, which promote reduction in self-harm during interventions. Langley and Klopper (2005) combined the perspectives of individuals with BPD and HCPs, identifying the core component in positive interventions. A summary of the findings from these studies is given below.
Helleman et al. (2014) looked at how people with BPD view brief admission (1-5 nights) at psychiatric hospitals across the Netherlands. This intervention is recommended by Dutch multidisciplinary guidelines for patients with BPD in a crisis (Kaasenbrood, 2015).

Patient reported goals of a brief admission are to overcome a crisis without loss of control and to try to prevent negative outcomes such as self-harm or suicide. Patients themselves request the admission, and during which they follow an individualised brief admission treatment plan. The individualised treatment plan is negotiated between patient and clinician prior to the first admission. The plan aims to promote autonomy, and outlines the admission goal, the maximum frequency of admissions per year, the allowed duration, medication, preferred attitude from nursing staff, and specification of conditions for premature discharge. Patients do not follow structured therapy groups (as these are provided in community care), but can request a conversation with a nurse.

Seventeen outpatients with a diagnosis of BPD with a mean frequency of twelve brief admissions (range 2-68) over a three year period discussed helpful aspects of their admissions. Helpful aspects included ensuring the plan was regularly evaluated to check it was still applicable as their needs varied over time. For example, participants reported sometimes rest and time out were needed, and at other times rhythm, activity, or conversation was helpful. They described knowing the service existed gave them a sense of security, and they appreciated being able to enquire about an admission at any time, commenting how hard it was to call to prevent a crisis. They explained tensions rose quickly meaning sometimes they were too late to be able to prevent self-harm. Patients reported needing an admission to be able to continue with intensive therapies which activated overwhelming emotions and memories.
Contact with a nurse was described as the most important aspect of the admission with conversations at the beginning of admission breaking the ice for conversations later. Specific helpful aspects included knowing which nurse they could talk to, and taking an informal approach over a cup of coffee or on a walk. They described finding it hard to start talking about problems and emotions, feeling emotionally ‘locked-up’, and a nurse proactively approaching them was easier. They explained that talking felt like a revelation and prevented self-harm, and contact with a nurse helped them to re-establish a connection to themselves. Participants reflected upon these conversations after discharge. When this contact did not occur, participants reported feelings of tension, abandonment, rejection, and anger, and the brief admission was viewed negatively.

Other valued aspects of brief admission were time out to be able to rest, an implemented structure, being distracted, and meeting fellow participants. They found pleasant, distraction activities decreased levels of tension, such as taking a walk, bath, or having a cigarette, and that nurses could help by identifying potential activities. The structure of the ward with regular meals helped patients to regain control of their lives and implement this structure when they returned home. Contact with other patients was viewed ambivalently, some found this supportive, and others reported contact with a disturbed or regressed patient felt unsafe.

Overall, the evaluation of a brief admission could be either positive or negative. When the overall evaluation was positive, patients reported regaining strength needed to function in their daily lives. When patients became more experienced with brief admissions they felt able to become more autonomous, and take more responsibility for recovery, and self-esteem increased. A negative overall evaluation enhanced feelings of loneliness and hopelessness.
Helleman et al. (2014)’s study furthered findings from previous research reporting patients view peer support as a key component in an intervention (Bowen, 2013), by suggesting peer support is context dependent, and individuals can also experience difficulties in their contact with other patients. Helleman et al. (2014) suggest a supportive attitude is one in which a patient feels seen, heard, and accepted. This might take the form of rest, distraction, conversation, or in-depth discussion of a crisis. The helpful aspects of contact with a nurse echoed previous research into the common factors approach to successful treatment in BPD (Weinberg et al., 2011), specifically attention to emotions and an active approach from HCPs.

Contact with a nurse as the crucial foundation without which the intervention was reported ineffective is supported by earlier research. Nehls (1999) found brief hospitalisation was experienced as a safe controlled environment, but insufficient, and dialogue with caring others was desired. Further research has suggested trust and hope are key elements in contact. Farran, Herth, and Popovich (1995) emphasised hope in itself can be an intervention strategy leading to expanded functioning, which can be cultivated by HCPs. A similar finding was reported by Langley and Klopper (2005) who combined the perspectives of individuals with BPD and HCPs, and concluded individuals with BPD experience significant challenges establishing trusting relationships with HCPs. Positive experiences of interventions started from trusting relationships, from which individuals were supported to develop a greater sense of responsibility for themselves and their future.

Lindgren et al. (2004) looked in more depth at how individuals experienced interactions with others in interventions to prevent self-harm. The researchers did not explicitly recruit individuals with a diagnosis of BPD, but the majority of participants self-identified as having BPD, and all had a history of recurrent self-harm. Lindgren found five
themes represented patients’ experiences of care. The first theme patients identified as wanting HCPs to see their emotional distress at a deep level, looking at what lies beneath their symptoms and appreciating their uniqueness with assets, desires, and needs. It was experienced through the staff’s kindness, openness, and giving of time. Participants explained when others saw strength in them they began to see strength in their own self. In contrast, not being viewed as a unique human with assets, as well as vulnerabilities, generated negative feelings and created a barrier to communication with HCPs.

The second theme centred on being valued and was shown when individuals were taken seriously, allowed to take responsibility for their own care at their own pace. When this occurred they began to value themselves. On the opposite end of the spectrum, participants reported not feeling valued and described professional stigma around self-harm, becoming objectified, and their opinions being discounted. To illustrate, one participant stated “if I say that I can’t sleep, that doesn’t matter, because I am supposed to sleep”.

The third theme reflected feeling connected to others, their surroundings and feeling secure to avoid self-harm. They described being able to have telephone contact when needed. In contrast, dependent on the atmosphere, their environment could feel like a trauma in itself and generate feelings of abandonment. This occurred when HCPs did not take the time to talk to them, there was long periods of unscheduled time on the ward, and therapeutic relationships were terminated without warning.

The fourth theme involved HCPs having confidence and hope which instilled hope in individuals for the future, whereas HCPs uncertainty, hesitancy and seemingly lack of confidence was felt as being unworthy of care. The final theme was experienced as being understood and helped to consider healthy ways of expressing themselves. Participants
expected HCPs to have a level of competence talking about self-harm. They described staff setting limits and boundaries when they felt unable to do it. Whereas, experiences of being shouted at by HCPs or treated as a burden led to further devaluing of themselves.

This study identifies, more important than the specifics of an intervention, is how it is experienced through interactions with others. The over-arching theme was being confirmed by others, which the researchers likened to validation, a key concept in Linehan’s (1993) DBT approach where the therapist communicates the patient’s responses makes sense. The rationale being through showing validation the individual begins to validate themselves. This is supported by a similar study by Samuelsson, Wiklander, Åsberg, and Saveman (2000) who emphasised the importance of individuals being validated by HCPs for healing, and to cultivate a wish to carry on living. A lack of being validated leads to increased self-harm, unwillingness to seek help and feeling worthless (Linehan, 1993). Black et al. (2014) suggest interactions with others play a key role in the success of an intervention because social roles interact with the need to self-harm. Relationship breakdowns can act as a causal factor in self-harm, however positive interactions can prevent further destructive behaviour. In Black et al.’s (2014) study, individuals described their otherwise inevitable suicide as being solely prevented by these protective roles.

The intervention literature suggest secure trusting relationships and a safe environment provide the foundation for helping reduce self-harm, but whether this results in permanent change is unknown. Considering a longer term perspective is important to understand ultimately how individuals move away from self-harm to more adaptive strategies for coping with distress. A closely related field which can shed a light on long-term processes is through the recovery literature.
Recovery in BPD

Few studies have looked at individuals’ experiences of interventions as shown above, however there is a growing literature associated with how individuals with BPD view recovery. The recovery literature aligns closely with the experience of interventions as individuals often consider how their experiences of seeking help through interventions impeded or enhanced their recovery. This section will consider the key findings from this area to represent how interventions fit within a process occurring over time reducing self-harm.

Recovery in personality disorder literature is a controversial term (Nehls, 2000), with the meaning of personal recovery being complex and often not clearly defined. Anthony (1993) defined recovery within a rehabilitative stance, as living a satisfying life despite the limitations of illness, rather than total remission of symptoms. Longitudinal studies demonstrate while symptomatic remission is relatively common in individuals with BPD, longer term recovery of psychosocial functioning is rarer (Zanarini et al., 2012).

Shepherd, Sanders, Doyle, and Shaw (2016) conducted a systematic review of the qualitative literature in personality disorder and recovery identifying three studies, of which two focused upon participants with the diagnosis of BPD (Holm & Severinsson, 2011; Katsakou et al., 2012). The third study comprised participants with the majority having a BPD diagnosis but also other types of personality disorders (Castillo, Ramon, & Morant, 2013). These studies involved relatively large numbers of participants and identified three overarching themes present across all studies. These were safety and containment as a prerequisite to recovery, social networks and personal autonomy in the recovery process, and identity construction as the process of change. These themes are considered in more detail below.

Safety and containment as a prerequisite to recovery referred to individuals feeling in order for personal change to occur, it was necessary for them to feel safe to express distress
through individual relationships, social networks, or environments. Toxic or rejecting environments or relationships impeded or regressed change. The experience of leaving or changing environments, such as discharge or transfer between services was highlighted as a potential risk regenerating distress and further self-harm. This finding is consistent with a large body of literature emphasising the role of a trusting therapeutic relationship as the lynchpin in promoting change (Adshead, 1998). It also supports attachment theory (Bowlby, 2005) suggesting during time of distress individuals seek out attachment sources, mirroring early life behaviour. Fonagy and Luyten (2009) argue one of the facets of BPD is a lowered threshold for activation of attachment behaviour.

Recovery was seen by individuals with BPD as a developing exercise of personal autonomy. The development of personal autonomy through systems of care has been highlighted by researchers representing an ongoing process mirroring levels of independence (Fallon, 2003). In Shepherd et al.’s (2016) review individuals described turning points in which they recognised the need for change and their role in securing this. This had to be carefully balanced against a recognition that change occurs within social networks. Tensions could arise between competing demands, with participants speaking about differences between their priorities and those of services. For example, participants described their wish to address difficulties in personal relationships, whereas HCPs focussed on domains purely related to risk, such as self-harm. Social networks and peer support has been demonstrated to play a role in change processes. Perry and Pescosolido (2015) found activation of social networks is a key component in help-seeking behaviour reducing distress, specifically when others are orientated towards recovery. Cohen and Wills (1985) argue social network support can act as a buffer against social stress, with the role of support groups in physical illness well
documented, for example, cancer survivorship groups. On the other end of the spectrum, a lack of social support, specifically experiencing stigma impedes recovery.

The final theme identified by recovery literature was identity construction (Shepherd et al., 2016). Identity construction was described as developing an identity in which their experiences of difficulties were integrated alongside other competing identities. This view is supported by research by Adler (2012) who found when individuals integrated experiences of psychotherapy into their identity they showed permanent change. Sometimes individuals adopted an illness identity which stalled progress, but recovery involved moving beyond this state and developing hope for a future identity, incorporating a stronger, more confident self able to experience emotion without becoming overwhelmed. Shepherd et al.’s (2016) review found individuals were cautious of the word recovery, unsure whether their difficulties could be ‘recovered from’ and emphasised a vigilance needed to be maintained against self-harm. The researchers concluded it appears crucial that safety and containment through interpersonal, professional, and personal relationships is established before identity construction and subsequent recovery can occur. They suggested interventions take into account professional and client attachment styles and incorporate close supervision, in order to support individuals with BPD closely.

The recovery literature suggests interpersonal interactions and social network support provide a foundation for new identities to be constructed, potentially leading to permanent change. It is unknown how these processes occur alongside interventions. The current study aims to combine individuals’ perceptions of interventions and recovery to create an overall picture of how self-harm processes can be changed.
Need for the Present Study and the Research Question

There is a wealth of literature considering individuals’ perspectives on their diagnosis of BPD and self-harm, emerging literature on recovery and BPD, and scant literature from a qualitative perspective looking at interventions. However, there is a lack of any research holistically examining individuals with BPD perceptions of interventions taking into account reasons for self-harm and thoughts on recovery. The present study aims to pull together these strands of research to create a framework for understanding interventions to reduce self-harm. In alignment with counselling psychology philosophy, and recommendations from national clinical guidelines in the United Kingdom, valuing the individual’s agency in decisions concerning them (NICE, 2009), this framework will be constructed from individuals with BPD symptomatology’s views and experiences. As such, the research question that is posed within this project is: How do individuals who self-identify as having BPD symptomatology perceive interventions to prevent self-harm?
Chapter 3

Methodology

Chapter Introduction

This chapter outlines the methodology of the present study through the consideration of the research design and philosophical position. This is followed by the procedure for data collection, the participant demographics, and the rationale and protocol used to analyse the data. Within these sections, the inherent limitations are discussed alongside how they have been mitigated in the present study. The chapter ends by considering ethical issues relevant to the research.

Research Design

A qualitative design was chosen to address the research question for three reasons. Firstly, Strauss and Corbin (1990) suggest qualitative methods can be used to uncover and understand what lies behind any phenomenon about which little is yet known. Currently very little is known about how self-harm interventions are perceived by individuals with BPD symptomatology, and therefore this research design enables a greater understanding of this area. Secondly, Strauss and Corbin (1990) note qualitative methods also can be used to gain novel and fresh perspectives on phenomena about which quite a lot is already known. Previous research has investigated perceptions of individuals on their BPD diagnosis and self-harm (Black et al., 2014), however the novel perspective in this study is researching the area of self-harm intervention encompassing a holistic view on the process. Lastly, qualitative methods can give intricate details of phenomena that are difficult to convey with quantitative methods. The purpose of this study was to investigate how interventions are conceptualised by the people they are intended to help and to develop a theory, therefore qualitative methods
collecting individuals’ perspectives and generating in-depth data seemed the most suited to this research question.

One of the criticisms of a qualitative approach is trying to extract meaning requires a certain level of inference, and therefore the analysis will always contain an element of subjectivity from the researcher (Rennie, Phillips, & Quartaro, 1988). As such, it is necessary to outline beliefs about what knowledge exists (known as ontology), and how knowledge is constructed (known as epistemology), which underpin the philosophical stance of the present study, as this will have unconsciously and consciously informed the research design, the method used to conduct interviews with participants, and the resulting analysis. By identifying the philosophical position for this research readers will have a greater understanding of the context from which the findings were interpreted.

**Ontology and Epistemology**

The last sentence in the previous paragraph epitomises the ontological and epistemological positions informing this research. Namely, the ontological is aligned with a critical realism perspective and the epistemology is situated within contextualism. The way in which these philosophical approaches fit with the present study are discussed below.

A critical realist approach advocates how facts are perceived, particularly in the social realm, depends partly upon our beliefs and expectations (Bunge, 1993; Madill, Jordan, & Shirley, 2000). The current study takes the view certain statements are somewhat objective, i.e. the world is round and people saying the world is flat will not make it so. However, there is an acknowledgement that within a social environment interpretation of objective reality will always be influenced by individuals’ prior knowledge and experiences. This ontological position can be illustrated through the example of a life drawing class, whereby the model
(being objective reality) poses in the centre and artists (holders of knowledge) draw in a circle around the model. Two artists from opposing sides of the circle will have completely different drawings of the model, so much so it might be hard to tell they are of the same person, however neither drawing is correct over the other, or is a complete depiction on its own. Another artist in the circle may choose not to draw the model at all, nevertheless this does not mean the model does not exist. However, it can be difficult to interpret conflicting perspectives, and therefore some method for understanding differing viewpoints is needed. This is the study of epistemology. The present study uses contextualism as the epistemological lens for the interpretation of knowledge.

Contextualism goes slightly further than critical realism and acknowledges the researcher, and the subject of research, are both conscious beings interpreting and acting on the world around them within networks of cultural meaning (Giorgi, 1995). Parker (1994) marries the two approaches together stating contextualism may use a critical realist stance which grounds individual perspectives in social practices whose underlying logic and structure can, in principle, be discovered. Therefore all accounts of knowledge are infused with a degree of subjectivity. A particular strength of the contextualist approach is the idea of triangulation, which holds by collecting multiple perspectives we are building a more complete picture of the knowledge (Madill et al., 2000). Although it is accepted some accounts may be more persuasive or more relevant to particular research questions (Parker, 1994). Therefore it is possible to retain truly novel perspectives which would be discounted in other paradigms, such as positivism, if consensus is of more value (Tinsley, 1992). Referring back to the life drawing example above, this perspective means both artists with different illustrations of the model add value to the knowledge of the model, and at the same time
differences can be acknowledged and not discounted i.e. one drawing may be more detailed than the other.

Contextualism argues that in order to make sense of these different and sometimes conflicting perspectives there is a strong rationale for researchers to articulate the context from which they and participants approach the area of interest (Wilkinson, 1988). This might include providing details such as age, gender, ethnicity, and other relevant factors. Returning to the life drawing example, it would help an outsider to make sense of the drawings if they were provided with information such as the artists were on opposite sides of the room, their level of experience, and their purposes for their drawings. To draw comparisons to the present study, this means this research takes the stance it is important to collect some forms of demographic data, namely previous types of self-harm and prior experiences of interventions, to provide some context for the reader to interpret differing accounts of individuals with BPD symptomatology’s experiences of interventions. More details on the data collected for this purpose is included in the demographic and questionnaire sections below. Furthermore, contextual information is provided on the researcher for the same purpose. This information is contained with the trustworthiness section below and the personal reflections section within the discussion chapter.

**Data Generation**

This section presents an overview of the data generation process. Typically in the presentation of study methodology participant characteristics are presented before data collection. However, in this study the data generation section is presented first in order to describe the questionnaires of which the outcomes are reported on in the participant section.
The data which formed the basis for the analysis consisted of semi-structured interviews conducted with participants. Two questionnaires were used to collect participant demographic information. Below the procedure for data collection and rationale for the interview process is outlined. This is followed by a description and discussion of the questionnaires used to collect contextual information about the participant’s self-harm and experiences of interventions.

**Interview procedure.**

**Rationale for interview procedure.**

The interview was semi-structured to allow the participant to go into detail on areas which were important to them and allow the exploration of ideas and themes the researcher had not foreseen (Kvale, 2008). In discussion with the head of the personality disorder pathway at Manchester Mental Health and Social Care Trust [MMHSCT] when the research was at its infancy the potential dangers of an interview which was too structured were highlighted. An overly structured interview could lead to collecting data in a pre-conceived format, and missing an individual’s relationship to interventions as a coherent narrative. Mearns and McLeod (1984) state the richness and relevance of findings may depend more on the quality of the relationship between researcher and participant than on the rigour of the analysis of data. Therefore an informal interview style with the participant was used to gather rich informative data. Additional strategies were employed to facilitate this process further. This included opening the interview with a broad open question asking participants their thoughts on interventions in general, and if anything in particular stood out for them to enable free-association on the topic area. The interview was closed in a similar open manner, by asking if there is anything they would like to say but had not yet had the opportunity to do so.
However, despite encouraging participants to explore topics, the format for the interviews followed a semi-structured schedule. It felt important to have some structure in order to orient the participants towards their thoughts on interventions to prevent self-harm, rather than on self-harm or other topics such as their experiences of a diagnosis of BPD. Research on HCPs working with BPD have found staff can feel overwhelmed and disoriented in their work due to emotional liability (Linehan, Cochran, Mar, Levensky, & Comtois, 2000), and it was thought structure would ground the researcher and participant as the material discussed was potentially emotionally charged.

*Interview protocol.*

The interview procedure started with introductions and a brief explanation of the rationale for the research, and an overview of the procedure for their involvement. Participants were asked whether they had read the participant information sheet and whether they had any questions. Participants then read and completed the consent form (see Appendix AE), two participants asked for this to be read to them. Following this, participants completed two questionnaires (see *questionnaire* section below). Participants were encouraged to ask any questions if they were unsure about what a particular question was asking, and the researcher checked after each questionnaire how the participant was feeling and whether they were wanted to continue. No participants wanted to terminate the process prematurely. On completion of the questionnaires participants were asked to take part in a semi-structured interview, which was audio-recorded. The questions asked during the interview were based on literature outlining methods to facilitate participants to talk freely, and think in alternate ways about a phenomena (Denzin & Lincoln, 1994; Kvale, 2008). These methods were combined with the research topic to have a dialogue with the participants about their experiences of
interventions, and their thoughts on why a particular intervention might be helpful or unhelpful to themselves and others. The focus of the interviews was guided by the participants’ responsiveness and reactions when asked about particular interventions, alongside emerging areas of interest from the concurrent data analysis (see data analysis section for more information about how data analysis informed data collection). This process was facilitated by exploring their experiences and opinions in more depth using the interview schedule. The interview schedule is included at Appendix AF.

**Questionnaires.**

The two questionnaires were used to assess self-harm behaviour, detect borderline personality disorder symptomatology, and gather previous experiences of interventions to prevent self-harm. The purpose of these questionnaires was to collect demographic information to aid readers of the research to have an understanding of the participants’ background and experiences. It also introduced participants to the topic area and focused their responses on interventions to self-harm, rather than self-harm or BPD in general. A review of self-harm measures was carried out and three potential measures were identified, The Deliberate Self-Harm Inventory [DSHI] (Gratz, 2001), Self-Harm Behavior Questionnaire [SHBQ] (Gutierrez, Osman, Barrios, & Kopper, 2001), and the Self Harm Inventory [SHI] (Sansone & Sansone, 2010). The SHI was chosen on the basis of being a brief measure which is reliable, free of charge, and developed for use in borderline populations.

**Self-Harm Inventory [SHI].**

An adapted version of the SHI was used to assess self-harm behaviour (Sansone & Sansone, 2010). The SHI is a self-report measure with yes/no responses. The SHI total score is the number of yes responses with a maximum score of 22. It takes less than five minutes to
complete and is available free of charge. Research (Sansone, McLean, & Wiederman, 2008; Sansone, Wiederman, & Sansone, 1998) has indicated SHI screens for lifetime prevalence of 22 self-harm behaviours, detects borderline personality symptomatology (with 84% sensitivity with an SHI score equal to five or greater), and predicts use of healthcare. Modifications were made to the SHI for use in this study to make the language more accessible to a UK based population, and to reduce the burden associated with trying to remember the exact frequency of each activity by including categories for frequency (between one to five times, five to nine times, and 10 times and over). The modified version was circulated in a peer group of five qualified and training counselling psychologists to check for understanding and equivalency in meaning. No further changes were identified. A copy of the original SHI and the modified version are given in Appendix AG.

**Perceptions of Interventions to Prevent Self-harm [PIPS].**

A review of the interventions to prevent self-harm literature identified no questionnaire in use that was fit for purpose in this study. Therefore the PIPS was developed from a systematic review of the literature of interventions to prevent or reduce self-harm in individuals with BPD (Noble, 2015), and included additional interventions suggested by voluntary organisations (MIND, 2013) and the Self-harm Awareness For All [SAFA] organisation (see Appendix AH). The questionnaire was not designed to be exhaustive but to activate participants’ memories and experiences in this area for the interview.

The questionnaire was designed to take no longer than five minutes and asked participants whether they had experienced a number of interventions. If so they were asked to rate how helpful they perceived the intervention to be on a Likert scale from 0 (extremely unhelpful) to 7 (extremely helpful). If they had no previous experience of the intervention they
were asked to imagine how helpful or unhelpful they felt the intervention would be. The questionnaire included a free text box at the end for the participants to add any interventions not previously mentioned. This questionnaire was also circulated in a peer group of five qualified and training counselling psychologists for comments. A few typographical changes were made. A copy of the PIPS is included in Appendix AI.

**Participants**

This section describes the eligibility criteria and recruitment procedures for participants. This is followed by a summary of the demographic information collected on the participants who took part in the present study.

**Eligibility criteria.**

The study aimed to recruit 12-20 males and females aged 16 to 65 years who self-identified as having BPD or interpersonal difficulties and a history of self-harm. This number of participants was aimed for as McLeod (2011) states 12-20 participants is a guide for collecting enough data for theoretical saturation, whilst keeping a manageable amount of data to allow in-depth analysis in a grounded theory approach (grounded theory is the method of analysis used in the current study). To be included in the research, participants had to express themselves verbally, and indicate they were willing to participate in the study (i.e. commit time to be interviewed and a desire to share their experiences), had a past or current history of self-harm, and considered themselves to have BPD or problems in their relationships with others, and were aged between 16 to 65 years. 65 years was used as the upper age limit as the common upper age limit in research ethics documentation, denoting the boundary between adulthood and older adult/elderly populations (Roebuck, 1979).
Participants were excluded from the study if they were identified as having learning or English language difficulties which would have prevented participation in the interview process. Participants were also excluded if they were currently receiving services as an inpatient. This decision was taken because there is a literature indicating individuals in an inpatient settings potentially have less insight into their difficulties, and likely to be in a high level of psychological distress (Shepherd et al., 2016; Zanarini et al., 2008). Therefore they may be more likely to become distressed in an interview or find talking about their experiences triggering. Furthermore, there is a difference in interventions available for individuals in inpatient settings to those in the community (Bateman et al., 2015), and as the focus of the present study was on gathering experiences from individuals who were outpatients prior to any interventions, then only individuals meeting this criteria were included.

**Recruitment procedure.**

Recruitment took place between February 2015 and November 2015. Opportunity and snowball sampling methods were employed and recruitment took place across MMHSCT and SAFA, a self-harm charity based in Cumbria. The head of the personality disorder pathway within MMHSCT was approached for advice on appropriate departments, and contact details for managers in services which had regular contact with individuals with diagnoses of personality disorders. The research was also advertised on a website for National Health Service [NHS] study recruitment (see screenshot at Appendix AJ) to generate interest for those individuals not currently in receipt of services. In total ten departments took part in the research. Psychology and psychotherapy department service managers were approached initially by email, and then a face-to-face meeting was arranged with the department. During
the meeting the rationale for the research was outlined, the practical elements to recruitment explained, and any concerns about the study were answered. HCPs were taken through the following procedure for recruitment:

Step 1. HCPs were asked to familiarise themselves with the ‘inclusion and exclusion criteria for HCPs’ form (Appendix AK). This information was for HCPs only, and provided a brief overview of the research and outlined the eligibility criteria for participants.

Step 2. HCPs were asked to approach any suitable individuals using the ‘initial information sheet for participants’ (Appendix AL), as a guide to introduce the research, and ask individuals if they would be happy to take part.

Step 3. If the individual was interested in participating either the HCP or the individual could fill out a ‘participant registration form’ (Appendix AM) including the individual’s contact details.

Step 4. If the individual agreed to participate, then the HCP was asked to give them a copy of the ‘participant information sheet’ (Appendix AN).

Step 5. The HCP either informed the researcher or the service manager they had a potential participant.

Post-boxes (Figure 2) were securely placed at each department within the staff area for HCPs to deposit registration forms. To act as a prompt to remind HCPs about the study when they were seeing patients, brightly coloured laminated cards were handed out (Figure 2).
To keep recruitment momentum departments were visited or telephoned weekly to check on the status of the post-boxes, and a departmental email was sent once a month via the service manager reminding HCPs about the study. Departments also placed copies of the ‘initial information sheet for participants’ on notice boards in waiting rooms.

Interested participants were then contacted and a date for interview was arranged at least two weeks after they had received the participant information sheet. Participants were given two weeks to give them adequate time to consider their participation as per the ethics procedure. More information on the ethical considerations in the present study can be found at the end of the chapter.

**Participant demographics.**

This section presents the relevant demographic data of the participants who took part in the research, and quantitatively summarises participant’s perceptions of interventions to contextualise the findings.

Twelve participants (two males and 10 females) between the ages of 22 to 55 years (average age of 38 years, Standard Deviation [SD] = 10.56) were recruited from psychology and psychotherapy services, self-harm charities, psychological crisis services based at A&E,
and the Citizen Scientist website. The average number of different types of self-harm behaviours participants had engaged in over their lifetime was 12.5 (SD = 3.32). All participants had engaged in more than five self-harm behaviours specified by Sansone and Sansone (2010) to be indicative of BPD symptomatology (with specificity of 84%). The most common types of self-harm were cutting (11 participants), hitting themselves (10 participants), attempting suicide (10 participants), torturing themselves with self-defeating thoughts (10 participants), and overdosing (9 participants). The three least common behaviours were distancing from god as a punishment (1 participant), abusing laxatives (2 participants), and losing a job on purpose (2 participants). Participants also named other self-harm behaviours they engaged in that were not listed in the SHI. These were diabetic abuse of sugar and insulin, over-spending, breaking things they cared about, sabotaging clubs or hobbies, biting themselves, and overworking.

All participants had tried over ten different types of interventions (average of 16 interventions, SD = 4.01). The top five most common interventions attempted to prevent self-harm were physical activity (12 participants), individual therapy (12 participants), playing music (11 participants), taking medication (11 participants) and going to bed (10 participants). The three least common interventions attempted were reading a letter written by themselves or others (3 participants), making a list of reasons not to self-harm (3 participants), and having a combination of individual and group therapy (3 participants). Other interventions not listed in the questionnaire but that participants used to prevent self-harm were creativity projects including artwork, directing theatre groups and running a blog (5 participants), spending time with children (1 participant), having a symbolic tattoo (1 participant), attending a self-help group (1 participant), using 24 hour crisis point services (1 participant), work (1 participant),
pets (1 participant), throwing soft items at walls (1 participant), and begging for help (1 participant). See Table 2 for summary demographic and self-harm information collected. Participants have been assigned a pseudonym.
Table 1. Participant demographics

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Recruiting organisation</th>
<th>SHI score</th>
<th>Number of intervention types tried</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Paul</td>
<td>33</td>
<td>Male</td>
<td>Charity</td>
<td>10</td>
<td>17</td>
</tr>
<tr>
<td>2</td>
<td>Janet</td>
<td>50</td>
<td>Female</td>
<td>Charity</td>
<td>9</td>
<td>19</td>
</tr>
<tr>
<td>3</td>
<td>Nicola</td>
<td>22</td>
<td>Female</td>
<td>Psychological crisis service</td>
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<td>13</td>
</tr>
<tr>
<td>4</td>
<td>Amy</td>
<td>34</td>
<td>Female</td>
<td>Psychology &amp; psychotherapy service</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>5</td>
<td>Kimberly</td>
<td>30</td>
<td>Female</td>
<td>Psychology &amp; psychotherapy service</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>6</td>
<td>Laura</td>
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<td>7</td>
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<td>55</td>
<td>Female</td>
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<tr>
<td>11</td>
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<td>39</td>
<td>Female</td>
<td>Citizen Scientist</td>
<td>16</td>
<td>23</td>
</tr>
<tr>
<td>12</td>
<td>John</td>
<td>45</td>
<td>Male</td>
<td>Psychology &amp; psychotherapy service</td>
<td>12</td>
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</table>

Summary demographics for interventions.

Separate to attempting the intervention was the perceived usefulness of the intervention at preventing self-harm. The perceived usefulness of an intervention to prevent self-harm on average across all participants is presented in Figure 3, where 7 is extremely helpful and 1 is extremely unhelpful. The dashed line represents a Likert score of four, at which point an intervention was neither helpful nor unhelpful, and error bars represent the
standard deviation of scores. Figure 3 does not include interventions suggested by participants
that were not in the original questionnaire because additionally suggested interventions were
unique to that individual and therefore there would only be one rating for that intervention
which would skew the results, as opposed to the original interventions in the PIPS which all
participants rated. The most helpful interventions were physical activity (average score 6.08,
SD = 1), individual therapy (average score 5.75, SD = 1.82), and going to bed (average score
5.67, SD = 1.23), and the least helpful were making a list of positive things about themselves
(average score 2.92, SD = 2.02) or reasons not to self-harm (average score 3.5, SD = 1.68),
and riding it out (average score 3.08, SD = 1.38). The standard deviations in Figure 3 shows
within each intervention type there was a large variation in whether it was perceived as helpful
or unhelpful between participants.
Figure 3. Average perceived helpfulness of interventions.
Data Analysis.

The data analysis section covers a brief history of grounded theory and the rationale for using it as the method of analysis in this research. The analysis procedure is outlined, alongside deviations from the standard protocol and reasons for doing so. The trustworthiness and limitations of a grounded theory approach is considered and efforts to mitigate these in the current study are discussed. This section ends with criteria for judging the quality of a grounded theory and how the present study aims to meet these objectives.

History of grounded theory.

Grounded theory as a method of qualitative analysis was originally outlined in the text *The discovery of grounded theory* by two sociologists, Barney Glaser and Anselm Strauss (Glaser & Strauss, 1967). Their values and research background is briefly presented below as this highlights the philosophy of grounded theory and the intentions for its use.

Strauss was influenced by interactionist and pragmatist ideas which contributed to the development of the method. These ideas included the need to get out and inside the field to understand a phenomenon, the importance of theory being grounded in reality to develop an area of inquiry, and exploring what experience is, and how it continually evolves. Strauss strongly advocated that people should have an the active role in shaping the world they live in, and a recognition is needed of the complex interplay between conditions, meaning and action, stating reality is change and process and not structure and content (Glaser & Strauss, 1967).

Glaser was influenced by innovators in quantitative analysis, and later while doing qualitative analysis recognised the need for a well thought out, explicitly formulated, and systematic set of procedures for coding and testing hypothesis generated during the research process. Both
researchers placed great importance on producing research that was of use to professional and lay audiences (Glaser & Strauss, 1967).

Glaser and Strauss created grounded theory as a theory that is inductively derived from the study of the phenomenon it represents (Glaser & Strauss, 1967). Grounded theory differs from quantitative approaches as it does not begin with a theory which is then proven or disproven, and yet it is distinct from other qualitative methods which are less systematic in nature. A grounded theory approach begins with an area of study and what is relevant to that area is allowed to emerge. Data collection, analysis and theory are in reciprocal relationships with each other. To implement this reciprocal philosophy and allow the theory to emerge in the present study, participants were encouraged to talk about areas related to interventions that were of interest to them. For example, one of the participants, John talked extensively about the importance of timing in influencing how effective an intervention can be, as a result he was concerned in the interview that he had gone off on a tangent as the quote below illustrates:

John: I do wonder to what extent I have talked to you about interventions in self-harming behaviours which is what I think you’re interested in. I don’t know that I’ve been that helpful in that regard.

However, allowing these perspectives was the embodiment of the philosophy of grounded theory, looking at new avenues and areas related to the topic of interest, which had not previously been considered, that were being generated by the data itself. Therefore, John’s and other participant’s perspectives on areas relating to the central phenomena were helpful in this regard.
Rationale for grounded theory.

Grounded theory was selected because it aims to discover new ways of making sense in the social world, the goal of the analysis is to generate a theory, and this theory is grounded in the data rather than being imposed upon it (Glaser & Strauss, 1967). This aligned with the methodological aim of the research to devise a theory on why interventions are perceived as helpful or unhelpful, which is created from the data, and separate from the stigma that has been associated with BPD symptomatology.

McLeod (2011) stated grounded theory produces pragmatic frameworks for understanding categories and process models that are effective in specific contexts. He proposed it is no accident grounded theory is popular in medical and nursing research as it is a systematic and valid approach, providing a way of conveying to busy doctors and nurses something of the private experience of their patients. Polkinghorne (2005) commented on how grounded theory relies on both narrative and paradigmatic ways of knowing, combining abstract categorisation with narrative vignettes. This way of presenting the analysis fitted with the overall aim of the research hoping to provide a framework for interpretation arising from the data, and at the same time attempting to portray some of the experiences of people with BPD symptomatology.

Moreover, Denzin and Lincoln (1994) state grounded theory represents a form of qualitative research that is systematised and fits well within a ‘modern’ rational, social science. However, although the approach is systematic, Glaser and Strauss (1967) acknowledged creativity is required, as building theory implies interpreting data, as it needs to be conceptualized and the concepts then related to reality. Researchers working in this tradition hope their theories will help to build knowledge and the theory’s implications will have useful applications (Strauss & Corbin, 1990). This aligned with another of the research
aims, to add to current knowledge and therefore potentially create useful applications and stimulate debate about future interventions. Rennie et al. (1988) suggested the reduced emphasis on co-construction in grounded theory, compared to other qualitative methods, provides a way of studying relatively larger numbers of individuals and has implications for generalizability. Similarly, this also complemented the aims of this research, to enable insight of how interventions can be perceived by individuals with BPD symptomatology, rather than directly how some individuals with BPD symptomatology perceive interventions. However, this research can only be considered an exploratory analysis and great caution must be taken before drawing comparisons wider across individuals exhibiting BPD symptomatology.

The fit between grounded theory and epistemology.

Grounded theory was chosen from a pragmatist perspective because it seemed to best fit the methodological aims rather than the epistemological position, however researchers have stated grounded theory is an approach which can be applied within a realist or contextualist framework (Madill et al., 2000). Charmaz (2008) argues a grounded theory approach is ideally placed to bridge positivist and interpretative methods, as it can incorporate both ideological standpoints, as findings can be considered to be discovered within the data or the result of construction of inter-subjective meanings. As outlined in the epistemology section above, this study takes the position of the former, findings are discovered within the data but findings are coloured by our beliefs and expectations and can never reflect reality completely, and therefore an appreciation of context is vital to aid a deeper understanding of the findings than can ever be found by just the data itself.
Procedure for grounded theory analysis.

Interviews with participants were transcribed verbatim. Grounded theory was employed to analyse the transcripts using NVIVO (Version 10 for Windows, Victoria, Aus: QSR International). The grounded theory analysis was completed by following the procedure outlined by Strauss and Corbin (1990). This is a widely used method and was adopted in order to have a clear set of steps to follow during the analysis (see Figure 4).

Figure 4. Steps in Strauss and Corbin (1990) model of grounded theory

Data collection was carried out alongside data analysis to allow the emerging theoretical framework to guide the areas to cover in the following interview. The analysis began with open coding in which conceptual labels were applied to the events in the transcripts. Events were coded by meaning units which represented each discrete incident, idea, or event, and could be a sentence, paragraph, or passage of text (Strauss & Corbin, 1990). In the case of category properties meaning units could be one or two words. Meaning units were chosen rather than line by line coding to avoid breaking the intended meaning of a statement, which could span across several lines. See below for examples of different meaning units coded under the consistent support category as a temporal aspect of interventions that work category:
Consistent support (category) examples.

Meaning unit: one word

Researcher: So it seems like there might be something important about people staying? That you have somebody, what’s the word

Janet: Constant

Meaning unit: phrase

Paul: She listens. She never missed an appointment [pause]. So. Makes her a good one in my book.

Meaning unit: paragraph

Nicola: so it was like more when you first go to your counselling sessions, there’s a person I’ve never met and I’m gonna have to talk to them about my private things but obviously it gets easier and a lot more relaxed once you get to know, after a few sessions

Similar phenomena were coded under the same label to build up clusters of codes which appeared to be related to one another. Subsequent datasets were evaluated alongside previous datasets for similarities, differences, and new concepts. Techniques were implemented to enhance theoretical sensitivity, and engage with alternative ways of thinking about codes or identify potential blind spots. These were the flip-flop technique and constant comparison of two or more phenomena (Strauss & Corbin, 1990). Transcripts were deconstructed and reconstructed by concepts, until new data did not reveal more information
about a concept. Similar concepts were grouped together to form categories, and related codes became their properties and dimensions. See below for an example of properties and dimensions influencing *pacing* in the category *interactional change*. From the information below it became apparent that one of the properties of a helpful other is someone who matches the pace of the individual, therefore *pacing* became a property with dimensions ranging from too fast to too slow.

*Going at my pace*

Amy: And this guy phoned me back and he was on the phone for three hours with me.

Dawn: I would have gone after six weeks if she had put any constraints on me. Or I would have turned up every week and gone everything’s fine! Everything’s fine! No I haven’t done anything this week, it’s all fine! So the fact that she was just curious was perfect.

Paul: When I get in a state I have to sit on the floor I can’t sit in a chair. She sat on the floor with me [laugh]. God love her

*Going too fast*

Karen: I ran away, I ran out. Because she threatened to get social services involved and [*name of son*] was only 14, errmm which freaked me out

*Going too slow*

Karen: I’ve wasted NHS resources because I’ve not made any progress
Categories were further elaborated by following a coding paradigm to define causal conditions, phenomena, context, action strategies, intervening conditions, and consequences for each major category. Concurrently, axial coding developed relationships between categories and sub-categories by applying abstract labels to link themes. Memos were used to record the emerging theoretical framework and tentative hypotheses relating categories to each other.

Data collection ceased when no new codes or relationships emerged with subsequent transcripts related to the core category, this was at interview 12. At this point I engaged in selective coding, examining the data for core categories which identified relationships between major categories. All categories were written onto post-it notes on a white board in order to flexibly work on the framework. See Figures 5-7 below to see the development of the framework over time.
Figure 5. Early stage grounded theory development

Figure 6. Developing grounded theory

Figure 7. Final version of grounded theory
When the framework appeared to be static it was tested against the transcripts. It became clear some categories were circular because they related to similar phenomena, and were therefore merged into one category. Also parts of the framework did not fit the experiences of particular participants, therefore the framework had to be further refined to encompass different perspectives. From the final framework the analytical narrative ‘the central story’ was written to check the coherence of the category structure, and outline the process unfolding over time following the experiences of the participants.

Once this process was complete categories were furnished with their properties and dimensions, and a conditional statement specifying the dimensions in which the phenomena occurred (see Appendices AQ-AS, AU-AZ, BB). The grounded theory was elaborated using the coding paradigm shown in Figure 8. Figure 8 describes the criteria for each part of the coding paradigm alongside an example of a category from the findings which is applicable to that stage.
Figure 8. Coding paradigm for the grounded theory (Strauss & Corbin, 1990) (example categories shown in italics).

A. Causal Conditions
- Events, incidents, happenings that lead to the occurrence or development of a phenomenon
  - Example category: Established beliefs and causal factors

B. Phenomenon
- The central idea, event, happening, incident which a set of actions or interactions are directed at managing, handling, or to which the set of actions is related
  - Example category: Alternative path to self-harm

C. Context
- The specific set of properties that pertain to a phenomenon; that is, the locations of events or incidents pertaining to a phenomenon along a dimensional range. Context represents the particular set of conditions within which the action/interactional strategies are taken
  - Example category: Decision to do things differently

D. Action Strategies
- Strategies devised to manage, handle, carry out, respond to a phenomenon under a specific set of perceived conditions
  - Example categories: Interventions that work, negative aspects of seeking help, trial, error and evaluation

E. Intervening Conditions
- The structural conditions bearing on action/interactional strategies that pertain to a phenomenon. They facilitate or constrain the strategies taken within a specific context
  - Example category: Time-course of self-harm

F. Consequences
- Outcomes or results of action and interaction
  - Example category: Sunset of self-harm
Deviations from Strauss and Corbin (1990) grounded theory.

The Strauss and Corbin (1990) protocol was deviated from by the present study’s review of previous literature. Typically in grounded theory the researcher does not make any attempt to review existing literature in advance of collecting the data to ensure the researcher approaches the data with an open mind, so themes and categories emerge rather than being imposed. Taking this into consideration, nevertheless, a literature review was conducted investigating interventions to prevent self-harm behaviours. This decision was taken for two reasons, firstly the literature review was used to form the questionnaire given to the participants asking about their previous experiences of interventions, additionally it provided a quantitative evaluation of the intervention’s helpfulness, and collecting this information was important for the contextualist stance of the research (Madill et al., 2000).

Secondly, the literature review was thought to increase sensitivity in the research interviews by immersing the researcher in the area of self-harm intervention. This approach can be used in grounded theory analysis as Strauss and Corbin (1990) note there are three possible sources of category labels used during data analysis, an analyst’s own common sense constructs, technical terms drawn from theoretical or professional literature, and the language used by informants. Therefore it was believed a review of interventions to prevent self-harm could generate useful material to inform this process and generate a source of construct labels. At the same time, the researcher was mindful to stay close to the data derived from the participants as there was a potential danger a grounded theory constructed largely from concepts taken from professional literature could place data in pre-conceived categories. One mitigation against this was that no previous framework existed (to the researcher’s knowledge) examining how individuals with BPD symptomatology perceive interventions aimed at preventing self-harm. Therefore it was unlikely a framework from the literature
would be imposed upon the data. However, before completing the analysis the literature regarding the process of how self-harm occurs, or why individuals self-harm was consciously not reviewed, in order that any theory was derived directly from the participants and not influenced by any pre-existing literature in these areas. After completing the analysis the existing literature in these areas was reviewed to compare the present grounded theory to the existing knowledge base (see literature review and discussion chapters).

**Trustworthiness.**

Trustworthiness is considered a measure of quality in qualitative research situating research within a particular context. Williams and Morrow (2009) present a cross paradigm approach to achieve trustworthiness through consideration of the balance between reflexivity and subjectivity, integrity of data, and clear communication of the findings. The balance between reflexivity and subjectivity is considered in the limitations to grounded theory and researcher bias and assumptions sections below. The integrity of the data was maintained by implementing a quality framework for grounded theory, see criteria for judging a grounded theory section below. Part of this quality framework is checking that the findings are understandable which met the third element of trustworthiness, outlined by Williams and Morrow (2009), which is clear communication.

**Researcher bias and assumptions**

In this section the researcher’s background and assumptions potentially influencing the data are outlined, alongside the efforts made to reduce the impact of these beliefs. The researcher is a white female, late 20s, from a middle class background originally from the North of England. Within the research context, the researcher held an outsider perspective (Morrow, 2005), not meeting the criteria for chronic self-harm and BPD symptomatology as
per the participants in this study. Dwyer and Buckle (2009) comment an outsider perspective can mean researchers fail to grasp nuanced meanings in the data. However although the researcher had an outsider position in regards to eligibility criteria for the study, on closer examination it seemed differences between the researcher and participants were more complex. Taking self-harm for example, some of the SHI questionnaire criteria for self-harm included torturing yourself with self-defeating thoughts or drinking to excess. It is assumed a large proportion of the population could meet these criteria. Most people will likely have engaged in some activity at one time or another knowing it will result in some damage to the self. Therefore it is possible to access states of mind which increase theoretical sensitivity to the topic of interest, at the same time keeping at the fore-front it is never fully possible to understand someone else’s perspective, and differences between participants can be as great as between the researcher and participants.

The researcher’s stance towards the topic area is akin to an ideological and critical paradigm. Guba and Lincoln (1994) state ideological and critical perspectives are concerned with the potential to create change. A primary focus is on increasing consciousness through representing the perspectives of those who have been silenced or disempowered, and therefore the assumption is research participants are collaborators in an investigation. Patton (2002) related ideological research to catalytic authenticity, which builds on the capacity of those involved to take action and identify change-making strategies. The researcher’s aim for the present study, which will have subconsciously infiltrated the research, was to hear the perspectives of individuals with BPD symptomatology, a minority group which has been associated with stigma (Aviram et al., 2004) and generate a theory which may potentially be used to enact change.
In order to increase qualitative trustworthiness (Morrow, 2005) the researcher explicitly drew attention to their horizons of understanding (Rennie, 1994). A bracketing interview (Peshkin, 1988) was employed to explore researcher assumptions before carrying out data collection and a research journal was kept (see Appendix AO for an extract). Furthermore, a five minute reflection interview after each participant was completed (Kvale, 2008). This data was revisited upon completion of the data analysis to examine whether any assumptions appeared to be impacting the grounded theory. No alterations were made. Themes from the bracketing interviews and the research journal have been incorporated into the reflexivity section in the discussion chapter.

**Limitations of grounded theory and how these were addressed.**

**Categorization.**

Qualitative approaches and particularly grounded theory has been criticised for fracturing the data (Charmaz, 1995). Madill et al. (2000) states the process of creating categories separates statements from context, and therefore the complex and often contradictory way in which views are expressed can be lost. This was a concern for the present study which has not been dismissed lightly. Due to the researcher’s counselling psychology training there was an appreciation that knowledge situated within its unique context aids a greater understanding. There was a pull to publish transcripts in their entirety and let participants speak for themselves or choose a more narrative approach. However, as Potter and Wetherell (1995) point out categorization is necessary to make a bulk of material more manageable. The present study was guided by existing literature perceiving this client group as hard to treat by HCPs, and suggesting HCPs often feel hopeless and burned out when trying to prevent individuals from self-harm (Perseius, Kåver, Ekdahl, Åsberg, & Samuelsson,
2007). It was hoped some of the findings from this research would help HCPs have a greater understanding of this client group, and therefore it was important the illustration of the findings was of practical use to them. HCPs in the modern age are very time and resource-constrained, therefore the researcher believed the information had to be in a digestible format, using categories so HCPs could get an overview quickly, and then later if they were so inclined they could delve deeper into individual’s accounts through themes and narrative vignettes.

*Neutrality.*

Thomas and James (2006) highlight one of the assumptions of grounded theory from an audiences’ perspective is it can be presented as an objective reality, from which a cognitive framework has been placed neutrally and without bias. This approach would ignore the fact the theory is just that, a theory created by one individual on the basis of a particular set of data. Therefore the grounded theory presented in this research is not aiming to say this is reality that has been discovered. Akin to whether an axe is a weapon or a tool, grounded theory can be used to portray an objective reality or a subjective one depending on the hands it is in. The stance of the present study towards the findings is similar to the critical realist position presented earlier, the resultant framework is simply one understanding of the data, and other researchers could and should perceive it differently. This is a strength rather than a weakness as debate enables a deeper level of understanding than any one perspective. Throughout the thesis the findings are intended to be read as *an* understanding of the phenomena rather than *the* understanding.
Reflexivity.

One of the limitations of grounded theory previously noted has been the relative lack of emphasis on researcher reflexivity compared to other qualitative methods. This reflexive element is important to consider the impact of researcher assumptions and background on the way the data is interpreted, and also as the researcher’s development as a counselling psychologist. However, McLeod (2011) noted a researcher could not possess theoretical sensitivity paying attention to the potential multiple meanings, as is needed in grounded theory, without reflecting on the researcher’s biases and assumptions and therefore introducing an element of reflexivity. A formal process of reflexivity took place throughout the research by conducting bracketing interviews and keeping a research journal. Personal reflections on the research process are included in the discussion chapter.

Criteria for judging grounded theory.

Glaser and Strauss (1967) state a well-rounded grounded theory will meet four central criteria for judging whether it understands the phenomenon it was meant to study. The four criteria are fit, understanding, generality, and control. In order to increase the quality of the grounded theory in the present study these criteria were embedded into the analysis process. The following section explains how this was achieved.

Fit.

Glaser and Strauss (1967) suggest to ensure the theory is faithful to the everyday reality of the area under study and is induced from diverse data, when the theory is taken back to the area under study it should still fit the data. The present study aimed to fit the findings to the data by checking the theory was applicable to participant’s narratives. As an example, in an earlier version of the grounded theory each element within the beliefs about others...
category was mapped to a corresponding element within the belief about self category. On further examination of the data it became clear the relationship between beliefs about others and beliefs about self was more complex than the original mapping, and because it was a peripheral area of the theory there was not enough information to fully account for the intricacies of these relationships. Strauss and Corbin (1990) note one of the difficulties of grounded theory can be accepting what is not known relating to the area of interest, and where further areas of investigation will be needed. The grounded theory had to be altered to reflect the data and remove information that was indicated but not substantiated.

**Understanding.**

Glaser and Strauss (1967) state the theory should make sense to both the persons who were studied and those practising in the area. One of the ways the present study aimed to implement this criteria was by purposefully writing in language understandable to multiple audiences. It was tempting to use abstract labels and academic language for categories to enhance the perceived sophistication of the resulting grounded theory. However Oxenham and Sutton (2015) propose specialist language can prevent accessibility, and wherever possible the present study tried to refrain from doing so to increase readership and enhance the potential for real-world impact. In addition the findings were presented through the use of diagrams aiming to present the analysis as clearly as possible.

**Generality.**

Generality considers whether the data is comprehensive, and interpretations conceptual and broad, so that the theory is abstract enough and includes sufficient variation to make it applicable in a variety of contexts related to the area being studied (Glauser & Strauss, 1967). To implement generality in the present grounded theory the conditions to which phenomena
applied were explicitly outlined by writing analytical narratives for the core-category and sub-categories. During the analysis every part of the core category and main sub-categories were defined using properties, dimensions, and a conditional statement (found in the Appendices AQ-AS, AU-AZ, BB), in order to specify the general parameters of the theory.

Control.

The last criteria suggested by Glaser and Strauss (1967) to ensure quality is control. Control refers to a principle stating if the hypotheses proposing relationships amongst concepts are systematically derived from actual data, then later the theory can be used to initiate real-world action. Whether this grounded theory results in real-world action remains to be seen, however the discussion chapter outlines how the theory could be used by HCPs to challenge the status quo and think differently about the way in which self-harm prevention is currently conceptualised, and to initiate change collaboratively with individuals who are engaged in self-harm (see implications section in discussion chapter).

Ethical Considerations

This section explains the ethical procedures and considerations relevant to the present study. Ethical compliance began by a review of the study proposal by a panel of researchers from within the School of Environment, Education and Development at The University of Manchester. Following this, the study was reviewed through the National Research Ethics Committee procedures by Greater Manchester West, and ethical approval was obtained (see Appendix AP). Approval from MMHSCT was granted to approach trust departments. Local approval at research sites was gained from approaching service managers. The research followed ethical research requirements of The University of Manchester (2014), the Health
and Care Professions Council (2012), and the British Psychological Society (2010) when carrying out the research.

The ethical considerations pertinent to this study are discussed below.

**Research not therapeutic context.**

It was highlighted in the participant information sheet there were no potential physical risks for participants taking part in this study. However the questions asked during interview required the participants to reflect upon their experiences of interventions to prevent self-harm, which could be a considered a potential emotional subject. Care was taken to conduct the interviews in a sensitive manner using skills from the researcher’s counselling psychology training. At the time of conducting the interviews, the researcher had over 350 hours of therapeutic practice. Counselling skills such as empathic listening were employed whilst conducting research interviews to contain the participant and try and prevent them feeling overwhelmed by their experiences. However, the researcher was mindful to distinguish between the two environments, therapeutic and research. Participants were made aware from the outset of the research purpose through the participant information sheet.

**Informed consent.**

Whilst it was not anticipated participants would experience a high level of emotional distress, the researcher was aware some participants may have found talking about their experiences upsetting and at their current stage in life not be in an emotionally stable position to participate. HCPs were asked to use their professional judgement when approaching potential participants, as to whether they would be comfortable discussing interventions they have experienced to prevent self-harm. Potential participants actively contacted the researcher to register their interest and had a minimum of a two week period after receiving the
participant information sheet to decide whether they would like to take part. On the day of the interview the participants were asked checking questions to clarify their understanding of the research and written consent was obtained.

For the same reason, member checks were not part of the research procedure or ethical approval. It was thought that during the interview process participants’ safety could be contained by the researcher using the above protocol, however sending participants a transcript of their interviews could be potentially upsetting depending on their circumstances and emotional state at that point.

**Right to withdraw and further support.**

Participants were informed if they wished to stop at any point or preferred not to answer any questions, they were free to do so, and not participating or withdrawing from the research would not have any impact on their quality of care. In the event participants wished to make a complaint about any aspect of how they were treated at any stage of the research process, they were given details of the procedure through the information sheet which provided contact details for the research supervisor, the Research Governance Team at the University of Manchester, and the National Research Ethics Committee complaints procedure. Participants were encouraged to contact a named contact at the organisation if they required further support. The permission of the named contact had been sought prior to the interview. Participants were debriefed at the end of the interview and given a debriefing sheet (See Appendix AQ), which contained relevant contact details for additional support services in their local area.
Limits of confidentiality.

Participants were allocated an anonymous code and their data was fully encrypted and kept in line with Data Protection Act 1998. They were notified the results of the study may be published however their involvement would not be identifiable. They were informed (through the information sheet and face to face meeting) that confidentiality would only be breached if it was felt by the researcher they were at serious risk of harming themselves or another person. A protocol was in place in the event of any such occurrence. This involved immediately seeking advice from the research supervisor and named contact at the organisation, and appropriate action would have been taken. Any immediate danger would have involved emergency services or the crisis response team. Participants were aware they would be informed of any decision to breach confidentiality. This provision was not required during any of the interviews.

Parental consent.

The research did not request parental consent from participants aged 16 and 17 years. Due to the nature of circumstances often surrounding individuals with BPD whereby parental physical and sexual abuse is common, and their relationships with family can be complex and destructive. Zanarini et al. (2000) reported 84% of people with BPD described experience of biparental neglect and emotional abuse before the age of 18. Therefore it was thought requesting parental consent may prevent participants taking part in the study, and it could be seen as unnecessarily restrictive to exclude views of individuals who would otherwise want to be heard. Approval was granted for participants aged 16 and 17 to self-consent by the National Ethics Research Committee. This proved not be needed as all participants were over 18 years of age.
Chapter Summary

This chapter has presented the methodology adopted in the present study. The ontological and epistemological positions have been presented through a critical realist and contextualist approach. The methods of gathering data through interviews were summarised and the rationale for the approach used was given. The study uses grounded theory to analyse the data, of which the history of the method and the procedure followed was described, and a detailed consideration of the implications of using grounded theory has been discussed. Finally the ethical issues relevant to this research have been outlined.
Chapter 4

Findings

Chapter Introduction

This chapter uses grounded theory to present the findings of the present study, which were generated through the process of undertaking interviews with individuals with BPD symptomatology, during which individuals discussed their perceptions of interventions to prevent self-harm.

As per a traditional grounded theory approach, the central story is outlined first as a narrative encompassing the general phenomenon (the perceptions of interventions to prevent self-harm) experienced by the participants. The central story explains how the various categories link together and the axial processes between categories. This is followed by a visual depiction of the central story (referred to as the overall paradigm) to illustrate these relationships between categories.

The grounded theory found one core-category *an alternative path to self-harm*, and two smaller sub-categories *established beliefs and causal factors* and *time-course of self-harm*. The chapter deviates slightly from the traditional method of presenting grounded theory, which is to present the core category first followed by sub-categories (Strauss & Corbin, 1990). In the present study the categories are described in the order in which they occur in time to help the reader flow through the process as told by the participants. This means the two sub-categories are presented first followed by the core-category.

It may be questioned why the sub-categories *established beliefs and causal factors* and *time-course of self-harm* are relevant given the research question concerns individuals’ perceptions of interventions to prevent self-harm. There are two reasons for this, firstly to
present the findings in accordance with grounded theory philosophy, whereby there is a
research question in mind but through applying an inductive approach, categories arising from
the data are considered relevant and significant to the area of interest, and therefore these
categories are included in the findings. In the present study these areas included participants’
prior experiences, reasons for self-harm, and level of emotional tension as influencing the
interventions they sought and how effective they were. Secondly, as Gunderson (2009) points
out without having an understanding of how an individual understands themselves, it is hard
to understand their reasons for self-harm. Similarly, without understanding the consequences
of using interventions it is hard to envisage whether they are likely to be adopted. Therefore
the broader context surrounding interventions to prevent self-harm is presented in the
grounded theory to enhance understanding of the overall process.

Throughout the chapter the text in italics refers to a category or sub-category.
Categories have been illustrated with quotations from participants to give vignettes of
individual’s experiences. However, not all categories have associated quotations, and the
categories and subcategories vary in size. The variations in category size and use of quotations
are deliberately presented in this form as this is indicative of how much a particular category
was discussed by participants, and possibly representative of its relative importance in the
participant’s mind to the topic. This is discussed further in the discussion chapter.

In quotations from the interview transcripts a number of full stops such as this ‘…’
identifies where superfluous text has been removed to improve the readability for the reader.
All personal identifiable information has been removed or changed to protect identity.
The Central Story: Exiting the Self-harm Cycle

The central story told below reflects the common experiences of those individuals who took part in the interviews. This is described in order to help the reader understand how the categories link together conceptually to form the overall theory.

Individuals have early life experiences with significant and trusted others which leads them to form opinions about other people and impact on how they view themselves. Individuals judge themselves critically having the greatest expectations of self. They consider themselves to contain no positive aspects, therefore they are unworthy of care and believe they should not express how they feel. This leads to automatic self-expression denial. At the same time they have strong needs to be met by others.

This juxtaposition of opposing forces, strong needs against a strong belief of self being worthy of having needs met, causes an internal struggle which remains dormant and is ignited by a trigger resulting in a build-up of emotions. The triggers are unique to the individual but often multiple factors collide to create an altered emotional state. This state varies among individuals, for some they feel dissociated, and others feel their emotions are on fast-forward, and there is a heightened sensitivity to surroundings. At this stage the urge to self-harm is building, but it is difficult to express to others. The need to self-harm can be interrupted at this stage by an intervention. If an intervention is not used the urge to self-harm will reach a peak where the ability to intervene disappears. The individual enters an unstoppable self-harm mind frame and self-harm occurs.

Self-harm has multiple purposes. Individuals describe how self-harm helps with this internal conflict by releasing a build-up of emotion or is a distraction to escape mental pain, and ultimately helps keep them together by changing how they are feeling. Self-harm causes a rapid emotional descent and there are negative consequences in the aftermath of self-harm.
An individual makes a decision to do things differently as the result of environmental, physiological or interactional change (a change spark event). This events create a new awareness of their situation, which leads to a reconsidering of self-harm and a recognition of self-agency. Motivation is required to start the alternative path to self-harm. At any point during the decision to do things differently there can be barriers to change which stop this from happening, then self-harm will result instead of an intervention.

If the individual decides to take an alternative path to self-harm the intervention needs to match the purpose for self-harm. Interventions that work involve expressing and communicating, being provided with knowledge, having a purpose, grounding, and finding others. For the intervention to be useful it has to fulfil temporal criteria of being instant, constant, and long term. There are negatives to accessing help, including unravelling being overwhelming, and handing over some control. The ending of help can result in feelings of rejection and abandonment.

If the overall experience of an intervention is evaluated negatively, individuals continue to self-harm. Self-harm becomes less when the individual evaluates the overall experience of an intervention positively, and builds up multiple interventions that work in a process of trial, error, and evaluation. Then individuals enter the sunset of self-harm where self-harm is infrequent, and there is a focus on maintaining changes and using their experiences to help others.

This central story explains the overall structure of the findings and acts as a framework from which the rest of the chapter goes into more depth into the individual categories. Figure 9 displays this central story visually (also known as the overall paradigm in a grounded theory) by demonstrating how the categories are related to one another.
Figure 9. The overall paradigm containing the main categories and their relationships
Established Beliefs and Casual Factors (Causal condition/Subcategory)

The category established beliefs and causal factors is one of the two main sub-categories of the grounded theory and refers to individuals’ prior beliefs and expectations leading to self-harm. It has seven sub-categories (level 1), six categories at level 2, and three categories at level 3. These are shown below in Table 3. Table 3 outlines the categories and sub-categories within this section.

Table 3. Category structure of established beliefs and causal factors

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-cATEGORIES (level 1)</th>
<th>Sub-categories (level 2)</th>
<th>Sub-categories (level 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Established beliefs and causal factors</td>
<td>Rollercoaster relationships</td>
<td>Greatest expectations of self</td>
<td>Distraction</td>
</tr>
<tr>
<td></td>
<td>Beliefs about others</td>
<td>Self contains no positive</td>
<td>Escape mental pain</td>
</tr>
<tr>
<td></td>
<td>Beliefs about self</td>
<td>Unworthy of care</td>
<td>Keeping me together</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Automatic self-expression denial</td>
<td></td>
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<tr>
<td></td>
<td>Needs to be met</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Internal struggle</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trigger</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The multiple purposes of self-harm</td>
<td>Self-harm to release the internal struggle</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Distraction</td>
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<td></td>
<td></td>
<td>Escape mental pain</td>
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<td></td>
<td></td>
<td>Keeping me together</td>
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<tr>
<td></td>
<td></td>
<td>Settle the struggle</td>
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</tbody>
</table>

In this section, as per a grounded theory approach, the relationships (axial processes) between sub-categories (level 1) are presented first. This is followed by the contents of each sub-category.

The overall structure found between sub-categories (level 1) indicates childhood experiences with significant others (rollercoaster relationships category) lead to beliefs about
others (beliefs about others category) and self (beliefs about self category). These beliefs result in the individual not feeling worthy of having their needs met. At the same time they also have a desire to have their needs met (needs to be met category). This internal struggle (internal struggle category) results in a build-up of emotion in the presence of a trigger (trigger category), and self-harm changes how the individual is feeling (the multiple purposes of self-harm category). This is demonstrated visually in Figure 10.

Figure 10. Visual representation of axial processes in the category established beliefs and causal factors
The categories within *established beliefs and causal factors* are now discussed in turn.

**Rollercoaster relationships (level 1).**

Individuals described relationships with significant others in their childhood and adolescence resulting in not being able to trust them consistently (see quotes below), or not feeling able to express how they were really feeling (Dawn and Paul).

Rebecca: My mum was an alcoholic as well, so I’ve grown up. It would be different, she’d either be really good and helpful and be a proper mum, or she wouldn’t be there, she’d be out drunk so always was up and down with my mum. So I’ve never really had a stable sort of upbringing. So it maybe stems from that.

Lisa: My family, well my mum lied to me for a while, well 22 years about my real dad, so when that all came out I had to deal with all of that, and that’s when you hate yourself, and why’s she lied to you, and if she’s lied to you, if your family can lie to you, that says it all doesn’t it? Cos you think your family you can trust and obviously if you can’t trust your family you can’t trust anyone.

**Beliefs about others (level 1).**

Individuals’ early life experiences formed their beliefs about others. Participants compared themselves to others and felt they were worthless. They believed others were not to be trusted, judged critically, and were unsupportive. Karen described how she could hear her husband’s voice in her head telling her she didn’t have real problems like other people. John talked about not feeling good enough to be able to talk to others who did not have mental
health problems. Rebecca stated feeling less than others resulted in withdrawing from interactions with others. A number of participants described situations where people had judged them negatively, and this subsequently impacted on being able to open up to others.

Some participants felt people around them found it hard to provide support because they did not understand mental health issues, were busy or had their own difficulties, found self-harm too distressing, or did not care. Karen, Amy, and Kimberly described how friends and family appeared to accept and ignore the self-harm when they were younger and up to the present day. For more information on the properties and dimensions of the beliefs about others category see Appendix AR.

Beliefs about self (level 1).

The beliefs about self category contains four sub-categories described in turn below. The specific properties and dimensions of the beliefs about self category can be found in Appendix AS. The analysis indicated when participants were engaged in a cycle of self-harm they described their beliefs about themselves to be fixed and life unlikely to change.

Greatest expectations of self (level 2).

Individuals who described being judged negatively by others often judged themselves negatively as well. They were extremely self-critical, having high unrealistic standards for themselves which they acknowledged they would not judge others by. Participants berated themselves for their feelings, thoughts, and reactions in situations. Kimberly expresses these thoughts below.

Kimberly: I think before growing up especially, I always felt I didn’t have a reason to be messed up like I was. I didn’t have a reason to feel the way I felt. There was a lot of guilt around it, there’s children starving in Africa, why do I
feel this way? I always compounded things and made myself feel more shitty, because it was bad enough that I felt the way I felt, but on top of it, I was like you don’t have a right to feel this way.

Participants felt like they needed to be strong and not allow others to see them struggling. Paul described how he felt he had to carry on and show the world he was coping. Kimberly, Nicola, and Janet were in helping occupations and felt they were not supposed to have mental health issues because they were meant to be the strong ones.

Janet: I’m an ambulance driver. I work in an environment where we deal with people with mental health issues all the time, so for me to admit that I’ve got my own mental health issues was just, I couldn’t, I didn’t feel comfortable in doing it.

*Self contains no positive (level 2).*

As a result of failing to meet their high standards, individuals perceived themselves to be worthless and contain no positive aspects, only negative ones, as described by Lisa and John.

Lisa: I don’t see positives in me and I know there is good and bad in people and maybe I have got good points, but I’ve always had my bad points pointed out to me not my good.

John: I feel like I’m a drain on society, that I’m worthless, that the world would be a better place if I wasn’t in it.

When confronted with positives about themselves Amy, Janet, and Dawn talked about dismissing them or not being able to believe in them fully (illustrated by Dawn below).
contrast to this, Paul felt he could access negative attributes about himself quickly and believe them without effort.

Dawn: So a positive list of things about myself I would hate. Cos it would feel like [pause] here are all the things that I should be all the time and right now I’m not any of them. And you know, or here are things that I have, this is what I could be, if I was less rubbish, or this list is a load of bollocks and it’s only because you don’t know me or I don’t know me, or whatever it is.

Unworthy of care (level 2).

Participants seemed to link having no positives about themselves and feeling worthless to being unworthy of care. Dawn and Paul talked about having no right to expect to get better and felt they were wasting HCPs time.

Paul: I’m not worthy of having help. No [sniff]. One thing I hate myself [pause]. Of what I have done. So much. Really really hate myself. I don’t like who I am.

And later ….

Paul: I’m taking up valuable time and they should be helping people who really need help. And not some idiot who thinks to cut himself. [long outtake of breath]

Automatic self-expression denial (level 2).

Participants described believing they were unworthy of care led to a difficulty in expressing their thoughts and emotions. Participants talked about blocking emotions, bottling them up, and gave explanations such as not wanting to feel emotions, not feeling able to
express emotions, and not knowing how to deal with emotions if they did express them. Rebecca described how sometimes when talking to people she felt unable to find words that accurately captured what she was thinking. Karen felt she was able to communicate verbally how she was feeling but not able to physically express any emotion. Sometimes as a result of feeling overwhelmed in situations Rebecca and Paul would shut down their emotions. They acknowledged this process, referred to as ‘running away’, intensified the problem.

**Needs to be met (level 1).**

Another sub-category (level 1) within *established beliefs and causal factors* category was needs to be met. Participants described needs to be fulfilled by others. These were the need to be validated and the need to be cared for. The need to be validated referred to seeking approval from others and any disapproval being intolerable. Participants tried to seek validation in different ways. John described experiences of being the teacher’s pet, Janet wanted excessive approval from her boss, by making an appointment with him to discuss an aspect of her personal life and asking for his blessing. Participants talked about how fleeting external validation is and how the process is tiring, constantly trying to work out what someone wants and trying to give it to them, and more effort is required to get the same validation again later.

Paul: And then five minutes later that feeling will have gone and I would then think that drawing is shit again and it doesn’t matter if I knew you or not. If you gave me that praise and validation [pause]. It’s brilliant [laugh]. But the problem is [pause] when people give you the validation and the praise you have to work extra hard to get that validation and praise from that same person, even harder. It takes more to do.
Participants also expressed the need to be cared for by others and how this was difficult to articulate, so they would do actions which resulted in care, as described by Rebecca.

Rebecca: I think I’ve took 26 overdoses just to get me in hospital. I take enough tablets so that it’s sort of life threatening, so I have to stay in hospital even though I don’t want to die. I like to have to be in hospital so I need to be looked after. It’s like I sort of need the care and the attention. And when I’m hospital in that sense it feels safe, I feel happy like I don’t have to deal with anything cos I’m really ill and people are caring for me.

**Internal struggle (level 1).**

Individuals highlighted that beliefs about others and themselves were incompatible with their strong needs to be met by others. This seemed to cause an internal conflict and a build-up of emotion which existed in the background of their lives like a dormant volcano. These emotions then seemed to be activated and intensified in the presence of a trigger.

**Trigger (level 1).**

Individuals talked about different triggers which activated the internal struggle and the emotional cascade, and a need to change how they were feeling through self-harm. Some of the triggers identified by the participants are listed below in Table 4. They are not intended to be exhaustive, but to illustrate there are many factors activating an internal struggle resulting in the need to self-harm. It is important to note most participants did not feel it was one single trigger causing the self-harm, but multiple factors colliding which created the build-up of emotion.
Table 4. Triggers for self-harm

<table>
<thead>
<tr>
<th>Triggers for self-harm</th>
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<tbody>
<tr>
<td>Depression and stress</td>
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<tr>
<td>Absorbing other’s negative emotions</td>
</tr>
<tr>
<td>Grief</td>
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<tr>
<td>Hormones</td>
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<tr>
<td>Haywire thinking</td>
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<tr>
<td>Black and white thinking</td>
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<tr>
<td>Imagining worst case scenarios</td>
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<tr>
<td>Focusing on uncontrollable events</td>
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<tr>
<td>Lack of self-care</td>
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<tr>
<td>Relationship breakdown</td>
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<tr>
<td>Arguments with others</td>
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<tr>
<td>Feeling let down by others</td>
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<tr>
<td>Expecting to be abandoned</td>
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<tr>
<td>Rejected by others</td>
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<tr>
<td>Toxic environment</td>
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<tr>
<td>Environmental irritant</td>
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<tr>
<td>Stressful sensory-overload</td>
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<tr>
<td>Traumatic incident</td>
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</table>

The multiple purposes of self-harm (level 1).

The final sub-category (level 1) within the established beliefs and causal factors category is the multiple purposes of self-harm. The multiple purposes of self-harm category contains two sub-categories (level 2) and three lower order categories (level 3). Properties and dimensions of the multiple purposes of self-harm can be found in Appendix AT. An overview of the multiple purposes of self-harm category is presented below, followed by an outline of the sub-categories.
Participants all used self-harm to change how they were feeling. Participants described how particular types of self-harm were used for different purposes. The type of self-harm often matched the trigger and the underlying belief. For example, Amy explained head banging was trying to rid herself of what someone had said about her, whereas smacking herself was anger directed at herself for believing the other person in the first place. In the extract below, Dawn describes how punching a wall grounded her, whereas cutting took her away from herself.

Dawn: I think sometimes it is, I think sometimes it is. I think if I punch a wall or something like that which happens kind of in an instant [clicks fingers] and then there is that sensation, like oo I do still have a body, because sometimes I can feel like it’s not really there anymore, or detached from it or whatever. But I think cutting is different and doesn’t usually do that, which I haven’t done for quite a long time. That's more kind of like, almost the opposite, it’s more like, it can’t be me because I couldn’t do it to me if it was me, so it’s this thing, and therefore the things that happened to it, didn’t happen to me they happened to this thing. So I think that's more distancing.

**Self-harm to release the internal struggle (level 2).**

Bearing in mind the form of self-harm had a connection to the trigger/s, self-harm was a temporary solution to the internal struggle. Participants talked about self-harm being a way to release this internal conflict in the following ways, as a distraction (level 3 category), to escape mental pain (level 3 category), to release built up emotions and keep themselves together (level 3 category).
Distraction (level 3).

Pain brought on through self-harm and the act of self-harm itself was seen as a distraction from thinking about other problems. To illustrate, Lisa felt rage to others she cared about and described how hitting herself had a lot less consequences than hitting others. A couple of participants talked about how the resulting damage to themselves was a distraction, as they had tasks to do to fix themselves, such as cleaning wounds and going to hospital.

Escape mental pain (level 3).

This category is related to distraction but was more fatalistic, it included serious self-harm where at least part of the intent was death bringing the end of pain. They saw death as a way to escape and be free. Karen who had an intense fear of others dying spoke about leaving people she cared about by dying, in order that she would not be the one left behind.

Keeping me together (level 3).

Self-harm was described by a number of participants as a way of holding them together. They talked about self-harm as a way of life, and how it had kept them alive by providing a way to release tension and upset. Dawn described self-harm as an insurance or a safety valve to prevent herself from suicide by putting her back in control. Nicola and Kimberly talked about the frustration of somebody thinking they were trying to kill themselves when they saw self-harm as life-saving.

Nicola: When I was self-harming I didn’t want to commit suicide, when I was younger it was relief, and then they were saying to me you are going to end up dead, and I was thinking you’re stupid, no I’m not.

In this category, self-harm was described as a way of releasing the internal struggle resulting from a conflict between beliefs and needs activated by a trigger. Sometimes self-
harm appeared to have another purpose, which seemed to be giving strength to one side of the struggle, supporting their beliefs or needs and thus also settling the conflict. This is discussed briefly in the following sub-category.

**Settle the struggle (level 2).**

Self-harm was described by two of the participants as a way of having needs met by sending a message to others. Karen described wanting a visible sign of self-harm for others to see, and Rebecca viewed serious self-harm as a way to obtain care from others. At other times participants felt self-harm reinforced their negative beliefs about themselves such as feeling like they should be punished, as described by John below.

John: I once prevented myself self-harming by smashing my phone. And I figured that, I mean it was an expensive thing to do, I wouldn’t care to repeat it, but marginally better than hurting myself…. damaging something I care about is also in itself a form of self-harm, because it’s depriving me of something that I want. And so, it’s another form of punishment. So I suppose it achieved the goal of the self-harm which was to punish myself, but in a way that wasn’t physically damaging to me.

Researcher: So in a way it was a lesser form perhaps of self-harm?

John: Depends how you look at it. I mean it hurt my wallet quite substantially. I then had to replace the mobile phone. And, but yeah, in a sense it was replacing one form of self-harm with another form of self-harm, but one which was less physically damaging.
This concludes the first sub-category of the grounded theory *established beliefs and causal factors*. The following section describes the process of self-harm unfolding over time.

**Time Course of Self-Harm (Intervening Condition/Subcategory)**

The category *time course of self-harm* is the second of the two main sub-categories in the overall grounded theory and refers to the process of self-harm. The time course of self-harm appeared critical to an individual’s ability to intervene and take an alternative path to self-harm. Where a participant was in the time course seemed to affect their ability to do things differently, and therefore it is the intervening condition in the overall paradigm. John emphasised the importance of the time-course of self-harm in the ability to intervene.

John: But at that point, at that trigger point, I don’t want to be stopped. And so any sort of self-help thing, about this is how you can avoid self-harming is kind of missing the point. ......It's a question of timing really, it's a question of realising that I have reached a dangerous point and making the decision to intervene in that before I reach the point of no return.

The *time course of self-harm* category has six sub-categories (level 1). These are shown in Table 5. Table 5 outlines the structure of sub-categories within this section.
As per a grounded theory approach the overall structure and relationships within this category are discussed first, followed by an outline of the sub-categories (level 1).

The overall structure found between sub-categories (level 1) suggest a trigger activates the internal struggle, and the individual experiences a build-up of emotion (emotion building category). This emotion rises steadily reaching a point at which the ability to intervene disappears (ability to stop self-harm disappears category) and an unstoppable self-harm mind-frame (unstoppable self-harm mind-frame category) takes over (intoxication of self-harm category). Once the individual has self-harmed they feel differently (peak emotion wave subsides category), but the aftermath of self-harm results in negative consequences (the aftermath of self-harm category). This process is presented visually in Figure 11.
Figure 11. Visual representation of axial processes in the category the time course of self-harm.
To describe this process excerpts from three participants’ discussions about the path of their self-harm are presented below. These excerpts are illustrated with sub-categories to show how the time-course described above seemed applicable to the different scenarios and individuals.

Janet: A lot of the time, a lot of the time, [pause] when the depression’s coming on (trigger category). [name of partner], my partner, picks up on it. But I don’t, I might indicate that I’m going downhill. [pause] but it’s like a sign, it’s like I’m going so far, and I’ll say to [name of partner] and then I’ll say, I’m not, I’m maybe not doing very well, (emotion building category) and then I’ll get to a point where I don’t really mention it (ability to stop self-harm disappears category), and then I start planning. [pause]. And I then, I shut off and then I’m planning because I’ve had enough, and then I don’t talk about it anymore (unstoppable self-harm mind-frame category)…. When I got to hospital, I just cried and cried and cried. And I slept for days (peak emotion wave subsides category).

John: Self-harm often feels like [pause], it feels like [drawing in air] a sort of steep slope and how can I, I’m trying to think an analogy, a good analogy for it, there is like an initiation (trigger category) and for the benefit of the recorder I am drawing a graph in the air which rises at first, reaches a plateau and descends rapidly. And there is an initial hump you have to get over, and if I can stop myself before I reach the top of that hump I can usually stop myself self-harming (emotion building category). If I haven’t managed to intervene in the process before the top of the hump (ability to stop self-harm disappears
category). Then there is nothing that will stop me self-harming. I just I’m completely unable to prevent it (unstoppable self-harm mind-frame category).

Amy: So it was kind of the different levels of the upset and the hurt you would feel, which would of kind of build-up but potentially build up quite quickly (emotion building category), and it’s at which, at which kind of point you would be able to either ground yourself or a point where it would kind of gone too far (ability to stop self-harm disappears category), whether you would then be hysterically crying, you know, reminiscing about all kind of things and the past, and yourself, and then depending on how far that second stage got would then trigger off the self-harm or not (unstoppable self-harm mind-frame category)….Once you’ve kind of gone through the moment and the emotion it does physically drain you (peak emotion wave subsides category).

The following section describes the time points in turn (sub-categories level 1) through discussion of emotional states and thought patterns. This provides the context in which individuals decide to use alternatives to self-harm, and accounts for some of the variation in whether interventions are successful.

**Emotion building (level 1).**

Triggers resulted in an undesirable emotional state which increased in intensity over time, but if caught early enough, by which individuals recognised they were in an emotional state which could lead to harming themselves, then they could intervene and prevent the self-harm. At this stage they might indicate to others they were struggling. Participants could have
very different emotional states, for some they felt fidgety or agitated (Amy and Rebecca) and others felt themselves to be distanced from the world (Janet, Sheila, and Dawn).

**Ability to stop self-harm disappears (level 1).**

At some point the emotion built to such a level that thoughts became crystallised and rigid, and the ability to intervene and stop self-harm disappeared. Individuals became incapacitated by emotion. Janet and Rebecca described how they became unable to concentrate or think logically. Sheila felt out of control, and Nicola could not communicate to others how she was feeling. Amy and Kimberly found they were unable to move location as it felt too risky.

Individuals described extreme emotional states, such as feeling like they had lots of different conflicting emotions which were on fast-forward, and not having enough time to process and understand how they were feeling. Individuals feeling like this described a heightened sensitivity to surroundings and others. Rebecca described how clothes would feel irritating, and being hyper aware of other’s negative perceptions of her. Other participants described feeling dissociated and largely unaware of their emotional state and surroundings. Dawn described finding herself in places and not being able to fully recall what had happened.

**Unstoppable self-harm mind-frame (level 1).**

All participants described how once the ability to stop self-harm disappeared they entered an unstoppable self-harm mind-frame. See table of quotations in Appendix AU. At this point self-harm was inevitable, they didn’t seek help from others, and described a process of progressively shutting down and planning the self-harm. A number of participants commented the peak emotional state tended to last around 20 minutes.
Intoxication of self-harm (level 1).

At some point the individual would self-harm. Participants described how the feeling of self-harm was intoxicating. It brought a tremendous release and participants described how in the moment they did not feel pain.

Paul: And it doesn’t. Nothing compares to the pain that you are feeling inside and you’ve felt like for ages, and you’ve tried to hold back, and then [pause] the blood starts to come up and you just watch it flow. It’s when you feel nothing, you’re just calm, it’s like you just don’t think about anything. It’s bliss. Your body is on [pause] hypersensitive to all your senses you can smell the blood, see it. [pause]. It’s just, it’s amazing what a simple act can do to your body [laugh]. It’s crazy.

Kimberly: And the only way I’ve been able to describe is, I would imagine it’s like a junkie shooting up for the first time, feels like that, how I can describe it. It’s, you’re in this, sort of, tense, stressed state where you feel like that you have no control over anything, and then as soon as I swipe the blade across and see the blood. It’s kind of like this rush of, just calmness and soothingness and I understand that most people don’t get that. Because most people don’t understand how [pause] slicing yourself open brings that relief. But for me that's what it does. And then I sort of go into like almost a catatonic state after I’ve done it.

Participants differed in the amount of perceived control they had over their self-harm. For some they had control over the act (Paul), and others felt they were powerless (Amy).
Paul: I think I do it on my arms. It’s more difficult during the summer because I can’t hide my arms [laugh]. So I’m very conscious of that as well, and that’s a big factor in me not doing it as much.

Amy: So the whole thing with the head hitting wasn’t a controllable thing, where I said, you know I will hit my arm instead because I can cover that bit.

Interventions were not viewed to be as effective and speedy as self-harm, and self-harm was seen by some participants as an addiction. Paul and Kimberly described being able to suppress the urge to self-harm for weeks at a time, but knowing inevitably they would self-harm again. Nicola felt she used things going wrong in her life as an excuse to self-harm.

**Peak emotion wave subsides (level 1).**

After self-harm participants calmed down and regained some control over their emotional state relatively quickly. Participants described feeling calm and quiet, or entering a catatonic state. Most participants described feeling completely drained and often participants went to their bed and fell asleep for extended periods of time.

**The aftermath of self-harm (level 1).**

Once the emotional state had subsided individuals experienced negative consequences associated with self-harm. They described fresh emotions arriving, such as guilt, shame, and embarrassment. Some participants chastised themselves for creating visible scars or damaging their body. When self-harm had progressed further than intended, participants had to take themselves, or be taken, to hospital. Participants had difficulty finding words to describe their self-harm to others, and as a result when others found out they withdrew from contact, or physically ran away.
Alternative Path to Self-Harm (Core-category)

Within the time-course of self-harm individuals could intervene in the initial stages when emotion is building, and make a decision to take an alternative path. This became the core category in the grounded theory, *an alternative path to self-harm*. This category refers to the circumstances surrounding an individual’s decision to look for alternatives to self-harm, the process they go through, and whether a shift towards future intervention use occurs. The *alternative path to self-harm* category has 6 sub-categories (level 1), 19 lower order categories (level 2), 28 sub-lower categories (level 3), and 6 low level categories (level 4). These are shown in Tables 6 and 7, which outline the categories and sub-categories within this section. The information has been split across the two tables for formatting purposes only, and should be read as pertaining to one overall category.
Table 6. Category structure of an alternative path to self-harm (part 1 of 2)

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-categories (level 1)</th>
<th>Sub-categories (level 2)</th>
<th>Sub-categories (level 3)</th>
<th>Sub-categories (level 4)</th>
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<tbody>
<tr>
<td>Alternative path to self-harm</td>
<td></td>
<td>Environmental change</td>
<td>Holiday</td>
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<td></td>
<td>Change of scene</td>
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<td></td>
<td>Sanctuary</td>
<td></td>
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<td></td>
<td></td>
<td>Physiological change</td>
<td>Hospital as final safe-keeper</td>
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<td></td>
<td></td>
<td>Interactional change</td>
<td>Outsider help</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Physicality</td>
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<td></td>
<td>Fostering belief</td>
<td></td>
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<td></td>
<td>Trusted secret knower</td>
<td></td>
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<td></td>
<td>Valued as a person</td>
<td>Asset stripping</td>
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<td></td>
<td></td>
<td></td>
<td>Caring attitude</td>
<td>Dismissive attitude</td>
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<td></td>
<td>Curious pacing stance</td>
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<td></td>
<td></td>
<td></td>
<td>Experienced other</td>
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<td></td>
<td></td>
<td>Awareness</td>
<td>Awareness of self-state</td>
<td></td>
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<td></td>
<td>Awareness of damage</td>
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<td></td>
<td></td>
<td>Embarrassment</td>
<td></td>
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<td></td>
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<td></td>
<td>Awareness of impact on others</td>
<td></td>
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<td></td>
<td>Awareness over time</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Decision to do things differently</td>
<td>Barrier to change - once bitten twice shy</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Reconsidering</td>
<td>Barrier to change - Keeping truth from others</td>
<td>Wearing a mask</td>
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<tr>
<td></td>
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<td>Recognition of self-agency</td>
<td>Barrier to change - No services</td>
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<td></td>
<td>Motivation</td>
<td>Barriers to change - The spiral trap</td>
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</tbody>
</table>
Table 7. Category structure of an alternative path to self-harm (part 2 of 2)

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-categories (level 1)</th>
<th>Sub-categories (level 2)</th>
<th>Sub-categories (level 3)</th>
<th>Sub-categories (level 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternative path to self-harm</td>
<td>Interventions that work</td>
<td>Matching interventions to purpose for self-harm</td>
<td>Consistent support</td>
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<tr>
<td></td>
<td></td>
<td>Expressing and communicating</td>
<td>Long term support</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Finding others</td>
<td>Instant support</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Having a purpose</td>
<td>Online support</td>
<td></td>
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<td></td>
<td></td>
<td>Provided with knowledge</td>
<td>Group therapy</td>
<td>Negative group experience</td>
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<tr>
<td></td>
<td></td>
<td>Grounding</td>
<td>Physical</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Sensual comfort</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Distancing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Negative aspects of seeking help</td>
<td>Unravelling is overwhelming</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Handing over control</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Ending of help creates feelings of rejection and abandonment</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Trial, error and evaluation</td>
<td>Multiple intervention synergy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The sunset of self-harm</td>
<td>Maintaining change</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Experiences for good</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In this section the relationships between level 1 and level 2 categories are discussed first of all, presenting the axial processes which link these categories together, which form the core-category. This is followed by a detailed description of each of the sub-categories with illustrated quotes from the participants.

The overall structure of the core-category indicates an individual experiences a change spark event (change spark category level 1), as a result of environmental (environmental change category level 2), physiological (physiological change through medication category level 2) or interactional change (interactional change category level 2). During this change spark event (decision to do things differently category level 1) there is a developing awareness of their situation (awareness category level 2), enabling them to reconsider previous habitual responses to coping with distress (reconsidering category level 2), individuals recognised their own agency (recognition of self-agency category level 2) and became motivated to act differently (motivation category level 2). They sought help and took part in interventions. Interventions that helped prevent or reduce future self-harm (interventions that work category level 1) contained one or more of the following attributes, finding others (finding other category level 2), grounding (grounding category level 2), providing knowledge (provided with knowledge category level 2), expressing and communicating (expressing and communicating category level 2), and having a purpose (having a purpose category level 2). For an intervention to be successful it had to match the purpose of the self-harm (matching interventions to purpose for self-harm category level 2), and fulfil temporal criteria of being instant, constant, and long-term. As a consequence of seeking help individuals found some aspects unhelpful (negative aspects of seeking help category level 1). They explained that unravelling is overwhelming (unravelling is overwhelming category level 2), the ending of
help reignited feelings of rejection and abandonment (*ending of help creates feelings of rejection and abandonment category level 2*), and handing over some control meant others focused on less important aspects or had their own agenda (*handing over control category level 2*). Individuals evaluated the intervention, in a process of trial, error, and evaluation which affected whether in the future they chose to self-harm or intervene (*trial, error and evaluation category level 1*). To consistently use alternative methods to self-harm, individuals had to have multiple layers of interventions to use in different circumstances (*multiple intervention synergy level 2*). When this occurred they moved onto a different path (*the sunset of self-harm category level 1*), maintained changes (*maintaining change category level 2*) and had a desire to use their experiences for good (*experiences for good category level 2*). The overall structure of core category is presented visually in Figure 12.
Figure 12. Diagram of the core category an alternative path to self-harm
The categories within the core-category, *an alternative path to self-harm* will now be described in turn.

**Change spark (causal condition level 1).**

The category *change spark* was a causal condition in the overall grounded theory resulting in an alternative process to self-harm. It had three sub-categories (level 2), *environmental change*, *physiological change through medication*, and *interactional change*.

**Environmental change (level 2).**

Environmental change referred to participants describing a new environment which was either enforced or voluntary, but felt safe and calming, and by which they experienced a shift in their thinking creating the possibility to do things differently. Specific properties and dimensions of environmental change can be found in Appendix AV. Participants discussed three scenarios (level 3 categories) creating this environment. These are outlined below.

**Holiday (level 3).**

Karen, Laura, and Amy all described that going on holiday put them on track for seeing a possibility of coping differently. Karen felt she always had to be doing things to exhaustion, and found she could relax and read on holiday. Laura struggled with looking after herself, and felt the structure of a full-board holiday helped her by allocating times for meals and activities. Amy was self-harming when drinking alcohol but felt unable to stop. She found going on holiday to a Muslim country where alcohol was not readily available helped her to realise she could go without drinking.

**Change of scene (level 3).**

For some participants a new environment was the change spark even when it was enforced. Participants could recognise at the time they were reluctant or even resistant to the
change but it marked the start of a path away from self-harm. Nicola talked about leaving her mum’s house and going to live with other family members. John talked about getting out of an abusive relationship by obtaining government funded housing.

Sanctuary (level 3).

A sanctuary was described by a number of participants as the turning point in their thinking. There were two aspects to a sanctuary, individuals described a safe space to go in a crisis (level 4), and hospitalisation being a final safe-keeper (level 4). The two categories overlap but there are important distinctions which is why they will be presented separately below.

Safe place to go in a crisis (level 4).

Individual described a safe place to go in a crisis as having certain attributes which are detailed in Table 8 below.
Table 8. Attributes of a safe place

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treated as a guest rather than a patient</td>
<td>Created a different more equal dynamic with the staff</td>
</tr>
<tr>
<td>A known entity</td>
<td>Knowing beforehand what would happen when they were there reduced nervousness as a barrier to entry, potentially leading to accessing a service earlier in a crisis</td>
</tr>
<tr>
<td>Relaxing atmosphere involving listening, talking and sharing with both HCPs and other service users</td>
<td>Created by only having small numbers of others, and thinking about the fit between service users</td>
</tr>
<tr>
<td>Available overnight</td>
<td>Nights found to be a particularly vulnerable time</td>
</tr>
<tr>
<td>Provides good basics for eating and sleeping</td>
<td>Difficultly caring for themselves when distressed</td>
</tr>
<tr>
<td>Prepares for the ending of the stay by making plans for afterwards</td>
<td>Help continue progress afterwards</td>
</tr>
</tbody>
</table>

Dawn described many of these characteristics in her visit to a safe place, and explains below how it helped her to feel differently.

Dawn: Probably that was the key thing in my recovery, was I had a point in which [pause] I had a stay in a place called [name of organisation], which is sanctuary for people in a suicidal crisis, where you go for four nights to a lovely house and you get to talk to people. And I came out of there not fixed but with the, a little seed of the idea that I had, that it was okay to expect that things might turn out okay? So I just, from there I started to recover I think, not that things didn’t get very bad from there and all that kind of stuff, but I became motivated for things to be better.
Hospital as a final safe-keeper (level 4). Participants described good and bad experiences of being in hospital. It was viewed as a last resort and most often succeeded in keeping them safe.

Dawn: I understand that for some people it's the thing that keeps them safe and there has been times definitely where it has stopped me from dying. You know and 48 hours later, I’m ready to start saying when can I get out of here? Erm, so sometimes it's the only option. But it's a pretty rubbish option.

In a crisis participants felt it was helpful when hospital provided an environment to escape from the world, rest, and sleep (Janet, Rebecca, and Dawn). In this crisis participants described how it was often important for HCPs to follow safety protocols, as they would look for items to harm themselves with. However, for many participants hospitalisation had strong negative attributes which affected its ability to help. Janet, Kimberly, Lisa, and Dawn felt it was helpful in a crisis but felt it was unhelpful in the long-term, and could actually make situations worse. Individuals noted the paradox of a hospital environment is that the key ingredients for nurturing someone who is fragile are often absent. They gave examples such as a lack of nourishing food, no opportunity for quality sleep, due to constant observation, and a tense environment due to hostile others, where other patients can behave unpredictably due to their mental states and medications. These situations enhanced feeling alone and vulnerable and could lead to further self-harm.

Physiological change through medication (level 2). Participants felt medication could be the ignition promoting a change away from self-harm when the communication with their medicator was open, they were prescribed a dose and type of medication which was felt to be at a correct level to alleviate symptoms, and they
were monitored for side effects. Specific properties and dimensions of physiological change through medication can be found in Appendix AX.

Janet and Dawn described the importance of the correct dose of medication. Low doses could help with residual problems such as stress and depression, and ‘big gun’ medication could help when they were feeling very low, or struggling to sleep, and wanting to harm themselves. Medication had to be monitored for side effects, for example Janet described large doses clouding her ability to think and speak, which was frightening for her. Participants were concerned about whether medication was addictive and if there would be long-term health consequences. Participants felt more comfortable taking medication when they had established an honest and equal relationship with their General Practitioner [GP]. If these conditions were met medication could be the catalyst for change, Sheila described how years of therapy felt ineffectual until she took a new medication which worked for her, and Nicola described how medication helped put her on a new track.

Nicola: Like I was getting, like about an hour or two if that. Errm, I wasn’t eating, like there were times when I weren’t eating and I was just really low, and I started mirtazapine and instantly started sleeping, started eating like a horse, and I think cos I was eating, sleeping, like my mood lifted a bit. Because I was that exhausted and it really did help

Researcher: So it was a turning point?

Nicola: Yeah I just needed that little lift, and then, so I could just pick myself up from where I was, it was giving me a little lift, so I could help myself almost.
Rebecca and Paul stopped taking their medication as they did not feel it was having any effect, and subsequently realised how much it was helping them to feel more balanced. Janet, Amy, and Laura described how the medication worked to promote change. They felt it did not make problems go away, but by taking the edge off emotional affect, medication made situations feel more manageable. Medication was seen by all participants as not a solution to self-harm.

**Interactional change (level 2).**

Interactional change described interactions with others which helped participants see their situations differently. The specific properties and dimensions of *interactional change* category can be found in Appendix AY. Participants discussed eight elements of positive interactions with others (level 3 categories), creating the possibility of change. These are outlined below, alongside any corresponding negative attributes (level 4 categories) making participants feel worse and contributing to their sense of feeling stuck in a cycle of self-harm.

**Outsider help (level 3).**

Participants spoke about an outsider helping them to seek help or see things differently. This individual could be their GP, therapist, or even a family member, as long as they were not directly related to the situation causing the need to self-harm. They felt an outsider could help them see the situation differently by picking apart the problem without being invested in the outcome.

**Physicality (level 3).**

Dawn, Kimberly, and John talked about the importance of someone physically being present with them rather than on the phone, or computerised therapy, or self-help.
John: I keep getting referred to self-help services and internet based CBT and DBT, and I really have a problem with that. Because I have extremely low levels of self-esteem, and feelings of self-worth. I feel like I’m a drain on society, that I’m worthless, that the world would be a better place if I wasn’t in it. And so on. And to an extent if I go to a therapist, and the therapist makes clear to me the positive aspects of my life and how the world is enriched by me being in it. I can start to believe them, and start to challenge my thoughts of worthlessness. Doing it myself on the internet, and the internet made me, tells me, to challenge these ideas, but I can’t, because when I say it I know I’m lying! And I know I can’t trust these thoughts in the way that I can if they are coming from somebody else.

*Fostering belief (level 3).*

A physical presence was only helpful if the other person saw positive attributes in the participant, especially if they could not see these attributes themselves. Another person’s belief seemed to give them some fuel and motivation to challenge their automatic response to self-harm. Amy looked at a letter written by her college head teacher about her positive character and achievements, and Paul laughed whilst talking about negotiations with his therapist over his positives.

*Trusted secret knower (level 3).*

A number of participants talked about the paramount importance of trusting the other individual, and conversations being confidential. There was a lack of progress when the participant distrusted the other person. Laura, Kimberly, and Dawn talked about therapy in
adolescence and in their experience it was not a confidential setting, and therefore they played mental games with therapists and remained trapped in existing thought patterns.

*Valued as a person (level 3).*

Participants described experiences with others where they were acknowledged as being more than their self-harm. This enhanced their self-worth and helped foster a relationship which could enable change.

*Asset stripping (level 4).*

In contrast to being seen as an individual, participants talked about a process of asset stripping that occurred when they sought help which reduced the likelihood of change. Dawn described this as removal of your personality and anything that makes you ‘you’, and becoming a ball of risk to be managed. Kimberly described a similar feeling of being depersonalised by explaining she felt everyone who self-harms is ‘painted with one big brush’, which did not fit with her experiences of herself and others, who all had different reasons and behaviours for self-harm. Connected to this was the importance of the other person acknowledging their unique methods of coping before considering any change. When participants were asset-stripped and given impersonal advice they felt frustrated and distanced from others. Paul, Nicola, Sheila, and Amy described how being given generic advice rather than being treated as an individual made them feel like they had not been understood, and they felt more hopeless and this perpetuated the wish to self-harm.

Dawn: Somebody making a suggestion that’s, that glib, then there’s that time that you really haven’t got the magnitude of what’s taken me to that point.

Researcher: It’s almost taken you further away from that person?
Dawn: Well you just think, well you haven’t got a fucking clue have you? It’s bloody ridiculous. It would immediately just make me feel partly belittled and not heard, and not, you know, that kind of stuff. And it would probably make me think that person doesn’t have a clue what they are talking about.

*Caring attitude (level 3).*

Asset stripping and impersonal advice made participants feel others did not care about them and reduced likelihood of seeking help. Participants talked about little gestures of help making a big difference at times leading up to self-harm, because they were feeling more sensitive and vulnerable. John explained he was empowered by friends on the internet trying to talk him out of risky behaviours and improve his mood because it meant someone cared about him. Lisa talked about her experiences of therapy and how they had helped to reduce self-harm. She felt the single difference between helpful and unhelpful therapy had been when she felt the counsellor had cared about her.

*Dismissive attitude (level 4).*

Participants talked about others making them feel worse than they originally felt by dismissing them. Participants experienced events where others did not take them seriously and treated them as an inconvenience, when this happened participants closed down and did not seek further help. Amy and Kimberly discuss their experiences below.

Amy: Yeah, her telephone manner when she heard me upset. There was a key word that she’d said, that made me think you don’t, you’ve got no idea the position that I’m in right now, and when I’d quickly said, you know, really sorry to bother you and I put the phone down.
Kimberly: Some nurses have basically said you are wasting a bed. Basically. Um, so it's the way they talk to you, it's the way they look at you, the way they physically treat you when they are taking your blood pressure, taking your blood. It's not hard to tell that they, they think you are wasting their time. Basically. Which I can appreciate because obviously I work in the NHS now, and I know how many sick people are out there. And the demands and beds and stuff, but I also think it’s also a really shitty approach to take because for somebody who’s just done that to themselves the last thing they need to feel is like they are wasting space.

Karen talked about trying to seek help and being rejected.

Karen: And she came out and she said we’re not going to offer you a place, and I’d been told that they rarely turn anybody down and that was it then, I just thought like jumping off the nearest bridge.

And then later how this reinforced her beliefs about herself.

Karen: It's the medical side, that's not, because they just want, they want to treat people there that have had serious accidents, and all the people that are there through no fault of their own, whereas time wasters like myself that have taken overdoses or cut their arms or whatever. They have done that to themselves and we’re not worthy of the same attention.

Janet felt staff did not care about how she would manage outside the hospital and repeatedly called her by her partner’s name, and as a consequence she felt she could not tell
staff her plan to harm herself again. Paul felt he saw so many different people and recounted his story numerous times that therefore no one really cared, and resulted in him feeling worse.

Curious pacing stance (level 3).

Participants described their attitude towards self-harm shifting when others gently enquired about their situation through exploring, and presumed not to know what the participant was feeling, and they felt others genuinely wanted to understand. Laura talked about the importance of others owning up to what they did not understand. Janet explained her partner does a lot of research into self-harm, and therefore she felt like the two of them were working through it together.

Going at the pace of the participant was key in combination with a curious stance above. Paul, Amy, and Dawn described interactions where the other person was going at their pace which marked the start of finding other ways to cope apart from self-harm. When the pacing felt too slow, participants tended to get frustrated and annoyed with themselves for their lack of progress, but going too fast led to participants retreating from the other as they felt pressure to change before they were ready. Dawn explained how she and the therapist spent a couple years just playing with ideas until she was ready to think differently.

Dawn: But not really, and she wasn’t attached to me stopping self-harming at all, which was brilliant as well, she didn’t kind of, there wasn’t oh you must not! There was no pressure or contracts or anything like that. So it was just two years of exploring how it fitted in to my life, and then it had got to a point where it really was a problem and so that eventually, you know, we kind of crossed a bridge, oh actually it’s all a mess. And then we started doing therapy properly [laugh].
Researcher: And it sounded like it was helpful that she didn’t put those constraints on?

Dawn: Oh so helpful, yeah. I’d would have gone after 6 weeks if she had put any constraints on me. Or I would have turned up every week and gone everything’s fine! Everything’s fine! No I haven’t done anything this week, it’s all fine! So the fact that she was just curious was perfect.

Experienced other (level 3).
A couple of participants highlighted another person’s level of experience made a difference in whether they were able to make changes. John felt therapists should have a strong theoretical foundation in a therapeutic model, and then deviate from this as required by the needs of the individual. Kimberly explained from her experiences with HCPs they did not understand self-harm, and therefore they tend to avoid it. She felt the more experience and training given on self-harm the more potential for improved help. Paul felt that inexperienced and newly qualified HCPs get overwhelmed by self-harm, and this leads to him feeling like his problems are too big to solve.

Decision to do things differently (context level 1).
The decision to do things differently category formed the context within the overall grounded theory and refers to the cognitive process resulting in seeking interventions. The specific properties and dimensions of this category can be found at Appendix AZ. This category has four sub-categories (level 2) awareness, reconsidering, recognition of self-agency, and motivation, and nine level 3 categories. In the following section each sub-category is discussed alongside any potential barriers which prevented change from taking place.
Awareness (level 2).

Participants described developing a number of different types of awareness. These were an awareness of repeating self-destructive patterns, why they were self-harming, an awareness of their emotional state and when it was escalating, awareness of the impact self-harm was having on others, awareness of the damage they were doing to themselves, an awareness of wider systems in which they were operating, and an awareness of context when they looked back over time.

Awareness of self-state (level 3).

Kimberly felt a deeper understanding of why she self-harmed helped to bridge the gap between being consciously aware she was getting towards self-harm, and being out of control and beyond reasoning. Amy, Kimberly, and John explained that becoming aware of their emotional state escalating meant there was an opportunity to choose how to respond. When participants lacked awareness of their self-state they described a process of unintentional self-harm, where there was no opportunity to intervene as self-harm ‘just happened’.

Awareness of damage (level 3).

Some of the participants became aware of the damage they were doing to themselves and the possibility of death. They decided the situation was serious, and action had to be taken to do things differently. Nicola described it as a ‘wake-up call’.

Nicola: I literally like woke up one morning and I was, just don’t know what happened, I was just clearer headed and I was just like, what am I doing, and I just felt like if I didn’t stop and change I would end up dead.
Embarrassment (level 3).
Amy and Nicola described how they became aware of others seeing their self-harm and felt incredibly embarrassed. Nicola for being sectioned, and Amy for the damage she had done to her face. This embarrassment pushed them to find another way to cope.

Awareness of impact on others. (level 3)
Participants described a developing awareness of the impact of their behaviour on others they cared about, often this was precipitated by another person disclosing the effect they were having on them, and asking them to get help. Nicola described not seeing the impact she was having on others meant she did not see the need for change. She explained this changed through family therapy.

Nicola: It really shocked me. It really made me look at myself because it was tearing my family apart, and there was other things going on in the family, and it was, I didn’t really realise, I’d kinda was the centre of attention. They didn’t need that, so it helped, family counselling.

Participants became aware if they did not find other ways of coping then others would leave them. A strong incentive to do things differently was the impact on children. Karen and Paul talked about not wanting their children to see their self-harm. Nicola wanted to make sure her younger sibling did not witness it, and Rebecca prevented self-harm because of its potential impact on her unborn child.

Rebecca: Yeah, and the only reason I’ve not self-harmed is because I’m pregnant. And then I’m paranoid if something happened to the baby or, being able to cope with that sort of emotional feeling or stuff.
Later…..

Rebecca: Cos I was really struggling that bad, it was the first thing I’ve ever tried, but I thought I need to speak to someone before I hurt myself, and I’d normally just prefer to hurt myself, but because I’m pregnant it was like the only thing I could think of, like the last resort.

*Awareness over time (level 3).*

Nicola, Rebecca, and Kimberly felt looking back on difficult situations months or years later gave them an insight into their current circumstances. Sheila and Lisa emphasised they could not have reached an understanding of their self-harm sooner, and time was needed to gain a different perspective.

*Reconsidering (level 2).*

In the second sub-category of decision to do things differently category, participants questioned their habitual self-harm coping response, and reconsidered previous automatic rejections of help. Paul realised he did not want to use the crisis team anymore and started to reconsider the interventions he engaged in. He realised he did not actually believe they would work, and therefore he would have to find new forms of help. Nicola was using harm reduction techniques to manage self-harm, which lost impact or eventually snowballed into forms of self-harm. She explained she was not looking at the reasons why she was self-harming and decided to take therapy seriously. Sheila realised she was not going to get out of hospital, and things would remain the same unless she started engaging in some help, so she started exercising and attending group and art therapy.

Participants reconsidered their circumstances because old coping mechanisms lost effectiveness, or they reconsidered the value of their own life, or simply ran out of other...
options. Nicola, Dawn, and Amy reconsidered their own life after reading letters from others about them or after losing someone. Laura and Amy felt they had run out of options. Laura thought guided meditation sounded rubbish, but when she had not slept for a number of nights and could not think of any other options, she tried it and was surprised to find it helped. Amy reconsidered her previous rejection of medication.

Amy: You know I’m not coping, errrm, and so therefore you know I am holding my hands up, again at this point, kind of holding my hands up, which has taken me a lot to be able to do that, to be able to say, yeah okay you know prescribe 10mg, give me the lowest dose of what you can, just to see if this is going to help me. Because at this point you know my options are, don’t feel, I don’t feel I have any options.

This process of reconsidering was on-going and occurred even during interviews as the following extract demonstrates.

Janet: I think group therapy I’ve always immediately turned my nose up and said no [pause].

Researcher: Is there a particular thought that sticks in your mind of what it would be like?

Janet: I think images on television that I’ve just seen and just thought it’s not for me. But now I’m reconsidering.

Researcher: Mmm
Janet: I have to give it some thought. [laugh] [pause] No it’s okay, I’m open to group therapy. You’ve changed my mind on that one [laugh].

*Barrier to change - once bitten twice shy (level 3).*

Individuals were reluctant to take an alternative path to self-harm when they had previous negative experiences of seeking an intervention. Dawn explained the impact of previous unhelpful interventions.

Dawn: And the consequence of that, is when people have had the intervention that was in the NICE guideline, and they didn’t get fixed, that they are even more broken, or they are wrong, or they are difficult or they are whatever.

Individuals described experiences of being silenced, not being taken seriously, and others breaking their trust. These experiences seem to reconfirm their beliefs about themselves and others, such as others judging them negatively or feeling less than others. These negative experiences occurred in a variety of settings, psychotherapy, group therapy, with psychiatrists, helplines, charities, and hospitals. John explained how being previously silenced in group therapy acted as a barrier to him currently participating, and altered its effectiveness for change. Rebecca felt unable to ask for help and she struggled to leave the house when she was upset, and therefore she felt like the only option was to take an overdose to get help. In the extract below she explains why she feels unable to contact services.

Rebecca: I’m never comfortable ringing helplines just through one experience that I did have. Was when I was in [name of hospital] and somebody rang, errm, the crisis line and I was on the [name of unit] and I heard them laughing, saying oh its them again, so since then I’ve never felt comfortable
to ring in case it was just like one of, they were just like, oh it’s her again or not taking it serious sort of thing.

**Recognition of self-agency (level 2).**

In the third sub-category within *decision to do things differently* category, individuals recognised they had a role in preventing self-harm, where previously they had felt powerless. Nicola realised she had to change her ways of coping and her situation. Kimberly came out of a period of several life threatening suicide attempts realising only she could improve her life. Paul described realising he had to seek help rather than expecting it to happen, and described it as the hardest thing he ever did.

**Barrier to change - keeping truth from others (level 3).**

An important element of recognition of the problem seemed to be disclosing their difficulties to others. Individuals censored themselves and decided not to ask for help, even though they knew they needed it.

**Barrier to change - wearing a mask (level 4).**

Nicola, Rebecca, Paul, and John all felt they put on a mask with other people to portray they were coping or shut others out. This prevented them asking for help or sharing the truth with others.

John: I use my drama training to appear more confident and outgoing than I actually am. I call it my mask. It’s something that I hide behind. I’m using it right now.

Paul: For me to portray those answers to other people is very difficult for me. [pause] I have, like I have a mask, and I wear a mask… They would just see
me how I’m sitting here now, if you see me sitting here now you’d think I was alright.

Nicola: I almost put on a different person when I was out. Like I wasn’t the same person when I was at work, like I could put on someone totally different, almost like a different person.

Participants kept the truth from others because, similar to the aforementioned once-bitten twice shy category, their previously held beliefs about others were activated and not challenged. They gave explanations for keeping the truth from others such as not wanting others to worry, feeling others would not understand, or feeling others would leave because they would see the real them.

Laura: It’s not something people want to talk about, and it’s not something you can just pick up the phone and say this is what I’m going through, people just don’t want to hear about it, and sometimes if you’ve not spoken to someone for a while, it’s all the breaking the ice stuff first and it’s difficult. And sometimes you ring people up and they just want to talk about their problems.

Sheila: I wouldn’t want to tell friends, surprisingly I have a good friend network. Because when the shit really got bad in 2007, I scared them to death. I wouldn’t want to do that again.

*Barrier to change - no services (level 3).*

When individuals looked for an alternative route to self-harm some participants described not being able to access services for a variety of reasons. Dawn and Paul lived in
rural areas without any nearby services. Karen and Laura lived in cities, and were turned away from support because services reported they were too busy.

Motivation (level 2).

Even with awareness, a reconsidering of their present circumstances, and recognition of their own agency, participants still did not proceed with an alternative path to self-harm without motivation. Motivation is the final sub-category within the decision to do things differently category. Participants described having willpower (Nicola), finally being motivated for things to get better (Lisa), or forcing themselves to break a pattern. Kimberly explained her motivation helped her away from self-harm when previously she had been pushed into change by others.

Kimberly: Yeah definitely it was me entirely. Pushing it, and wanting it and I think that's the big difference, is it was finally myself that wanted it and it was finally you know because it was me, and it was 100% me that wanted it. I think that's what’s made it easy. I think when you are a teenager and you feel like you have to do it. You’re not really going to engage because you're a teenager and I was always a teenager. So that thing that's enforced on you, this official thing. You’re not going to want to be a part of it. Whereas as an adult I chose it. I think that’s what made it different.

Barrier to change - the spiral trap (level 3).

Individuals lacked motivation for an alternative path for a number of reasons. They perceived themselves to be trapped in a spiral where they felt hopeless. Karen felt change involved risk and she was scared of the unknown. A couple of participants named alcohol as a change-resistor, which kept Nicola, Amy, and Dawn from doing things differently.
Dawn: Yeah there was tumbling down, there was an initial self-harming one, and then I came to a point where I realised I couldn’t stop self-harming unless I stopped drinking, because I was self-harming when I was drunk basically. So there was no, I couldn’t drink without ending up in a mess and in hospital.

This concludes the decision to do things differently category comprising the cognitive processes which result in seeking interventions. The next category focuses on interventions participants found helped them to prevent self-harm.

**Interventions that work (action strategies level 1).**

Interventions that work is the largest sub-category within the core category an alternative path to self-harm, and refers to interventions participants found helpful in reducing their need to self-harm, or as an alternative to self-harm. These interventions formed the action strategies in the overall grounded theory. This category features six sub-categories (level 2) and eight lower-order categories (level 3). Specific properties and dimensions of interventions that work category can be found in Appendix BA. This section first presents the general properties of helpful interventions, through a discussion of the need to match interventions to the purpose of the self-harm, and then describes specific interventions found to be helpful.

**Matching interventions to the purpose for self-harm (level 2).**

A fundamental tenant of interventions that work was the necessity for the intervention to match the underlying purpose for self-harm. To explain this further, the intervention had to bring about a change in emotional state in the same way the self-harm would, helping them calm down or letting them express anger, for that individual. For example, Rebecca explained the purpose of self-harm was to extract care from others, therefore an intervention had to also
obtain care from others for it to be effective, e.g. a technique involving interactions with others such as therapy, and not self-help. If an intervention did not match the purpose for self-harm, the intervention could actually exacerbate the problem. Dawn explained others not really understanding how she enters a hypnotic state before self-harm has meant mindfulness, meditation, and breathing exercises have caused further harm in the past. Kimberly described how cutting provides a release for anger, which she has now learnt she can release by balling herself up, smacking the floor and keeping her hands busy, and later rocking herself to bring about a calm state. As a result she does not need to cut. She explained if she was given options sooner which matched her need for self-harm she would have stopped self-harm a lot earlier.

Music can be used to illustrate an intervention working differently for participants, depending on their emotional state and purpose of self-harm. Laura found happy music and Kimberly found angry music helpful in preventing self-harm. Whereas Sheila could not listen to music at all when distressed. John and Dawn found the effects of music to be variable, sometimes helpful and at other times making a situation worse. Janet and Amy stated there was a delicate musical balance. Janet found sad music made her feel worse, upbeat music made her feel better, and too upbeat music made her feel agitated. Amy found sad music helped her to discharge emotion, and happy music made her feel worse by reminding her of happier times, and the stark contrast between then and now. These differences in the way participants viewed music demonstrates the variation in participants’ perceptions of all interventions. Different interventions worked for different people, and participants stressed any strategy should be fluid and adaptable over time. As well as the need to match an intervention to the purpose of self-harm, any helpful intervention incorporated three temporal
elements (level 3 categories); consistent, long-term, and instant support. These elements are discussed in more detail below.

*Consistent support (level 3).*

For an intervention to be successful it had to be regular and consistent, for example achieving the purpose to which it was intended and not missing scheduled appointments. Participants explained this helped them to build up trust in the support. When support was limited, by only being available at certain hours of the day, or provided for a set number of weeks, or was inconsistent, participants felt dependent but angry and resistant to change, and reported dropping in and out of services without any progress.

*Long-term support (level 3).*

The process of finding and testing interventions took a long time, and participants felt longer term support had the potential to create the most impact. Paul felt he started to feel a change in therapy after six months, and Dawn felt change began after two years. Lisa and Rebecca felt on-going therapy, as a place to examine their thoughts and feelings privately, would make a big difference for them by keeping them in a steady state. Participants described when they received follow-up care by a known individual, this motivated them to keep on an alternative path to self-harm. This follow up care did not need to be regular, Lisa and Rebecca described having four appointments spread across a year being helpful after an initial period of intensive support.

When an intervention was not long-term, individuals described feeling left and concerned about what to do next, for example Karen described getting used to therapy when it felt suddenly over which demotivated her. Laura described going to A&E when suicidal and being prescribed a relaxant drug, and worrying about what to do when it wore off.
Instant support (level 3).

Instant support was important due to the trajectory of emotional escalation leading to self-harm (see time-course of self-harm section). If support was not instant, emotion would rise above the level where an intervention was possible, and individuals would enter the unstoppable self-harm mind-frame. John described using Facebook to obtain validation from others, but a delay in replies from others could be too late to stop him self-harming. Participants described many instances of attempting to access support taking months and years. During this waiting process they felt stuck and continued self-harm. Lisa highlighted the importance of instant support.

Lisa: So to me, like I say, if you broke your foot, you don't wait three months to get it sorted out, you get it seen to straight away. You don’t when you’ve got mental issues you wait, and you wait and you wait.

If support was not instant it potentially made individuals feel worse and self-harm more likely.

John: I think if you are in crisis and you ask for help that help has to be immediate, or you have to feel that you have been listened to. Fairly immediately. Or in my case it will make me worse. Because it feels like a rejection.

This immediate support had the potential to prevent self-harm. Individuals described instant sources of support which helped them take an alternative path, such as phoning the Samaritans. Participants explained although it might seem impractical it was important some form of support was available 24 hours a day. Participants described knowing support was
instantly available often helped, even if they did not end up accessing it. John described how knowing an ambulance was on its way calmed him and meant he was not in a self-harming place when it arrived. Sheila, Amy, and Janet described keeping numbers on their phones on speed-dial but not feeling the need to call them.

Amy: That it’s there and that's what it’s there for. Particularly for me and the circumstances that I have been in before, knowing that, that was there, was a comfort, and making sure that I’ve put that number in my phone, just for, just in case. I’ve never used it but just knowing.

This concludes the section looking at general features of interventions that were found to be helpful to prevent self-harm. The next section looks at specific interventions indicated by participants to prevent self-harm. The grounded theory found five interventions (level 2 categories) that were helpful in this regard; expressing and communicating, finding others, having a purpose, provided with knowledge, and grounding. These are discussed below.

Expressing and communicating (level 2).

Expressing and communicating emotions seemed to release an emotional build up and reduce the need to self-harm. Participants described becoming aware of their feelings, allowing themselves to feel them, naming them, exploring them, and being allowed to express them formed a new way of coping. Expressing and communicating took place in a variety of environments. Therapy was reported by most participants as a place where they could learn to express and communicate their emotions. They described the importance of regular contact and a strong therapeutic relationship where they could be honest. When these conditions were met, therapy formed a safety net as a place to manage emotional tension. Nicola, Amy, and
Kimberly found therapy helped them to recognise their emotional states and gave themselves permission to express themselves.

Janet: When I feel I am dipping, she perhaps has been [pause] sort of metaphorically speaking, when I have been dipping she has almost been like a safety net for me.

Paul described using artwork and a journal to express how he was feeling, and showing this to others he trusted, and this helped him to communicate his emotions. Janet found writing a blog and poetry cathartic and provided an emotional outlet. Dawn, John, and Laura all used forums or blogs to structure their thoughts and communicate them to others. In both of these scenarios it was important this information was validated by another person rather than simply writing them down. Laura, Kimberly, and Lisa felt music could speak their emotions for them.

Rebecca described how expressing and communicating her emotions was an on-going process because it released an emotional build-up, but tension would return if she was not doing it regularly. Participants described when they regularly expressed and communicated their emotions it became easier. In contrast, if they stopped, their emotional state would escalate and at some point they would lose the capacity to do so.

**Finding others (level 2).**

Participants described finding others with similar experiences helped them to find alternatives to self-harm. Participants mostly found similar individuals through group therapy, but also through self-help groups, internet forums, and hospital settings. The *finding others* category contains two sub-categories, online support and group therapy.
Online support (level 3).

Participants found others in similar situations online through Facebook or internet forums. Paul and Lisa read online without engaging with others, whereas Laura, Dawn, and John read, wrote, and replied to others. Reading about other peoples’ situations helped them to feel less alone and learn from other people’s ways of coping. Participants who wrote online explained they usually did not go into detail about the trigger and just stated they needed help. Receiving messages from others helped participants feel others cared about them. Facebook was described by Karen and John to be a portal for receiving help when they posted messages asking for support. Laura felt that reminding herself of good memories on Facebook made her want to get better and not want to harm herself. Moreover, Dawn, Janet, and Laura described how trying to help others online made them feel better about themselves. Janet explained she felt better as helping others took her thoughts away from herself.

Group therapy (level 3).

All participants who described meeting with others face to face, usually through group therapy, explained beforehand feeling nervous thinking it would be too difficult and intense, and expecting to have to share intimate personal details. They perceived it would not help much and a lot of self-motivation was required to initially attend. Once they began, for the initial period participants described feeling overwhelmed and not being able to say much. Rebecca and Sheila even described feeling worse in the first few weeks and months, as they struggled with previous self-beliefs such as automatic self-expression denial (see earlier category on beliefs about self). Perceptions shifted over time as they became more comfortable with the group environment, and felt able to discuss their problems and give feedback to others.
Laura: Cos I never thought I would sit in a group, I’ve always said I would never sit in a group, but I’ve actually got, at first I wouldn’t speak, I was like dead nervous, and I was like really shy and everything and I thought what am I doing here? But now I talk and I’m able to say if I feel bad, and talked about my experiences and when I’ve felt self-harming, and when I’ve been self-harming. I’ve talked about it, and we’ve talked about different things that have been bothering us. There is quite a lot of common themes within the group so it’s like good really. I’m glad I’ve gone.

A large part of the importance of group therapy was the reciprocal nature, as Janet explained, you give support to others and you receive support back. This had the potential to shortcut the recovery process. Dawn explained different people bring different insights she never would have imagined, or allowed herself to think, but actually she found herself agreeing with them. Having empathy for others in a similar position created empathy for themselves, and finding out others managed to get through similar situations generated hope that the participants would be able to tackle their own difficulties. Most participants found it extremely helpful when others listened and validated their experiences, as they felt less alone and damaged. However, although finding others was helpful for most participants who tried it, it was not enough of an intervention by itself. John describes one of the problems of group approaches below.

John: Which seems to be the underlying principle behind [type of peer-led group therapy], the idea that people who have actually lived through the same pain you have, may have instinctively a better idea with how to deal with the results than maybe a health care professional would. And I think there is a
certain amount of truth in that. I think the flip side is it's the blind leading the blind. And I think a balance needs to be struck between the help that we can provide each other, and the hurdle that we can’t overcome ourselves, and need some external support from healthcare professionals to overcome.

Within the *group therapy* category there was also a sub-category reflecting negative group experiences, which resulted in the intervention not helping to prevent self-harm. This is outlined below.

*Negative group experience (level 4).*

When participants were feeling extremely vulnerable they found it difficult to listen to other people’s problems. Group experiences could be triggering if others were not motivated to recover. Rebecca struggled to listen to others as she felt she could not take on more problems and needed to make others in the group aware she was struggling more than them. As a result she would take overdoses to show the group she was struggling the most.

Rebecca: When I’m in group and I’m listening to people saying they’re struggling and stuff. Like I need to make them aware that I’m struggling more, so it becomes not like a competition, but I feel like I need to take an overdose or self-harm so they know I’m struggling, because I can’t express it in the same way they do.

*Having a purpose (level 2).*

Another intervention in the *interventions that work* category is having a purpose. Participants described activities such as work, helping others, and having tasks to do as helping them to avoid self-harm. Participants explained helping others and spending time
doing a productive activity was absorbing, kept them distracted from their own problems, gave them a sense of self-worth and validation, which counteracted the constant negative thoughts they thought about themselves (Janet and Paul).

Dawn: I think voluntary stuff is really good in that way, when you do something else and it mattered to them, you don’t get to decide whether or not it mattered. Because it mattered to them and they do the deciding. And you kinda can’t disrespect them enough to say well it didn’t matter. If you know what I mean? So it gets round all of that negative thinking stuff.

Laura described helping friends with job applications. Dawn found volunteering at charity events when she was feeling vulnerable, and being given jobs to do when attending A&E extremely helpful.

Dawn: This nurse who had just come on shift who was the head of the shift came in, found me, found what I’d done and [pause] talked to me just about normal stuff for about 10 minutes, worked out what kind of person I was somehow, magically, got me to fix their printers. She was like, my printer is not working, you’re a computer programmer do you think you could, she kind of realised I needed a job to do, so that was going to be better than actually leaving me there getting myself into more of a mess. She was like I don’t do heads, I do bodies. The people who do heads take hours to come I’ve asked them to come but in the meantime [laugh] can you fix my printer? So she just kind of got me doing stuff, you know, making cups of tea for the nurses, she just kept me occupied, and in the end it was about 18 hours before. So I
breached the four hours thing. So I was in the department about 18 hours before they could sort it out an admission....She just gave me stuff to do and treated me like a useful person.

Paul, Karen, and Sheila highlighted having a job gave them a purpose and a structure to their week, which could be used to scaffold life around, e.g. sleep, food, and socialising. However, engaging in purposeful activity did not work when the individual was too distressed, highlighting the importance of timing in this intervention, and its potential to have beneficial impact towards the beginning of an emotional build-up. Also Sheila and Dawn were cautious to maintain work in balance with other areas of their lives. When they were overworking they became trapped in a downward spiral of not looking after themselves properly, and became more likely to self-harm.

**Provided with knowledge (level 2).**

Another intervention that started the process of alternatives to self-harm was being provided with knowledge. John stated understanding is the basis of improvement, which was echoed by many of the participants. They fundamentally wanted some understanding of their situation before trying to make any changes. Rebecca and Paul described understanding themselves for the first time when they were provided with information about BPD. Dawn explained one of the good points about having a label is it usually creates access to support channels. However not all participants felt this way, Kimberly felt being diagnosed with BPD made her angry and withdraw from accessing support.

Participants accessed mental health services because they felt they could not improve their situation on their own, and needed an intervention. They felt a useful intervention was provided by specialists and not typically provided by others in similar situations. Participants
described prior to being ready to talk being given information and knowing the process for help, felt like the first initial step. Getting information about different forms of therapies, their diagnosis (if they had received one), and advice about coping techniques was found to be helpful, if offered as optional, and the other person was willingly to adapt an intervention to the individual. Amy and John described constructive advice about managing emotions, and Sheila received practical advice on how to manage her finances and create a weekly structure. When a HCP gave knowledge or taught an intervention, Lisa expressed the importance of building up the process in bite-size chunks otherwise she would become overwhelmed and give up.

**Grounding (level 2).**

Grounding is one of the specific interventions in the *interventions that work* category that all participants used to remain in a steady state system, and stop their emotions building up and reaching unmanageable levels. Grounding maintained an equilibrium between their focus on their internal state and a perceived outside, such as their body or the external environment. This took place by either taking their focus away from their internal state and connecting to the perceived external, or to help them withdraw to a more internal state when they felt too focussed on the external, e.g. an argument with others. The *grounding* category comprises three lower-order categories (level 3) physical, sensual comfort, and cut-off which are discussed in more depth below.

**Physical (level 3).**

Exercise was reported by Dawn, Sheila, John, and Karen, and physical activity such as walking, cleaning, or expending physical effort was reported by Laura and Kimberly, to create
a steady state system. A steady state system connected them to their body, created focus, regularised their routines, created endorphins and soaked up anxiety.

Dawn: Its mostly preventative, if I’m doing enough of it, then, cos I think the exercise is kind of the lynch pin in the system, where if I’m doing enough exercise then I’m connected to myself, then my stress levels are lower, I’m eating better, I’m sleeping better because I’m physically tired enough. Generally if I’m exercising enough then it means my routine is pretty good.

It could also be used in emergencies as well.

Dawn: If I got a phone call now to say that somebody I really cared about had died, I would probably go for a run tonight or tomorrow morning just to help myself process that. So it works in emergencies as well.

John used to ball up his socks and throw them at a wall if his emotions were building towards self-harm.

John: From the point of view of stopping self-harm it, really, it really is about not just throwing against the wall, but as HARD as you can possibly can and it’s very hard to throw a pair of socks hard.

Researcher: Yeah it’s something I’m going to try

John: They are not the most aerodynamic of objects. So to really get them bouncing off the wall in a satisfactory way, you’ve really got to give it some welly, and I think that effort is probably what helps prevent the feelings of self-harm.
All participants apart from Janet and Lisa, used some form of physical grounding to prevent further emotional build-up (see grounding table in Appendix BB). Participants expressed the reintegration of mind and body during grounding was protective against self-harm, and the effort of motivating themselves to do physical activity was the hardest part, and even reported that if they were forced to do physical activity this would be helpful.

Certain physical activities were found to be more useful than others, for example John found swimming as opposed to other forms of exercise was especially preventative against self-harm. He felt water was a sensory change which created distance from others, released tension, and regulated his breathing. He could process his thoughts and feelings and at the same time paradoxically he got respite from them as his mind was in his body. He also got a sense of achievement from completing the goal he had set himself. Nicola found similar elements when walking with music. There was a sensual aspect of the wind in her face, music created distance from others, and pressure was released. She explained describing and verbalising what she could see took her focus away from her internal state.

In contrast, participants reported when they were not physically grounded after an individual or group therapy session, they were more likely to self-harm. John felt in group therapy it would be helpful to connect individuals to their surroundings before they leave, through focussing on breathing or stretching to help them feel calm and in control.

*Sensual comfort (level 3).*

Participants used different forms of sensual comfort to calm themselves when their emotions were building. Dawn and Karen found animals and especially their pets grounding. Karen and Amy hugged cuddly toys, Laura described having a bath, Janet had showers, and
Dawn played with Lego. Sensual comfort could also be symbolic, Kimberly explained that knowing her tattoo, representing self-harm, was nearby meant she did not need to self-harm.

Amy and Laura created mental first aid boxes (although not described as such) containing different sensual comforts such as soft blankets, fragrant candles, and sweets. Amy felt the box needed to cover all five senses to potentially ground her. Participants felt the boxes should be tailored to the individual, Laura noted some people would detest the idea of candles. Participants also stressed the boxes should be to hand, as when they were distressed the window of opportunity for these items to help was small. The importance of a combination of different senses to provide grounding was echoed by Janet, who described showers were helpful due to the warmth of the water, the smell of the soap, visually seeing herself clean, and the sound of running water.

**Distancing (level 3).**

A number of participants reported cutting themselves off from others helped reduce their emotional build-up, as long as it was before the uncontrollable self-harm mind-frame. Participants reported physically distancing themselves by locking themselves in their houses (Lisa and Rebecca), removing themselves from confrontations (John), avoiding people, or others physically holding them from self-harming (Lisa, Kimberly, and John). Other participants described psychologically zoning others out by putting on sunglasses or listening to music (Amy and Nicola) to create distance when needed.

The majority of participants found going to bed was helpful depending where they were on the time-course to self-harm. Bed felt cut-off from the world, far from danger, and a soothing and quiet environment. Laura and Lisa described it as a safe haven where they were comfortable and could relax. Janet felt it was the only safe place where she would not hurt
herself. Kimberly would go to bed and sleep to help her escape. Rebecca, Amy, and Dawn described how when they were in an agitated state bed was not helpful, however once they had successfully completed a physical grounding exercise, then bed and sleep would be the best place to change their mind-frame.

**Negative aspects of seeking help (level 1).**

There were negatives associated with individuals deciding to take an alternative path and use the interventions detailed in the section above. These elements formed the category *negative aspects of seeking help*. This category had three sub-categories (level 2) which were, becoming overwhelmed with emotions, having to hand over some control to others, and dealing with the end of the use of a service. They are explored in more detail below.

**Unravelling is overwhelming (level 2).**

Participants found when they started to take an alternative path to self-harm it became clear self-harm was a way of keeping them together. They found themselves overwhelmed with emotions, and often felt worse about themselves before they started to see an improvement in their situation. Kimberly described feeling exhausted by the process of therapy, and Janet described becoming suicidal when starting therapy whereas previously she had only self-harmed.

**Handing over control (level 2).**

Participants understood they held some responsibility for their recovery, but handing over some control of their situation by seeking help had some difficulties. Sheila, Dawn, Kimberly, Janet, John, and Paul described HCPs having a different agenda to themselves, and therefore feeling like they were fighting against HCPs, or not being able to be honest with them. They also felt HCPs could focus on the wrong aspect (from their perspective) of their
problems which felt frustrating. These aspects included when the therapist focussed on him or herself, trivial issues, or did not look for the root of the problem. When Karen, Paul, and Janet felt they had no control at all, they felt the need to escape and physically ran away from services.

*Ending of help creates feelings of rejection and abandonment (level 2).*

When an organisation or an individual stopped giving help, participants felt rejected and abandoned. This potentially created an unmanageable emotional build-up and resulted in self-harm again. Karen talked about her feelings towards her last session of therapy.

Karen: I have this recurring dream vision, I don’t know what you’d call it, of going and booking a cheap hotel …. not caring and then taking all these painkillers and dying, and it’s, I’m not saying that's what I’m gonna do. But [pause] that's how much I’m dreading the [date], my last session with [name of therapist], is that keeps coming, popping up in my head.

Participants explained they were attached and felt dependent on therapists. Lisa and Rebecca described feeling like they were making progress but when therapy ended they felt they went straight back to square one. They felt it would be helpful to have intermittent appointments afterwards to feel a loose safety net was in place.

*Trial, error, and evaluation (action strategies level 1).*

The *trial, error, and evaluation* category is a sub-category within the core category *an alternative path to self-harm*, referring to the overall evaluation given by participants after an intervention. The benefits of interventions that work had to outweigh the negatives aspects of seeking help to continue the alternative path to self-harm. If the negatives outweighed the
positives, the individual would continue a self-harm pathway, and help-seeking in the future would be less likely, as their previous experiences of help would act as a barrier to change (see *once bitten twice shy* category in the section on *decision to do things differently*). When the evaluation of help was positive overall, individuals started a new process, building up knowledge and experience of interventions. If they were successfully preventing self-harm they seemed to have multiple interventions that worked under different situations, and they were actively evaluating the experience afterwards to see what worked and what did not. John explained the process was constantly evolving and therefore he needed regular contact with support as his needs changed over time. Dawn described the process of trial, error, and evaluation.

Dawn: Just through trial and error. It’s just over time, gradually finding things that work in certain situations or things that don’t, you don’t. Basically through getting it wrong, and realising, oh that didn’t help then, but it helped me on another occasion, and you kind of go well, what was the pattern there or what was different.

The trial, error, and evaluation category has one sub-category (level 2), multiple intervention synergy presented below.

*Multiple intervention synergy (level 2).*

Participants talked about having multiple interventions and multiple sources of support so it did not feel like they only had one option. The two participants who had an established alternative path to self-harm (Dawn and Kimberly) had multiple interventions which fulfilled all five attributes of successful interventions noted above in *interventions that work* category.
Dawn: The other most important thing is having multiple options for interventions, cos um what can be very difficult is when you need to ask for help from somebody, and you feel like they’re your only source of help, and it doesn’t work out. That's really hard….So, um, yeah I think that’s the main thing, that there is no one thing, it’s got to be lots of things.

These interventions needed to be at the micro level, things they could do themselves such as playing Lego or doing exercise, right the way up to the macro level such as a supportive GP and a plan in a crisis. Multiple interventions seemed to work synergistically where a combination of interventions made them a much stronger force in preventing self-harm, than any one intervention in particular. Additionally participants emphasised not every intervention works every time. There was ‘no magic bullet’ therefore multiple interventions meant when one falls through there was another to fall back on. Depending on the emotional state an intervention which helped on some occasions, on other occasions could make the situation worse if it did not match the purpose.

Dawn: It depends, it depends. If I can’t sleep because I’m having flashbacks or nightmares or whatever, then going to bed is the last thing I need to do because I need to just stay busy until that’s stopped. Whereas if actually the problem is I’m completely over exhausted because I’ve had a load of commitments, or I’ve been ill or whatever, then going to bed is perfect, so it depend doesn’t it? Where your head is at.

The sunset of self-harm (consequences level 1).

The sunset of self-harm is the final sub-category within the core category an alternative path to self-harm. Properties and dimensions of this category can be found in
Appendix BC. This category reflects the consequences of seeking alternative strategies to self-harm in the grounded theory, and concludes the findings chapter. Within the sunset of self-harm category there are two sub-categories (level 2), maintaining change and experiences for good.

**Maintaining change (level 2).**

Participants used active strategies to prevent returning to self-harm by continually learning new ways to cope, talking to themselves, and avoiding substances which had the potential to put them back in their former state of mind.

Janet explained it was like a rolling ball of momentum in which once thoughts of self-harm had eased, and alternative coping strategies were in place, it just became easier not to self-harm. Kimberly and Nicola believed self-harm was largely behind them as they now had other options. Nicola, Amy, and Dawn talked about accepting there would be hard times ahead, and knowing they could not eliminate emotional pain. This acceptance was coupled with a new found strength and a belief in themselves they would be able to get through the difficult times. Participants talked about feeling shocked about the way things had been, realising how far they had come, and feeling empowered when they managed to prevent self-harm.

Dawn: I feel really emotional, I could just have a good cry. It’s really nice to talk through it all, and just go oh I feel really okay now, but there’s still the odd blip, but the blips are in the scheme of things, the blips are pretty tiny compared to what they used to be like. And [overnight intervention] was about 7 years ago, so it’s been a long period of mostly stability with the odd blip.
Kimberly: That state has only really happened like, once in the last year.

Which is amazing [whispering]. It’s amazing for me.

**Experiences for good (level 2).**

Participants wanted to use their experiences to help others in similar situations and remove stigma. Participants spoke about their mental health difficulties to others. They hoped high profile role models would come forward, and generate publicity and raise awareness to break down barriers and enable others to seek help. Dawn, Kimberly, and John explained they were taking part in this study to highlight the importance of people doing research, as they felt there was currently a lack of understanding which prevents others from getting the help they need.

John: From my perspective the better mental health professionals understand what we as service users are going through, the more likely it is that I will get help that I need, and at least if I don’t, the person that comes after me, or the person that comes after them will.

Karen and Janet spoke about wanting to help others and give something back as they have received help.

Janet: Well because I could give something back now [pause]. Cos I’ve come a long way. So maybe, it maybe, I can give something back and not just [pause] take. So yes, you’ve given me something there [pause].
Chapter Summary

This chapter outlined the findings of the grounded theory looking at how individuals with BPD symptomatology perceive interventions to prevent self-harm. The categories were presented in the order in which they occurred in time for the participants, with the sub-category *established beliefs and causal factors* discussed first, followed by the second sub-category *time-course of self-harm*. The largest section of this chapter focussed on the core-category, *an alternative path to self-harm*, and described in detail the processes and interventions involved in prevented self-harm from the participants’ perspectives.
Chapter 5

Discussion

This chapter interprets the findings and discusses their significance in reference to the existing research field. The chapter begins with a comparison of the findings to previous literature, followed by a consideration of the clinical and wider implications of this research. The limitations of the study are outlined alongside a methodological discussion of data quality, leading to suggestions for further avenues of research addressing issues raised in the present study. The chapter ends with a personal reflection on the research process.

Comparison to Previous Literature

This section considers the findings of the grounded theory within the context of the existing literature, identifying similarities, differences, and new areas of knowledge. To briefly restate, the purpose of the research was to consider how do individuals who self-identify as having BPD symptomatology perceive interventions to prevent self-harm? The findings from the grounded theory identified the core-category an alternative path to self-harm, and two sub-categories established beliefs and causal factors, and the time course of self-harm. In the following section these categories are discussed in the order in which they appear in the self-harm intervention process (as per the findings chapter). Therefore the two sub-categories are considered first, followed by a more detailed discussion of the core-category.

Established beliefs and causal factors.

Participants identified difficulties in their relationships with others (rollercoaster relationships and beliefs about others categories), and negative beliefs about self. These
themes are similar to previous research proposing individuals experience estrangement in their relationships, and have self-beliefs of inadequacy and despair (Clarkin, 2006; Gunderson, 2009; Miller, 1994). The present study’s findings regarding negative beliefs about self identified participants held beliefs about themselves as containing no positive, being unworthy of care, and automatically vetoed emotional expression. This furthers Brooke and Horn’s (2010) proximal and distal factors theory which suggests individuals have self-generated negative thoughts, by providing in more detail the types of negative thoughts individuals have about themselves. This negative view of self links to previous research findings that individuals with BPD and self-harm hold internalised views of themselves as disempowered and devalued (Knight et al., 2003).

The findings from the current study are in agreement with Holm and Severinsson (2010), who stated that conflict occurs prior to self-harm, but the present study disagrees about the nature of the conflict. Holm and Severinsson (2010) propose conflict arises between a desire for self-sacrifice and relief of responsibility against a fear of intimacy. The present study argues conflict (internal struggle category) results from competing needs (e.g. need to be cared for) against established beliefs (e.g. being unworthy of care). The present study builds on research suggesting individuals experience confusing perceptual states and try to cope by self-harming (Black et al., 2014), by proposing this conflict results in an internal struggle between a need to express emotion, versus a belief of being unworthy of emotional expression, in the presence of trigger/s resulting in self-harm.

Many sources of triggers were identified by participants, supporting Schnyder et al. (1999) who stated that individuals give multiple reasons for self-harm. The explanations participants gave for self-harm in the current study fitted into categories identified by previous
reviews and research, such as interpersonal difficulties, punishment, dissociation, averting suicide, and as a coping strategy for emotional pain (Edmondson et al., 2016; Klonsky, 2007; Morris et al., 2015; Solomon & Farrand, 1996; Suyemoto, 1998). However, some of the explanations for self-harm given in the reviews were not identified in the present study’s findings, such as coping with sexuality or exploring boundaries. This could be due to these explanations being less commonplace, and due to the comparably small number of participants in the present study.

The present study supports previous research which suggests the separation between suicide and self-harm cannot be clearly differentiated (Edmondson et al., 2016; Maddock et al., 2010), and individuals show an ambivalent attitude towards suicide (Kapur et al., 2013; Messer & Fremouw, 2008; Perseius et al., 2005). Participants in the present study gave differing accounts of their intentions for self-harm, some participants viewed self-harm as a coping strategy, keeping them alive distinctly opposed to suicide. Other participants stated there was no intention of death but acknowledged the severity and lethal nature of their behaviour had a high likelihood of death, and others stated the intention was to die but this was at odds to their behaviour which involved non-lethal means and help seeking.

During interviews participants spontaneously discussed alternative forms of self-harm, such as breaking items of importance to them, excessive spending and gambling, and appeared to view these activities on a continuum ranging from self-defeating actions to traditional forms of self-harm. Therefore the present study supports research advocating for a broad definition of self-harm and a spectrum of behaviours (Middleton & Butler, 1998; Skegg, 2005). Furthermore, participants in the current study varied in their patterns of self-harm. Some used multiple ways and any means to harm themselves, and others would only engage in certain
behaviours, agreeing with a body of research findings that individuals cannot be classified by method of self-harm (Lilley et al., 2008; Owens et al., 2015).

**Time-course of self-harm.**

The category *time-course of self-harm* mapped emotional tension as a function of time, and indicated when self-harm occurred. Levels of emotional tension influenced whether self-harm proceeded as usual or whether an alternative approach was attempted. To the author’s knowledge this is a new way of conceptualising self-harm intervention, however it does relate to previous theories linking self-harm and emotional control. Gunderson (1984) and Clarkin (2006) state BPD is a core deficit in relating to others, in combination with a lack of emotional control, and that unmanageable emotion causes the need for self-harm. The time-course approach suggested by the findings in the current study supports literature reporting the purpose of self-harm is to be relieved of unmanageable emotion (Brown et al., 2002; Paris, 2002), and restores a feeling of balance (Brooke & Horn, 2010).

Subcategories identified within the time-course approach may indicate why interventions sometimes fail. All participants explained that their emotional distress escalates to an *unstoppable self-harm mind-frame*, at which point they want to self-harm and other options are shut-down. If interventions are given at this point in clinical or research settings then they are likely to be ineffective. This finding highlights the importance of accounting for the surrounding context of the individual, specifically levels of emotional tension, a view proposed by Nehls (1999) and Svenaeus (2000), rather than just delivering an intervention which would have little impact during these heightened states. Additionally, participants described an intoxicating state while self-harming, where their focus is purely on the act of
self-harm and less attention is paid to surroundings, which supports Black et al. (2014) who reported that individuals enter a zone focused on harm.

**Alternative path to self-harm.**

The core category an alternative path to self-harm referred to the process individuals with BPD symptomatology went through in order to reduce self-harm. The process began with an event (change spark category), resulting in a cascade of cognitions accumulating in the decision to do things differently. At this point individuals sought interventions, interventions that worked matched the purpose of self-harm and met certain criteria. There were also negative aspects to seeking help. Individuals evaluated their overall experience of seeking help (trial, error, and evaluation category). If the overall evaluation was negative they continued in a cycle of self-harm, if they had an accumulation of positive evaluations, they moved away from self-harm and used alternative coping strategies (the sunset of self-harm category).

The findings identified effective interventions and situated them within an overall process. This approach is in alignment with recommendations by Gunderson (2009) who stated a broader view of the self-harm process is needed, to develop a greater understanding of how interventions operate. A process approach also more closely resembles participants’ experiences. During interviews, all participants talked about their prior beliefs, motivations for self-harm, and associated consequences, in ever-changing dynamics as influencing their experiences of interventions. The overall process is one of the key findings from the present study, and as such when subcategories are considered in detail in the following paragraphs they are intended to be read as part of this overall structure, working cohesively to impact future self-harm, rather than any element in isolation.
One of the sub-categories within an *alternative path to self-harm*, the *change spark* category bears similarity to the turning points theme identified in Shepherd et al.’s (2016) review on personality disorder recovery. Turning points were identified as individuals identifying the need for change and their role in this. Similarly, a *change spark* event in the present study sparked a change of thinking and resulted in participants trying alternatives to self-harm. Shepherd et al. (2016) found for change to occur, individuals had to feel safe through social networks and environments. The present study also reached a similar conclusion that *environmental change* and *interactional change* are antecedents to searching for alternatives to self-harm. However, the present study furthers the findings of Shepherd et al. (2016) by providing more depth to these events, through identifying specific elements of a safe environment and characteristics of interactions with others, which create the groundwork for a different way of thinking to emerge. Elements within the category *environmental change* such as *holiday*, *change of scene*, and *sanctuary* tie to previous studies proposing individuals find an implemented structure, time out to be able to rest, and sense of security important to conceive of alternatives to self-harm (Helleman et al., 2014). The present study also suggests a possible explanation for why Nehls (1999) reported participants found the hospital environment safe but insufficient for long-term change. The findings suggest hospitals keep people safe and can initiate the process of looking for alternatives to self-harm, but is not a sustaining intervention strategy in itself, as it does not meet the criteria for *interventions that work*, discussed later in this section.

The large sub-category *interactional change* is proportionate to the amount it was discussed by participants. This supports the findings of Langley and Klopper (2005) and Shepherd et al. (2016) which state that trusting relationships are the foundational lynchpin for
change, and Helleman et al.’s (2014) study where participants reported that contact with a nurse was the crucial element in interventions. Within the category interactional change, some subcategories bear resemblance to components identified within the common factors of interventions research (Weinberg et al., 2011). These subcategories are fostering belief, in agreement with Farran et al. (1995) advocating the role of hope in positive interactions, trusted secret knower, caring attitude, curious stance and experienced other. Other subcategories within interactional change, valued as a person and caring attitude, could be comparable to a theme identified in Lindgren et al.’s (2004) study whereby participants wanted HCPs to see their distress at more than a surface level recognising them as unique. Additional elements of positive interactional change were found in the present study not identified by previous literature. These were the importance of an outsider to the self-harm situation and having a physical presence. At the opposite end of the spectrum in unhelpful aspects of interactional change, the subcategory of asset stripping supports research reporting it is unhelpful when HCPs focus on preventing self-harm rather than seeing them as a person (Nehls, 1999). Asset stripping in the present study was commented on by a number of participants whereby their uniqueness as a person was removed by services and they became a ball of risk to be managed, resulting in feelings of worthlessness and perpetuating self-harm.

The present study identified a third subcategory initiating change in the change spark category not previously identified in research, specifically physiological change through medication. The use of medication to initiate change makes clinical sense, as many individuals with BPD symptomatology are prescribed medication for residual difficulties, such as chronic low mood or sleep disturbance (Bateman et al., 2015). Therefore it is logical to assume when
some of these difficulties are resolved an individual might be better placed to conceive of alternatives to self-harm.

The category in the findings *decision to do things differently* referred to the cognitive processes resulting in engagement with interventions. This cognitive process has not been previously attended to and explicitly categorised in qualitative literature. However subcategories within this process namely *awareness*, *reconsidering*, and *recognition of self-agency* have been alluded to in recovery research (Shepherd et al., 2016), as aspects of turning points mentioned earlier. The sub-category *recognition of self-agency* parallels Lindgren et al. (2004)’s findings that personal autonomy is cultivated in effective interventions. The present study elaborates on this process emphasising the role of *motivation*, specifying types of awareness and identifying barriers which prevent an individual from seeking interventions. Specifically, the barrier to change within the subcategory *once bitten twice shy*, which refers to an individuals’ previous negative evaluations of seeking help, is supported by previous research finding that negative evaluations of help through unhelpful responses by others prevented future help-seeking and caused further self-harm (Becker, 1997; Helleman et al., 2014; Liebman & Burnette, 2013). Another barrier to change participants identified was a *lack of services*. This echoes opinions from the research field stating individuals who self-harm have limited access to care and there is a lack of specialist services (Bateman et al., 2015; Paris, 2012). Additional barriers to change identified in the present study and not reported in literature include *keeping the truth from others*, by *wearing a mask* and the *spiral trap*, whereby change-resistors such as alcohol prevented individuals from seeking help.

The category *interventions that work* contained the crux of the research findings within an *alternative path to self-harm*, and affected whether individuals prevented self-harm.
Implicitly mentioned in the participants’ narratives was the importance of an intervention matching the purpose of the self-harm. The literature makes little reference to this, but this finding explains some of the variation in why interventions differ in effectiveness among individuals, and even why there can be fluctuations in the effectiveness of an intervention for a specific individual. The findings indicate that interventions have to fit together with the need to self-harm like a jigsaw. If the purpose of self-harm is to re-integrate mind and body then an aspect of an alternative coping strategy has to create a carbon copy of the outcome (i.e. also re-integrating mind and body), otherwise interventions do not work. The findings show this process takes time for an individual, as they need to build up an awareness of their emotional state in order to intervene before self-harm takes place, and thereafter to work out interventions that work for them and in what conditions. Initially this takes place through trial and error and subsequent evaluation. This learning process provides a possible explanation for why reoccurrence rates of self-harm in individuals with BPD are high (Zanarini et al., 2008).

As a result of discovering this process, the present study agrees with Birch et al. (2011) who stated that exploring the meaning of self-harm could be therapeutically useful, and is in alignment with an understanding of the intervention process by Helleman et al. (2014), who reported participants found it helpful to have an individualised treatment plan, which was regularly evaluated for fit as needs varied over time.

The temporal subcategories of the category interventions that work specified consistent, long-term and instant support. The temporal elements advocated by participants embodies aspects of previously reported effective common factors in interventions, namely having a clear treatment framework from outset (Weinberg et al., 2011), and longer term support (Paris, 2010). Additionally, the benefits of accessing instant support highlighted by
participants in the present study has been previously mentioned by Helleman et al. (2014) and Lindgren et al. (2004), who found that being able to phone to access support was important as tensions rose quickly past the point where individuals were motivated to search for alternatives to self-harm.

The interventions reported by participants to help reduce self-harm included the sub-categories expressing and communicating, finding others, having a purpose, being provided with knowledge, and grounding. Expressing and communicating often took place through therapy, which was reported by the majority of participants to have a positive benefit. Although, of note participants did not discuss or express preferences for particular therapeutic approaches, other than in reference to duration where longer was better. It is unknown whether they are aware of the type of therapies they have accessed and/or whether the type of therapy holds any importance to them. The importance of expressing and communicating is supported by Helleman et al. (2014), and links to concepts of validation extremely prevalent in BPD literature (Linehan, 1993; Samuelsson et al., 2000). This category also makes theoretical sense, when considered within a context of an internal struggle between the need for expression and trying to withhold expression, and therefore by using other means of expression, and communication of distress participants have a reduced need for self-harm.

The intervention category finding others in order to prevent self-harm agrees with Perry and Pescosolido (2015), Cohen and Wills (1985), and Black et al. (2014) who propose social network support is key for recovery, especially when others are orientated towards self-harm prevention. In the present study, finding others took place within group therapy and online support. These elements could also be negative. The present study found groups were viewed as a negative experience when other group members were disturbed, supporting
Helleman et al. (2014) findings which report that group support is context dependent. *Online support* as an intervention strategy is not referred to in the current literature, and as it was suggested by participants to greatly prevent self-harm, it would benefit from further exploration through research. The potential benefit of this approach is not fully understood, as it seems individuals highly valued online support from peers, but in reference to HCPs a physical presence was important.

The subcategories within *interventions that work*, *having a purpose*, and *provided with knowledge* have emerged as interventions with scant reference in previous literature. *Having a purpose* appeared to help participants by distracting them from their self-harm, and challenging their beliefs about themselves being worthless, because through having a purpose others valued them and they received external validation. Lack of purpose might explain why Lindgren et al. (2004) reported self-harm gets worse when patients have long periods of unscheduled time on wards, as they have little to distract them and may then embody the role of the self-harm patient.

*Grounding* was another sub-category in *interventions that work* highlighted as an essential aspect in alternative approaches to self-harm. All participants reported using some form of grounding intervention helping to de-escalate emotional tension. These interventions consisted of physical activities, sensual comfort, and distancing activities. Interestingly, to the author’s knowledge no qualitative research has examined the effects of these types of interventions in reference to self-harm, although using exercise to alleviate mood is well documented (Penedo & Dahn, 2005). The findings suggest the role of grounding is a useful avenue for future research into interventions.
The category covering *negative aspects of seeking help* included the process by which participants started to examine their difficulties and generated feelings of being overwhelmed (*unravelling being overwhelming* category). This may explain findings in Helleman et al.’s (2014) study where self-harm became worse during intensive therapies. In the present study participants also reported handing over control to HCPs (*handing over control* category) was difficult, and the *ending of help created feelings of rejection and abandonment*. These findings potentially clarify why Shepherd et al. (2016) found discharge or transfer from services can cause new distress as participants may feel out of control and rejected at these points. Furthermore, these findings are in alignment with a body of research proposing individuals can view hospital environments as an additional trauma when they have no control for their own care (Fallon, 2003), there is conflicting priorities with HCPs (Shepherd et al., 2016), and relationships are terminated without warning, and strongly support the view individuals need to have some level of personal autonomy (Lindgren et al., 2004). NICE guidelines (NICE 2009) recommend individuals are supported to develop autonomy, and the current findings suggest participants also see this as an important element of interventions.

The present study identified interventions were given an overall evaluation (*trial, error, and evaluation* category). A negative evaluation resulted in future self-harm and less likelihood of seeking alternative ways of coping in the future. An accumulation of positive evaluations resulted in future use of alternative strategies to self-harm. Participants who were not engaging in self-harm were using multiple interventions and actively maintaining changes (*characterised in the sunset of self-harm* category). The aspects of long-term self-harm prevention suggested by the findings support research specifying the need for embracing a wide range of responses to interventions (Estroff et al., 1997), and are in agreement with
Shepherd et al. (2016) who stated individuals in recovery from BPD maintain a vigilant stance towards self-harm. Furthermore, participants in the current study wanted to use their experiences to reduce stigma and help others, similar to the concept of identity construction in Shepherd et al.’s (2016) review, whereby their difficulties were incorporated into their personal narratives. These positions of vigilance and adoption of new strategies for coping support the argument individuals with BPD symptomatology improve and are not unresponsive to treatments, also reported by Davidson et al. (2010) and Zanarini et al. (2012). Participants wanted BPD and self-harm advocates and associated media campaigns, suggesting their focus is not in eliminating diagnostic approaches completely, but that individuality in interventions is vital and further support is needed.

**Implications and Study Strengths**

The previous section described the findings in reference to the existing literature. This section now outlines the clinical and wider implications of the present study’s findings. This is done by first considering the implications of the process approach to interventions, and then the implications of specific interventions identified in the findings. This section ends with contemplation of the research within a wider context.

**Clinical implications.**

The findings demonstrate interventions to prevent self-harm need to match the need to self-harm. This potentially flips the current research approach to interventions on its head. Presently the research literature evaluates interventions on their overall effectiveness with the aim being to recommend through clinical guidelines the most effective interventions to all. Instead, the present study suggests HCPs work with the individual to identify the purpose for the self-harm in that moment, and then use more adaptive strategies which create the same
outcomes. This process requires the individual to have a pre-threshold level of arousal (i.e. before *the unstoppable self-harm mind frame* phase), which in turn needs the individual to identify when their emotional state is escalating by developing a level of self-awareness. This approach takes time and practice to build up awareness and trial different interventions. For clinical use, HCPs would need to scaffold individuals by using elements of helpful interactions identified *in interactional change category* to work at an individual’s zone of proximal development (Kerr, 1999), to guide them through the approach. The eventual aim being for individuals to mostly take ownership of their intervention process at some point.

A starting point for identifying effective individualised interventions in clinical practice could be through the intervention questionnaire [PIPS]. There was great variability in how effective individuals perceived interventions to be, as shown by the summary intervention information (see Figure 3 in participant demographics). Even when individuals rated a particular intervention roughly similarly, the conversation which discussed the intervention revealed great differences in how they viewed whether the intervention did or did not work for them. HCPs could use the intervention questionnaire to open a dialogue with individuals, regarding their thoughts on existing interventions and identify interventions they have not tried. HCPs could use their existing clinical interpersonal skills such as Socratic questioning (Westbrook, Kennerley, & Kirk, 2011), to learn more about an individual’s understanding of their self-harm. Implementing the intervention questionnaire in clinical practice ensures the main forms of interventions have been thought about and discussed with an individual, rather than basing assumptions on what works from a majority approach, and could potentially identify helpful interventions quicker than a non-structured approach.
Somewhat related to the implication presented above, the overall paradigm (see Figure 9 in the findings chapter) could be used in clinical practice as a framework or map to guide HCPs and individuals working to prevent self-harm. Two versions of the overall paradigm map could be developed, one for clients and an elaborated version for therapists. The therapist version could be used to independently formulate aspects of the individual’s process, whereas the client version could be used for joint working. These maps could be used in or after sessions (if used only as a therapist tool), to visually identify areas the individual is working on, adding notations to various stages. This process would discover gaps in their interventions toolkit and find potential barriers stopping individuals from attempting interventions, providing a focused but tailored approach. By following such an approach, practitioners and individuals could work collaboratively identifying many of the factors influencing their decision to self-harm and their views on interventions, and work towards changing areas with the least resistance first, a method known as the modifiable risk factor approach used in physical health settings (Carter, Reith, Whyte, & McPherson, 2005).

The paradigm map could also be used to implement another method of change taken from an unrelated field, known as the aggregation of marginal gains (Durrand, Batterham, & Danjoux, 2014). A method credited by the British Cycling Team for their success at winning the Tour de France (Durrand et al., 2014). The aggregation of marginal gains follows the principle that by accumulating multiple, seemingly insignificant improvements throughout a given process, then collectively it is possible to achieve a far superior output, and has been suggested applicable to bipolar disorder, utilising diet and exercise, gradual behavioural change, and peer support (Nierenberg, Hearing, Mathias, Young, & Sylvia, 2015). Adoption of this method could take place in conjunction with the paradigm map to chart progression,
and used by an individual to record their emotional state position on the time-course of self-harm during a previous intervention, or identify additional interventions which work in circumstances others do not. By aggregation of these small improvements it is suggested this will create a form of synergy leading to much greater prevention of self-harm.

Findings from the category *interventions that work* have clinical applications for developing future intervention strategies. The two participants who confidently felt self-harm was no longer required used interventions which matched all five of the criteria for *interventions that work* (i.e. expressing and communicating, grounding, having a purpose, being provided with knowledge, and finding others). The remaining ten participants who still actively self-harmed used some interventions but elements of the five criteria were missing. This could suggest it is necessary to have all five elements of interventions for a higher possibility of preventing self-harm. HCPs could work with individuals to identify missing elements in their interventions. Moreover, the findings indicate multiple techniques involving all five elements of *interventions that work* are needed to effectively prevent self-harm in the long-term. This knowledge can be used by HCPs to dispel any myths of a ‘magic bullet’, and encourage the use of multiple techniques through explaining different techniques having different purposes, and will work in some conditions and other times not. HCPs can encourage individuals to apply a scientist/detective mind-set to the process, working out what worked, what did not and why. Explaining, that like all skills it will take time to develop mastery over the process.

A factor which may potentially increase the difficulty of finding effective interventions is that the findings suggest the self-harm intervention process is dynamic. Participants reflected that interventions and their understanding of their self-harm changes over time.
Therefore if HCPs did choose to use the intervention questionnaire and paradigm map with individuals who self-harm, these should be repeated regularly as they will quickly become redundant. These tools would be best placed to facilitate reflective discussions and for ongoing monitoring rather than one-off use. Regular use could potentially be used to examine a particular instance or situation in more depth, identifying their level of emotional tension and the corresponding intervention attempted. By capturing this information it would be possible to build a portfolio of their self-harm interventions over time. To enhance the effectiveness of this tool it is suggested it is given to the individual to share with supportive people in their lives and attached to their medical records. By this approach if their regular HCP had to take a leave of absence or left the service, there would be an aid for another HCP to continue the process. Thus demonstrating to the individual that previous efforts to reduce self-harm are not lost. This could potentially empower the individual to feel there is a continuation of care and hopefully lessen feelings of abandonment.

The findings demonstrate exiting the cycle of self-harm is a complicated process with many components. This process takes time and has implications for a modern healthcare system where multiple short treatments with different therapists are common, and long-term support is rare. The present study emphasises the importance of long-term relationships, through finding that interventions that work involve long-term support, and the value placed by participants on connection to others in the findings others category, and also the finding that the ending of therapy derails progress and can cause self-harm. Long-term support is required for the individual to understand their self-harm, build up multiple interventions, and understand their applications. Furthermore, it is suggested by participants after they begin to take ownership of the intervention process check-in appointments are helpful. The findings
indicate these intermittent appointments after a long-period of therapy with the same practitioner creates the illusion of feeling held and supported. For example, three participants who had finished long-term psychotherapy and considered themselves stable, credited this to follow-up appointments spaced over the coming year, and yet commented they could not keep themselves safe after these appointments. The present study would argue individuals should be able to cultivate long-term relationships with practitioners. These check-in appointments after intense therapies could be sporadic and less therapeutically focused, however it is argued they create the connection with others which is a crucial element of *interventions that work* to prevent self-harm. Individuals with BPD symptomatology appear not to have consistent others in their lives that they can trust and create this connection with, evidenced through *rollercoaster relationships* and *beliefs about others* categories, and therefore the boundaried relationship with HCPs, akin to a prototypical adult parental relationship is needed. This modelling of healthy attachment relationships has proven efficacy in particular therapeutic approaches, such as MBT (Bateman & Fonagy, 2004). It could be argued these types of relationships foster dependence and could not be managed within a modern healthcare system, however all individuals depend on others to a degree (no man is an island!), and GPs manage people’s healthcare over their lifespan. An ongoing non-intensive relationship with HCPs which has appropriate boundaries could create the scaffolding required to implement other interventions and ultimately prevent self-harm.

**Implications of specific interventions.**

Whilst it is acknowledged that the research suggests multiple interventions are needed to exit the cycle of self-harm, the findings also have implications for specific interventions, which are considered below.
One of the findings reported by a number of participants is that certain interventions, being hospitalised and being responsible for, or in proximity to children stopped self-harm. However because these interventions did not treat the cause of self-harm they had no impact on future self-harm prevention. This has important implications for recommendations for self-harm prevention. HCPs are likely to know in practice that hospitalising patients does not reduce the likelihood of future self-harm, but hearing this from the perspective of individuals who self-harm adds more weight to the argument that support after intervention is vital to provide long-lasting change.

One of the subcategories finding others, within interventions that work category highlights beneficial characteristics of peer support with implications for future interventions. Participants highlighted knowing others in similar circumstances can be helpful in preventing self-harm, as long as the peer is not in an acute phase themselves or has no motivation to try and prevent self-harm. A number of participants credited online support as having a positive effect when aiming to prevent self-harm, and there was suggestion that a buddy system for self-harm, similar to Alcoholics Anonymous (Orrok, 1989), could be helpful for aspects of peer-led recovery. It was acknowledged by individuals that sometimes HCPs can be focused on change and sometimes a supportive mutual sharing helps individuals feel less alone, and peers can provide this. Implementing such a system would require careful consideration of associated risks. However, if HCPs have an understanding of the value of peer support, they can potentially be involved in systematic approaches and encourage individuals to create a support network.

Another subcategory within interventions that work, grounding, has potential clinical utility. All participants reported finding physical grounding exercises useful, suggesting they
should be implemented as part of any intervention package. The majority of participants talked about exercise having a failsafe benefit reducing self-harm, but had difficulty cultivating the motivation required to engage in activity. One participant remarked even enforced exercise would probably have a beneficial effect. The findings would suggest this should be examined further and potentially, and perhaps controversially, enforced physical activity should be a mandated part of interventions.

Another aspect of interventions that work with innovative practical application is the subcategory having a purpose. Having a purpose through a family role, job, or volunteering seemed to prevent self-harm. This supports previous research by Zanarini et al. (2014) who found the one of the six predictors of someone’s recovery from BPD is whether they are employed. The findings suggest individuals need to have a purpose to build self-worth in order to retain motivation to continue to choose alternative ways of coping. This discovery highlights that therapies in isolation are unlikely to be a complete solution to prevent self-harm, and a broader approach to interventions is perhaps appropriate. A holistic approach aligns with values from counselling psychology philosophy (Douglas et al., 2016), and suggests HCPs working with self-harm think across domains encompassing occupational, social, and cultural elements to interventions. Moreover, as pointed out by participants, therapy often makes the individual feel worse initially, and periodically, as emotive material is processed. An awareness of this is useful for HCPs working in this field to reassure themselves and their patients that this is part of the process, and not to cease treatment prematurely at the first sign of distress. As highlighted above, long-term support from HCPs is valued by individuals.
Wider context implications.

A number of participants made reference to the wider context within which they access help. These findings have implications for policymakers and future service provision. Participants reported accessing services knowing the intervention offered was not the right fit for them, but feeling they do not have other options and it was better than nothing. One of the outcomes of ineffectual support is when the intervention upon which all hope was placed fails, the individual feels they are beyond help resorting to self-harm as the default coping strategy, and perpetuating the self-harm cycle. This study proposes individuals need to have conversations with HCPs about intervention options and be able to make choices suited to them. In the current climate of the NHS, participants are reporting these options are limited and this is potentially impacting on individuals’ ability to be able to conceive a future without self-harm.

In the sunset of self-harm category participants stated their distress resulted from feeling they needed to hide their self-harm and emotional pain. This was alleviated by being open about their experiences and what they were feeling. One participant felt it would be useful to have a national campaign raising awareness around BPD and self-harm, and high-profile celebrity or public figure advocates would reduce stigma. A campaign like ‘Time to talk’, which was used to raise national awareness of mental health in the United Kingdom in 2014, and which resulted in one million conversations about mental health (Time to Change, 2014), could help destigmatize BPD and self-harm and result in individuals accessing services quicker. Furthermore, generating awareness could create opportunities for further funding for research and services, leading to improved support for individuals.
Limitations

This section outlines the limitations of this research in order to situate and contextualise the conclusions that have been drawn. Diesing (1971) states every mode of discovery develops its own standards for judging the quality of a research study. Strauss and Corbin (1990) suggest judging the quality of grounded theory through evaluating the validity, reliability, and credibility of the data, examining the adequacy of the research process, and judging the empirical grounding of the findings. These areas are considered below.

Validity, reliability and credibility of the data.

The nature of qualitative inquiry implies the findings are constructed from small numbers of participants. Thomas and James (2006) note there is a danger this method of analysis can be presented as an objective reality. It is important to take into account the findings presented in this study are not claimed to be the truth, but is one perspective of how individuals reduce self-harm through interventions. The effect of researcher bias has been considered previously in the methodology chapter, however inherent limitations within participant accounts also need to be highlighted. Memory is fallible and research has shown patients’ perceptions do not always correlate to objective measures (Haynes & Cook, 2007; Offer, Kaiz, Howard, & Bennett, 2000). Furthermore, just because a participant has experience of self-harm does not necessarily mean they will conceive of better interventions. For example, an individual with cancer is unlikely to instinctively know the best way to treat cancer, or have a better approach than HCPs. The present study has somewhat assumed participants will be able to present a different account of the self-harm intervention process, which will have clinical value. However, this account will still be subject to many flaws, some of which are highlighted below.
One of the possible consequences when creating an account of experiences of self-harm interventions in individuals with BPD symptomatology is potentially presenting an overly critical perspective on the topic. Linehan (1993) comments patients with BPD often fall short of their own expectations and their expectations of others, and impose demands and standards on themselves and others. Research by Lindgren et al. (2004) supports this view, finding staff fell short of the patients’ expectations of care, and there was no mention of HCPs exceeding expectations in any way. Therefore research from the present study’s perspective may represent an unrealistic idealised picture of care. Grounded theory aims to have impact on the phenomena studied (Strauss & Corbin, 1990), and thus makes suggestions for improvements and changes. It may be difficult to adopt all the changes proposed by participants. However, the present study argues it is helpful to know the support that is wished for in order to know what to aim towards, while conceding this is not always practically possible. At least by this approach research is identifying a direction of travel and not wandering aimlessly in the dark.

Another factor influencing the data is the participant demographics. The study conducted interviews with twelve individuals, of which all were English speaking and located in the North of England, United Kingdom. Males were under represented in the study (two out of twelve participants), this is a limitation as possible gender differences have been found in recovery (Schon, 2013), and coping behaviours in BPD (De Genna & Feske, 2013), and therefore the findings may be more applicable to women. However, as per the ethos of the present study which is guided by grounded theory philosophy combined with a counselling psychology perspective, the ways in which gender may have impacted the findings is not speculated upon. This is purposeful to avoid imposing gender stereotypes onto the findings,
which could not be substantiated. Cultural and ethnic information was not collected, however the majority of participants were White British. As such, the findings may not be representative of other cultures and geographical locations. Due to participants being based in the United Kingdom they all had access to the NHS which provides free healthcare to all, and therefore the experiences of receiving interventions and accessing services may be different to views of people without access to free healthcare. Moreover, the NHS in the United Kingdom is currently undergoing large scale cuts to funding and services as a result of global austerity (Karanikolos et al., 2013; McDaid & Knapp, 2010). The accounts of interventions reported in the findings from the grounded theory will be tied to this climate in a broader context, as well as BPD symptomatology specific. To illustrate, as stated in the implications section participants reported difficulty accessing services, only short-term support being offered, and HCPs were viewed as busy and stressed when individuals presented in A&E after self-harm. It is difficult to know whether these comments about lack of adequate interventions are reflective of mental health services as a whole, rather than specific to service provision provided to individuals with BPD symptomatology and self-harm.

Adequacy of the research process.

This section discusses limitations and strengths of the research process. One aspect to highlight is the impact of the semi-structured interview on the data. The interviews with participants were framed around the intervention questionnaire which was completed shortly beforehand. During the interview participants were asked general and specific questions about intervention experiences. This was purposeful to avoid transgression to general experiences related to self-harm or BPD. However, the semi-structured format will have influenced participants’ responses, and may have potentially prevented more spontaneous discussions,
and an overall coherent narrative describing their unique understanding of self-harm and how to prevent it. Furthermore, the method of analysis will have modified the original data gathered. The nature of grounded theory means it is necessary to lose the individual’s story in an attempt to create a generalised paradigm. This is both a strength and a weakness of the current study. Personal narratives and unique perspectives on interventions have become partially lost in this process, however the resulting theory should be applicable for a broader context than the individuals that took part.

One of the limitations of the present study is that only one person (the researcher) constructed the grounded theory. In Strauss and Corbin’s (1990) exemplar accounts of grounded theory, often multiple researchers are involved bringing different perspectives to the theory, and as a result strengthening the overall model. Due to the nature of the thesis and emphasis on independent inquiry it was not possible to have multiple researchers building the theory. The findings were discussed with supervisors and colleagues, however because they were not involved in the micro-level of data analysis their input was more checking for overall coherence than novel or opposing views of the paradigm. Introducing co-researchers to examine and analyse the data semi-independently of the primary researcher could potentially improve future publications of this work.

Another limitation of the research process concerns the analysis of the quantitative data collected, which was limited. There was a wealth of information generated from the PIPS and SHI questionnaires, of which only a snapshot is presented in the participant demographics section. This was purposeful due to the primary focus being a qualitative enquiry and the size constraints and scope of the thesis. However, Strauss and Corbin (1990) note multiple forms of media can be incorporated into a grounded theory, included
questionnaires and medical information. The present theory could be strengthened and consolidated through triangulation, encompassing a more detailed examination of the quantitative data collected and inclusion of additional forms of data, such as medical records.

**Judging the empirical grounding of the grounded theory.**

A general consideration of the limitations of a grounded theory approach has been considered in the *methodology* chapter and will not be presented here. However, Strauss and Corbin (1990) state there are seven criteria for judging the empirical grounding of a grounded theory and these will be considered in turn in relation to the study’s findings.

Strauss and Corbin (1990) note the concepts should be generated through the data (criterion 1) and the concepts should be systematically related (criterion 2). The present study generated the grounded theory through the interviews with the participants, wherever possible using conceptual labels generated from the participants’ words, and continuously referring back to the transcripts during analysis to ensure the meaning of statements stayed somewhat intact. The concepts were systematically related through means of the overall paradigm. Additionally, Strauss and Corbin (1990) state there should be conceptual density (criterion 3), and the grounded theory should account for variation in responses (criterion 4). The present study achieved conceptual density through specification of the conditions, context, action/interaction strategies, and consequences of using interventions for the prevention of self-harm. Furthermore, individual categories were elaborated and strengthened through the use of properties which were dimensionalised. The paradigm map accounts for a wide range of responses such as when self-harm is maintained or reduced, and why interventions are ineffectual dependent on emotional states.
Strauss and Corbin also note the broader conditions affecting the phenomenon should be built into the grounded theory (criterion 5). This is a particular strength of the present study. The resultant grounded theory takes into account processes over time and the context in which interventions occurred to explain variations in responses. However, a limitation of the present study should be noted, Strauss and Corbin (1990) state grounded theory should, wherever possible, take into account macroscopic conditions should as economic conditions, trends, and cultural values. Some of this is accounted for in the present grounded theory, such as the stigma experienced by individuals in relation to their self-harm, but other areas such as cultural values are not accounted for in the present study. Participant’s cultural contexts did not appear to be particularly salient in the data, however further examination of the data by an independent researcher could further verify whether this was the case. Criterion six states process and movement of action should be taken into account. In the present study, process was present through consideration of the passage of time through the grounded theory and stages of awareness in the category decision to do things differently. The overall paradigm has been presented as a process. The final criterion is whether the findings seem significant and the implications are considered (criterion 7, Strauss & Corbin, 1990). The implications of the grounded theory have been considered in the implications section above.

Avenues for Further Research

This section proposes areas of further enquiry arising from the research findings, starting with areas closely aligned with the present study and then moving more broadly to potential larger scale projects.

A useful next step in this research area would be corroboration of the findings through incorporating HCPs perspectives of the paradigm, by asking questions to determine whether
the theory fits with their working knowledge, and whether they perceive it to have any clinical utility. The current theory represents one view accounting for individuals with BPD symptomatology experiences of preventing self-harm, but this could be of little use to HCPs, if this is the case then a different model for working with individuals to prevent self-harm may need to be developed.

The current theory was devised from the research question focused on interventions to prevent self-harm, as a result the focus and detail of the paradigm is in the core category an alternative path to self-harm. The peripheral areas of the paradigm are less explored as there was a dearth of data in these areas. This includes research into the construction of self and prior beliefs in individuals with BPD symptomatology and self-harm. Further research could explore these areas in more depth to develop a better knowledge or working theory of these phenomena. This would help to illuminate how the cycle of self-harm is initiated, rather than more adaptive coping strategies being used in the first instance, and therefore how to prevent the cycle from being established. Research by Linehan (1993) proposes that a lack of validation results in a need to express distress in some form, but why self-harm is chosen over other methods is poorly understood. Additionally, research examining the interplay between interactions with others when seeking help, and the subsequent impact on future help-seeking behaviour would be a useful avenue for further work with clinical implications. The present study suggests cognitive barriers and negative evaluations of seeking help influence future help-seeking, but a more in-depth look at these interactions with others could identify subtleties in these processes. Many participants mentioned negative interactions with others when they presented to A&E following self-harm, and therefore naturalistic observational
studies would usefully capture some of these experiences. Although, the impact of being watched would to some extent change behaviour.

In contrast to the peripheral areas of the theory, the core-category had vast amounts of data. This data could be examined in more detail by analysing transcripts through different methods of analysis such as Interpretative Phenomenological Analysis [IPA] aiming to explore individuals lived experience (Reid, Flowers, & Larkin, 2005), or narrative analysis looking at how individuals understand their self-harm within their personal narratives (Riessman, 1993). These perspectives would add richness to this research area, by providing intimate accounts of experiences complementing the present study, which is more focused on a general account of the phenomena.

Furthermore, there was a large amount of quantitative data generated from the PIPS questionnaire, only a portion of which was presented in the participant demographics section as previously mentioned. Further research could conduct several lines of inquiry using this data, such as a quantitative investigation into the relationship between perceived intervention helpfulness and amount of self-harm reduction, whether interventions used are related to the methods used to self-harm, and whether there is a relationship between the extent of self-harm and whether interventions are attempted. As well as considering whether demographic factors such as age and sex have any impact on these activities. Some research has suggested there are gender differences in ability to recover (Schon, 2013). Moreover, several participants commented their perspective on self-harm and interventions changed as they got older, it would be interesting to see if these claims are substantiated empirically.

As mentioned earlier in the comparison to previous literature section, the phenomena of asset stripping damages an individual’s ability to prevent self-harm. Individuals need to be
seen as a person with unique values and purpose in order to exit the cycle of self-harm. However, it could be argued asset stripping also occurs in research whereby individuals are recruited and excluded on the basis of particular criteria, and the effectiveness of interventions is measured against a pre-existing criteria set by researchers for all participants. As Bateman et al. (2015) noted there is a dearth of effective treatments. Potentially, the participants in the current study could be giving an insight into why research shows interventions are not particularly effective. Participants in these studies are treated en masse. Future research could be more client-centred focussing on individually tailored interventions, or as a first step, any research looking at the effectiveness of interventions could be evaluated qualitatively as well as quantitatively. The present study does not argue traditional methods should be discarded. However quantitative studies could be redesigned to be more individually focussed, for example a Randomised Controlled Trial [RCT] could research whether the paradigm map improves Quality of Life [QoL] outcomes over 10 years. Research such as this incorporates findings from a qualitative perspective (i.e. paradigm map from this study), and outcomes based on the individual’s values, and takes into account the pace of change suggested by individuals themselves. By taking these small non-radical steps the focus will shift back towards the individual.

One of the limitations mentioned previously in relation to the current study is whether the views regarding a lack of service provision, commented on by participants, are representative of mental health services as a whole, or BPD specific. Similarly, it is unknown whether the theory incorporating interventions that work, and decision to do things differently, is applicable to other health conditions. Further research could compare the experiences of individuals with BPD symptomatology to individuals with physical health conditions
requiring psychological support (such as cancer), or to other mental health conditions requiring long term support (such as schizophrenia or treatment resistant depression).

Research has suggested individuals with BPD experience more stigma than other patient groups and have less access to services (Cleary et al., 2002; NICE, 2009; James & Cowman, 2007), however the research is outdated. Due to the current climate of austerity this may be more widespread across services. Furthermore, research could examine whether the grounded theory applies in different geographical and cultural regions, private healthcare systems, or healthcare systems reporting high levels of patient satisfaction e.g. Austria (Bleich, Ozaltin, & Murray, 2009).

**Personal Reflections and Reflexivity**

This section covers a personal reflection on the research process. Coffey and Atkinson (1996) note transactions emerging from the research process should be documented. Similarly, Van Maanen (1988) states a research history should be part of any qualitative study as part of a transparent account of the research. The introduction outlined my rationale for choosing this topic from within a counselling psychology context. This section summarises the personal impact of the research process, by considering the different stages of the project and the accompanying emotional experiences. The aim is to present the researcher’s experience of the project as this will have influenced the theory constructed and the conclusions drawn.

This research was carried out as part of a wider endeavour, the counselling psychology doctorate which involves, among other elements, completing 450 hours of face to face therapy with clients. In deciding to do the present topic for the research element of the doctorate, and as mentioned in the introduction, I was uncomfortable with the terms BPD and recovery. In my opinion diagnoses and a medical model of illness does not provide a complete account of
the causes of psychological distress. I believe maladaptive functioning arises as a result of social, environmental and cultural influences in addition to predisposing biological factors. I am also hesitant to use the word recovery, personally feeling the term potentially creates an idealistic outlook of the future, and implies individuals have failed if they are not symptom free. Despite these reservations, I was aware during my client work of a professional discourse around the term BPD, and I picked up a general consensus from HCPs that this client group was particularly difficult to treat. It led me to question the basis of this assumption. I found myself wanting to know if this group of people attached to a label of ‘BPD’ get better with time or interventions, and if not, why not? The more I researched to try and answer these questions, the more I found there were lots of theoretical accounts but scant literature generated from individual’s accounts. Thus started my venture into the present study.

**Ethics and despair.**

In order to get access to participants I needed to complete NHS ethics procedures. This procedure became a significant undertaking taking 10 months to complete involving a couple of hundred pages of associated documents, meeting with an ethics board of approximately 15 members to be questioned on the research purpose and procedure, and researcher certification to be deemed medically fit from healthcare services. At times during this process I questioned whether the project should be altered so access to NHS patients was not necessary, but my overriding thought was always that the research in its current form was of most interest to me, and as I was going to spend a couple of years immersed in the topic I wanted it to be something I found truly engaging.
Support, surprise, and frustration.

When I received the NHS ethics approval this was the green light to approach departments to enable participant recruitment. When I met with service managers most were very supportive, expressing the view that the research findings may replicate what is known in clinical practice, however the information is not captured in research. A viewpoint echoed by McLeod (2001) stating that a widening gap has emerged between research and practice, and emphasising the importance of an inquiry conducting research to inform practice and vice versa. I was surprised by the support from service managers as I had been expecting more resistance and I found this encouraging. A few managers wanted changes to aspects of the research design thinking participants could be triggered by talking about self-harm, and suggested interviewing HCPs instead, or omitting the term BPD in recruitment, despite reassurances only patients HCPs considered stable would be eligible to take part. I could see the rationale for these suggestions (protecting participants from talking about self-harm or having them associate with a label), but the proposed changes felt like the crux of the research would be missed. It felt important to get individuals’ perspectives precisely because stigma is experienced with the label of BPD and self-harm, and self-harm is not openly discussed. Couture and Penn (2003) and Nehls (1999) support this view. All the same, I started to doubt myself and approached a couple of well-known BPD advocates for advice, who encouraged the existing line of enquiry.

A nervous travelling salesman.

Looking back over my research diary it is littered with contacts and I have counted more than 40 departments approached. A number of these I visited attempting to convince them to allow the research at their service. Once a departmental lead gave the go-ahead I
would present the rationale and procedure for recruitment to their practitioners. I felt like a travelling salesman cajoling busy HCPs into recruiting participants, and it felt uncomfortable. At this time I was nervous that all of the effort on the NHS ethics procedure could amount to nothing if I had no participants. I kept thinking if I can just get the interviews with participants done, then the study can go ahead, and it is just down to me to write it up, but with the completion of recruitment came anxiety.

**Responsibility, delight, and anxiety.**

Listening back over the bracketing interviews completed after each participant’s interview I am babbling and excited about what I have heard. There was something about the articulate honesty in the way participants gave their opinions and experiences which felt electric. I felt privileged to be let into part of their inner world and I was consistently surprised by their responses. Behaviours, feelings, and thought processes which I would never have conceived of made sense when participants explained their rationale. Most participants offered further interviews if needed. This was not taken up as it would have contravened the ethics approval.

However, once the interviews were completed I felt I owed the participants to write up the findings in a way that honoured their experiences. I was very conscious their interview responses were thought-out and reasoned, and I became concerned about potentially removing elements of their experiences by constructing the grounded theory. I was wrestling with how to present the findings in a way that did not medicalise BPD and experiences of self-harm, and at the same time were presented in a discourse accessible to HCPs. As mentioned in the *methodology* chapter a large part of me wanted to publish transcripts in their entirety. I felt frozen from moving forward with the analysis, ultimately this was overcome by thinking any
analysis is better than none, resulting in a gradual freeing of my mind enabling construction of
the theory.

**Plodding and going inside for the write-up.**

At some point during the initial write-up of the findings the enormity of the thesis
became apparent. The size of thesis meant the writing process felt a very different entity to
previously authored journal articles and chapters. It was difficult to hold the entire thesis in
mind trying to maintain a flow throughout to tell a coherent account. In order to do so I
needed long periods of time away from human contact, this felt isolating but necessary, and
was characterised by moments of insight within long periods of monotonous researching,
checking, and writing.

**Final reflections and impact.**

I think to some extent the emotions experienced throughout the thesis process may
reflect the emotions individuals with BPD symptomatology go through trying to access help.
A number of participants commented on the difficulty accessing services, and this mirrored
the research process whereby it proved difficult to get access to participants to conduct
interviews. Clinicians have reported working in the area of BPD is like a turbulent
rollercoaster and this would sum up my experiences of the research process. I think these
experiences impacted on the research and I wanted to know how participants saw themselves
through others. This is reflected in themes associated with stigma and unhelpful aspects of
interactional change. Through the research process I became more aware of the lack of
intervention options felt by participants, and as a result I spent more time thinking about the
implications of the work and how the findings may be of use in clinical practice. My intention
is to consolidate this knowledge through the dissemination of the findings in journal articles and conferences, hoping to stimulate debate and further research in this area.

Chapter Summary

This chapter started with an overview of the main categories and sub-categories found in the grounded theory, exploring how individuals with BPD symptomatology perceive self-harm interventions, and discussed these findings in reference to existing literature. Implications of the findings were suggested by reference to their application in clinical use, changes to existing intervention practices and in a broader policy context. Next the limitations of the research were presented through consideration of the validity, reliability, and credibility of the data, adequacy of the research process, and judging the empirical grounding of the analysis. This was followed by suggestions for areas of further research to expand the current study’s findings. The chapter ended with a personal reflexive account of the research process to help contextualise the current study for readers and future researchers aiming to conduct further work in this area.
Chapter 6

Conclusions

This brief chapter provides a summary of the research process and states the final conclusions. The aim of the research was to investigate how individuals with BPD symptomatology perceive interventions to prevent self-harm. The first chapter introduced the research topic and key terms, and described the rationale for the current study by reference to clinical guidelines (NICE, 2009), suggesting a lack of effective evidence based interventions to reduce recurrent self-harm. This chapter also discussed the potential benefits of looking at this topic from a counselling psychology perspective.

In the literature review the various research fields which have relevance to the current study were drawn upon. This chapter started with a critical approach towards BPD diagnosis, and presented an overview of the research examining how individuals with BPD view their diagnosis and difficulties. This section was concluded with the current study’s stance towards these issues. The literature review then focussed on self-harm in particular, as research has suggested it is the high-risk behaviours, such as self-harm and suicide, which create difficulties between individuals and HCPs when providing interventions (Cleary et al., 2002; McCarthy et al., 2013; Wilstrand et al., 2007). Reasons for self-harm from the individuals’ perspective were discussed, alongside research looking at HCPs views on providing interventions for self-harm. Thus identifying the need for further research considering what might constitute an effective intervention to support individuals with BPD symptomatology, and HCPs working in this area. This was followed by an overview of the common interventions given to reduce self-harm in individuals with BPD, and the effectiveness of
these interventions. The intervention literature highlighted the small number of qualitative studies investigating interventions from the perspectives of the individuals themselves. Therefore the present study aimed to address this, by considering a broader holistic approach to find out how individuals with BPD symptomatology viewed interventions to prevent self-harm using qualitative methodology. In order to incorporate a long-term perspective, the last part of the literature review presented findings from research on recovery to identify processes of recovery which are relevant for successful interventions.

The methodology chapter described how the research was conducted and the philosophical basis underpinning the work. This chapter began by outlining the epistemological and ontological positions of the research, and described how a critical realist and contextualist approach informed the data collection and the chosen method of analysis. The recruitment procedure for the twelve participants who took part in the research was presented alongside their relevant demographic information. This data collection procedure involved a semi-structured interview and two questionnaires to generate the qualitative data for a grounded theory analysis. The chapter summarised the history of grounded theory, and the rationale for grounded theory in the present study was discussed together with how limitations of the approach would be mitigated. The methods used to ensure quality and trustworthiness of the data were also outlined, and the procedure followed during analysis was described. The chapter ended by considering relevant ethical issues.

In the findings chapter, the grounded theory was presented. The analysis began with the core story encompassing the overall theory of how the participants viewed interventions to prevent self-harm. The three categories identified by the grounded theory were stated. These included two sub-categories, established beliefs and causal factors, and time course of self-
harm, and one core category, an alternative path to self-harm. The chapter then discussed the relationships between these categories in reference to an overall paradigm. Following this the categories were outlined in turn with reference to their sub-categories to show a process unfolding over time. The findings emphasised a holistic approach to interventions may create an alternative route to self-harm, rather than any specific intervention or technique.

The discussion chapter situated the findings in reference to the existing research previously introduced in the literature review. The similarities, differences, and areas of new knowledge were pointed out, in order to outline the implications of the findings and their relevance for clinical practice and healthcare policy. At the same time, the limitations of the research were presented by looking at the validity, reliability, and credibility of the data, the adequacy of the research process, and the empirical grounding of the analysis. This led to suggestions for areas of potential further research. The discussion ended with personal reflections on the research process.

In conclusion, the study hopes to have contributed to knowledge by presenting a novel holistic approach to how interventions are perceived by individuals with BPD symptomatology to prevent self-harm. The research suggests individuals with BPD symptomatology perceive interventions as helping to reduce self-harm when interventions are long-term, consistent, and instant, and the intervention’s outcome matches the purpose for the self-harm. The use of interventions appears to be context dependent, specifically being affected by the individual’s level of emotional tension, and their cognitive processing during the decision to seek help. For long-term self-harm prevention, multiple interventions that meet particular criteria (allow expression and communication, facilitate grounding etc.) are required, and individuals need to be actively maintaining and evaluating these alternative
strategies. As a consequence, it is suggested HCPs, services, researchers, and individuals with BPD symptomatology work towards identifying an individual’s unique reasons for their self-harm, and support them to cultivate an awareness of their emotional state, and their perceptions of interventions as a first step. Before continuing to work on a collaborative enquiry, which aims to build up multiple useful techniques over time, alongside an understanding of how and when these interventions work. This holistic approach provides an alternative way of conceptualising the self-harm intervention process, and could potentially be of use to improve future intervention provision.
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McLeod, J. (2001). Developing a research tradition consistent with the practices and values of counselling and psychotherapy: Why counselling and psychotherapy research is necessary. *Counselling and Psychotherapy Research, 1*, 3-11.


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Appendices

Appendix AA

DSM-5 Criteria for Borderline Personality Disorder

To meet the DSM criteria (APA, 2013) for BPD individuals must meet five out of the following nine criteria (1) frantic efforts to avoid real or imagined abandonment (not including suicidal or self-harm behaviour as covered in criterion 5), (2) a pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealization and devaluation, (3) identity disturbance meaning markedly and persistently unstable self-image or sense of self, (4) impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating, not including self-harm), (5) recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour, (6) affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days), (7) chronic feelings of emptiness, (8) inappropriate, intense anger or difficulty controlling anger, and (9) transient, stress-related paranoid ideation or severe dissociative symptoms.
Appendix AB

Search Strategy for Literature Review

To construct the arguments presented in the literature review the following search methods and criteria was applied. All the searches were initially completed on Google Scholar. This was followed by subsequent hand searching of the reference lists of relevant articles and examining associated papers highlighted by the individual journal websites.

**BPD**

The search in this area began by looking for qualitative studies investigating individuals with BPD perceptions of their diagnosis or how they experience their difficulties. These papers presented, among others, a critical approach towards BPD diagnosis which then spurned further searches on the criticisms of BPD. A selection of these articles were chosen to represent the arguments presented in this section based on their relevance to the topic.

**Self-harm**

A search using the key-words ‘self-harm’, ‘BPD’ and ‘qualitative’ revealed a vast literature base. Therefore a selection of papers were chosen to represent the overall field, preference was given to the main reviews in this area and the latest research from individuals with BPD and/or self-harm perspectives.

**Interventions**

In a previous systematic review of interventions to prevent self-harm in individuals with a diagnosis of BPD, Noble (2015) identified three qualitative studies in this area. These papers were used to identify additional studies of interest to present an overall picture of the research in this area.
Recovery

A systematic review of the qualitative literature using the terms ‘recovery’, ‘personality disorder’ and ‘qualitative literature’ identified few studies in this area. The Shepherd et al. (2016) systematic review of this field identified three studies which were discussed in this section.
The table below presents a brief overview of some of the ways self-harm has been conceptualised from different theoretical perspectives. It is not intended to be exhaustive but to provide some illustration of the diverse and sometimes similar ways in which self-harm is understood.

<p>| Biosocial disorder | Linehan (1993) describes self-harm as biosocial disorder, biologically there is evidence to suggest some individuals have a heightened sensitivity to emotion, experience emotions more intensively and have a slower return to emotional baseline. The cause of which could be disturbed early environment, trauma, or a particular neurochemical pathway. This is paired with a social environment in which the individuals coping mechanisms and responses to this emotional dysregulation are invalidated. As a result of intense emotional experiences which individuals feel unable to tolerate they engage in impulsive and maladaptive behaviours such as self-harm. Self-harm is maintained through one of the following ways, either reduction of emotional arousal following self-harm negatively reinforces the behaviour, and/or anger, contempt, and shame from self-harm interfere with problem solving and emotional processing to act differently, and/or shame-related emotions directly lead to self-punishment, or an extreme desire to hide or disappear causing further self-harm, denial of behaviour or suicidal intent. |</p>
<table>
<thead>
<tr>
<th>Approach</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentalization based approach</td>
<td>Bateman and Fonagy (2004) suggest individuals lack the ability to emotionally expressive themselves or to understand the intentions of others as a result of experiencing trauma/neglect/lack of emotional availability from others (particularly attachment figures) in early life. This lack of robust awareness of mental states of self and others (known as mentalization) leads to an inability to communicate distress to others, lack of awareness of impact on self or others, and perceiving others will hurt them if they do not do what others want. Mentalization suggests self-harm serves the purpose of self-expression and communication for individuals with limited capacity for awareness functions.</td>
</tr>
<tr>
<td>Cognitive behavioural approach</td>
<td>Self-harm is conceptualised as a tool for emotion regulation, as a short term intervention to release pent up emotion and tensions (Fallon, 2003), which is maintained through positive and negative reinforcement (Nock &amp; Prinstein, 2004). Haines, Williams, Brain, and Wilson (1995) suggest individuals have a heighted emotional response which makes memories and life events harder to bear, and therefore self-harm is a coping strategy to manage and relieve severe emotional distress, overwhelming psychological pain, intrusive memories, and compulsions to repeat earlier traumas (Favazza &amp; Conterio, 1989).</td>
</tr>
<tr>
<td>Psychodynamic approach: object relations theory</td>
<td>Van der Kolk and McFarlane (2012) suggest self-harm results from an individual having an inconsistent internal object (developed from early life experiences in which individuals internalise a view of</td>
</tr>
</tbody>
</table>
an other), and therefore these individuals are unable to tolerate reality being good and bad. In order to manage reality, individuals frequently mentally split themselves and others into being wholly bad or good. Self-harm thus acts as form of punishment or atonement when they view themselves as wholly bad.

| Neurobiological approach | Research has shown self-harm provides relief from acute dysphoria and may be accompanied by analgesia (Stanley & Brodsky, 2005). Therefore it has been suggested individuals are using self-harm as a form of self-medication. Leibenluft, Gardner, and Cowdry (1987) demonstrated endogenous opiates are released during the acute phase of self-harm. |
## Appendix AD

### Common Interventions to Prevent Self-harm in Individuals with BPD

<table>
<thead>
<tr>
<th>Psychological treatment</th>
<th>The first evidence of effective treatment, DBT, was published in 1991 (Linehan, Armstrong, Suarez, Allmon, &amp; Heard, 1991), however the evidence base for psychological treatment is still greatly undeveloped (Paris, 2012). Most studies typically include more women than men, do not contain control groups, participant numbers are often small, and drop-out rates are high which make it difficult to assess the effectiveness of treatment (Bateman et al., 2015). Alongside the fact chronic self-harm is considered a long-term intractable behaviour which means improvements tend to be gradual. It has been suggested longer-term follow up data is needed in order to make any valid judgments. Two of the NICE recommended approaches (NICE, 2009), DBT and MBT are expanded upon below.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DBT</td>
<td>By far the most common therapeutic approach evidenced in the research literature is DBT, which was developed by Marsha Linehan (Linehan, 1993) for the purpose of reducing self-harm and suicidal behaviours. DBT is a structured, manualised method combining behavioural change and acceptance based approaches in four areas; distress tolerance, emotion regulation, interpersonal effectiveness, and mindfulness. This is implemented through an intensive programme of group skills training, individual therapy, and immediate telephone support. Typically DBT programmes last for 12-18 months.</td>
</tr>
<tr>
<td><strong>MBT</strong></td>
<td>Mentalization based therapy works on the assumption individuals with BPD have a core deficit in the ability to mentalize, which refers to the capacity to think about oneself in relation to others and to understand others’ state of mind, in terms of needs, desires, beliefs, goals, purposes, and reasons (Bateman &amp; Fonagy, 1999). In sessions therapists aim to activate the attachment system and provide a relational context to explore the mind of the other, increasing their ability to mentalize and reducing the need for self-harm. It is a manualised approach, ideally offered twice per week, with sessions alternating between group and individual treatment (Bales et al., 2012; Bateman &amp; Fonagy, 2004).</td>
</tr>
<tr>
<td><strong>Hospitalisation</strong></td>
<td>The unplanned hospitalisation of patients with BPD in a general psychiatric setting to prevent self-harm has been found to have limited value, and often negative consequences (Helleman et al., 2014). Regression, repetitive admission, and non-recovery from long-term suicidal ideation following discharge have been reported (Krawitz et al., 2004; Paris, 2002).</td>
</tr>
<tr>
<td><strong>Medication</strong></td>
<td>There is little evidence for the efficacy of medication in BPD, and no medication is explicitly recommended in clinical guidelines (NICE, 2009). One study has investigated the impact of Naltrexone (Sonne et al., 1996), an opioid antagonist on self-harm in BPD and showed a significant decrease in self-harm over a three week trial.</td>
</tr>
<tr>
<td>Collaborative approach with HCPs</td>
<td>However, the sample was extremely small (five participants) and post-treatment self-harm increased beyond baseline levels.</td>
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<tr>
<td>--------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Collborative approach with HCPs</td>
<td>Borschmann et al. (2013) developed an approach adopting joint crisis plans during a one hour meeting between a HCP, an individual with BPD, and invited personnel at the discretion of the individual. Topics for the joint crisis plan included positive things to do in a crisis, specific refusals regarding treatment in a crisis, practical help in a crisis, and useful telephone numbers. Completed joint crisis plans were given to the individual and attached to their electronic medical records. However, there was no reduction in the number of individuals reporting self-harm or the frequency of self-harm behaviours after 6 months compared to treatment as usual.</td>
</tr>
</tbody>
</table>
An investigation into how individuals who self-harm and struggle with personal relationships or self-identify as having Borderline Personality Disorder [BPD] perceive interventions to prevent self-harm

CONSENT FORM

If you are happy to participate please complete and sign the consent form below

<p>| | |</p>
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<tbody>
<tr>
<td>1.</td>
<td>I have read (or had read to me) and understood the information sheet and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.</td>
</tr>
<tr>
<td>2.</td>
<td>I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to any treatment/service.</td>
</tr>
<tr>
<td>3.</td>
<td>I understand that I will be asked to complete two questionnaires and I will be asked about my answers to one of the questionnaires. This will take approximately one hour and will be audio-recorded.</td>
</tr>
<tr>
<td>4.</td>
<td>I understand that if I disclose harm to others, high risk of suicide or criminal behaviours then relevant authorities may be contacted.</td>
</tr>
<tr>
<td>5.</td>
<td>I understand that I do not have to answer any questions I am uncomfortable with.</td>
</tr>
<tr>
<td>6.</td>
<td>I understand that my data will be anonymised, encrypted and kept for five years.</td>
</tr>
<tr>
<td>7.</td>
<td>I agree that any data collected may be passed as anonymous data to other researchers.</td>
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</tbody>
</table>

Please initial box
8. I agree to the use of anonymous quotes in any write-up.

9. I understand the findings from the research may be published.

10. I understand that data collected during the study, may be looked at by individuals from the university of Manchester from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.

I agree to take part in the above project

<table>
<thead>
<tr>
<th>Name of participant</th>
<th>Date</th>
<th>Signature</th>
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Appendix AF

Semi-structured interview protocol

**Opening**

Thank you very much for agreeing to meet with me. Today I am interested in hearing about things you or other people have tried to do to stop self-harming. We will talk a bit about your answers to the second questionnaire and I’ll ask you what you think has been helpful or unhelpful. You can talk about your experiences if you like, but don’t worry if you have trouble thinking what to say. That is okay. We have about an hour today, but if you would like to stop at any point just let me know.

Do you have any questions?

**Content**

*A. If they have some experience of intervention*

You have experienced Intervention X. Could you tell me a bit more about that?

You’ve marked it here, would you say it was helpful or unhelpful?

Why was that?

*B. If they have no experience of intervention*

You haven’t experienced Intervention X. Is there any reason you haven’t tried Intervention X?

Have you tried anything similar?

You’ve thought it might be here (on the scale), why do you think it might be helpful or unhelpful?

**Addressing the free-form box for interventions not previously specified**

Could you tell me more about Intervention X?

Is it helpful or unhelpful?

Whys that?

What did you think about filling in X questionnaire?

**Closing**

Is there anything you want to say that I haven’t asked about?

How are you doing after talking with me?

I have no further questions, do you have any questions?

**Prompts**

Do you remember an occasion when Intervention X happened?

Could you describe in as much detail as possible what happened?

Do you have any more examples of this?
What did you think then?

What did you actually do when you felt/thought…? How did your body react?

Could you tell me about a time it has been helpful?
Could you tell me about a time it has been unhelpful?
Why do you think sometimes it is helpful and sometimes unhelpful?
How do you think other people see Intervention X?
Do you mean that…?

Is it correct that….?
Appendix AG

Self-harm inventory (original and modified)

**SELF-HARM INVENTORY**

*Instructions:* Please answer the following questions by checking either, “Yes,” or “No.” Check “yes” only to those items that you have done intentionally, or on purpose, to hurt yourself.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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1. Overdosed? (If yes, number of times_____)
2. Cut yourself on purpose? (If yes, number of times_____)
3. Burned yourself on purpose? (If yes, number of times_____)
4. Hit yourself? (If yes, number of times_____)
5. Banged your head on purpose? (If yes, number of times_____)
6. Abused alcohol?
7. Driven recklessly on purpose? (If yes, number of times_____)
8. Scratched yourself on purpose? (If yes, number of times_____)
9. Prevented wounds from healing?
10. Made medical situations worse on purpose (e.g., skipped medication)?
11. Been promiscuous (i.e., had many sexual partners)? (If yes, how many?_____)
12. Set yourself up in a relationship to be rejected?
13. Abused prescription medication?
14. Distanced yourself from God as punishment?
15. Engaged in emotionally abusive relationships? (If yes, number of relationships?______)
16. Engaged in sexually abusive relationships? (If yes, number of relationships?______)
17. Lost a job on purpose? (If yes, number of times_____)
18. Attempted suicide? (If yes, number of times_____)
19. Exercised an injury on purpose?
20. Tortured yourself with self-defeating thoughts?
21. Starved yourself to hurt yourself?
22. Abused laxatives to hurt yourself? (If yes, number of times_____)

Have you engaged in any other self-destructive behaviors not asked about in this inventory? If so, please describe below.

*Figure 1.* Self-harm inventory. Copyright © 1995 Sansone, Sansone, and Wiederman
Self-harm inventory (modified)

Instructions: Please answer the following questions by checking either “yes” or “no”. Check “yes” only to those items that you have done intentionally, or on purpose, to hurt yourself.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Have you every intentionally or on purpose, done any of the following:</th>
<th>If yes: Less than 5 times</th>
<th>If yes: 5 - 9 times</th>
<th>If yes: 10 or more times</th>
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<td>1. Overdosed?</td>
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<td>2. Cut yourself on purpose?</td>
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<td>3. Burned yourself on purpose?</td>
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<td>4. Hit yourself?</td>
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<td>5. Banged your head on purpose?</td>
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<td>6. Abused alcohol?</td>
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<td>7. Driven recklessly on purpose?</td>
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<td>8. Scratched yourself on purpose?</td>
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<td>9. Prevented wounds from healing?</td>
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<td>10. Made medical situation worse on purpose (e.g. skipped medication)?</td>
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<td>11. Been promiscuous (i.e. had many sexual partners)?</td>
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<td>12. Set yourself up in a relationship to be rejected?</td>
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<td>13. Abused prescription medication?</td>
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<td>14. Distanced yourself from god as punishment?</td>
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<td>15. Engaged in emotionally abusive relationships?</td>
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<td>16. Engaged in sexually abusive relationships?</td>
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<td>17. Lost a job on purpose?</td>
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<td>18. Attempted suicide?</td>
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<td>19. Excessively exercised to hurt yourself?</td>
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<td>20. Tortured yourself with self-defeating thoughts?</td>
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<td>21. Starved yourself to hurt yourself?</td>
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<td></td>
<td>22. Abused laxatives to hurt yourself?</td>
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</table>

Have you engaged in any other self-destructive behaviours not asked about in this questionnaire? If so, please describe below.
Appendix A1

PIPS Questionnaire (Perceptions of Interventions to Prevent Self-harm)

Have you ever tried the following interventions to reduce or prevent self-harming?

There are no right or wrong answers. Please circle the response which fits with you. If you have any questions please ask the researcher.

1. Looking at a list of positive things about me

   YES  NO

If yes, how helpful have you found it to be?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<tbody>
<tr>
<td>Extremely unhelpful</td>
<td>Neither helpful or unhelpful</td>
<td>Extremely helpful</td>
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If no, how helpful or unhelpful do you think it would be?

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<tr>
<td>Extremely unhelpful</td>
<td>Neither helpful or unhelpful</td>
<td>Extremely helpful</td>
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</table>
### 2. Reading a letter I have written to myself

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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If yes, how helpful have you found it to be?

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<td>Neither helpful or unhelpful</td>
<td>Extremely helpful</td>
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If no, how helpful or unhelpful do you think it would be?

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<td>Extremely unhelpful</td>
<td>Neither helpful or unhelpful</td>
<td>Extremely helpful</td>
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### 3. Going to bed

<table>
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<tr>
<th>YES</th>
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If yes, how helpful have you found it to be?

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<td>Extremely helpful</td>
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If no, how helpful or unhelpful do you think it would be?

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4. Going online to a forum

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5. Making a list of reasons not to self-harm

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6. **Doing physical activity, for example, walking, cleaning, or dancing**

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7. **Playing music**

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8. Breathing exercises, meditation, or mindfulness

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If yes, how helpful have you found it to be?

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| Extremely unhelpful | Neither helpful or unhelpful | Extremely helpful |

If no, how helpful or unhelpful do you think it would be?

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| Extremely unhelpful | Neither helpful or unhelpful | Extremely helpful |

9. Reading

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| Extremely unhelpful | Neither helpful or unhelpful | Extremely helpful |
10. Acknowledging emotions

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If yes, how helpful have you found it to be?

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11. Riding it out, for example setting a timer for 10 minutes

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If yes, how helpful have you found it to be?

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12. **Having a warm bath or shower**

   **YES**  
   **NO**

If yes, how helpful have you found it to be?

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13. **Grounding exercises for example, holding ice cubes or flicking elastic band**

   **YES**  
   **NO**

If yes, how helpful have you found it to be?

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### 14. Helping someone else

**YES** | **NO**
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If yes, how helpful have you found it to be?

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### 15. Talking to friends or family (either on the telephone or in person)

**YES** | **NO**
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16. Talking to healthcare professionals (doctors, nurses, paramedics etc)

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If yes, how helpful have you found it to be?

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17. Phoning a helpline

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18. Individual therapy

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If yes, how helpful have you found it to be?

If no, how helpful or unhelpful do you think it would be?

19. Group therapy

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If yes, how helpful have you found it to be?

If no, how helpful or unhelpful do you think it would be?
### 20. Mixture of individual and group therapy

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*Extremely unhelpful* | *Neither helpful or unhelpful* | *Extremely helpful*

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*Extremely unhelpful* | *Neither helpful or unhelpful* | *Extremely helpful*

### 21. Going to hospital

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If yes, how helpful have you found it to be?

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</tbody>
</table>

*Extremely unhelpful* | *Neither helpful or unhelpful* | *Extremely helpful*

If no, how helpful or unhelpful do you think it would be?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
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*Extremely unhelpful* | *Neither helpful or unhelpful* | *Extremely helpful*
22. Taking medication

YES       NO

If yes, how helpful have you found it to be?

<table>
<thead>
<tr>
<th>1</th>
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</table>

Extremely unhelpful       Neither helpful or unhelpful       Extremely helpful

If no, how helpful or unhelpful do you think it would be?

<table>
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<tr>
<th>1</th>
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</tbody>
</table>

Extremely unhelpful       Neither helpful or unhelpful       Extremely helpful

23. This list does not cover everything you might have used to reduce or prevent self-harming. Is there anything else you have tried to do to reduce or prevent self-harming?

Please list, with a number from 1 (extremely unhelpful) to 7 (extremely helpful)
Appendix AJ

Screenshot from Citizen Scientist website

**OPINIONS ABOUT SELF HARM INTERVENTIONS**

An investigation into how individuals who self-harm and struggle with personal relationships or self-identify as having Borderline Personality Disorder (BPD) perceive interventions to prevent self-harm.

- Would you be willingly to speak about what you have found helpful and unhelpful when trying to prevent self-harming?
- Do you have a history of self-harm?
- Do you struggle with personal relationships or identify as having Borderline Personality Disorder (BPD)?

If yes, then I would like to invite you to take part in my Doctorate Thesis Research.

**What would it involve?**

- You would be invited to complete two short questionnaires and take part in a semi-structured interview lasting approximately one hour which will be audio-recorded.
- Interviews will take place at a date and time convenient to you.
- Confidentiality is assured and you will not be identified in any part of the research.

**How can I find out more?**

Contact Julia.nobie@postgrad.manchester.ac.uk to register your interest.
Appendix AK

Inclusion and exclusion criteria for HCPs

An investigation into how individuals who self-harm and struggle with personal relationships or self-identify as having Borderline Personality Disorder [BPD] perceive interventions to prevent self-harm

- This research study is part of a doctorate thesis at the University of Manchester. Findings from this study will be published in a thesis and possibly published in scientific journals. Confidentiality is assured, and participants will not be identified in any part of the research

- The purpose of this research is to explore what individuals who self-harm and have difficulties with personal relationships or identify with BPD think about interventions to prevent self-harm. This is the first time this has been researched. The results could potentially be used to develop more helpful interventions in the future with individuals having input into these decisions.

- If you have any clients or patients who fulfill the criteria below and you feel are suitable to take to take part in this research study, please pass them the initial information sheet.

  Thank you for your support.

Participant inclusion criteria:

- Have a history of self-harm
- Self-identify as having Borderline Personality Disorder [BPD] or difficulties in their relationships with others
- Aged between 16 to 65 years
- Are able to express themselves verbally
- Able to provide written consent

Participants cannot take part in the study if:

- They are below 16 years
- They have learning or English language difficulties which would prevent completion of a semi-structured interview
- They are unable or unwillingly to provide written consent

If you have any further questions about the research please contact:
Julia Noble
Julia.noble@postgrad.manchester.ac.uk

Or

Dr Terry Hanley (Supervisor)
terry.hanley@manchester.ac.uk
Appendix AL

Initial information sheet for participants

An investigation into how individuals who self-harm and struggle with personal relationships or self-identify as having Borderline Personality Disorder [BPD] perceive interventions to prevent self-harm

- Would you be willingly to speak about what you have found helpful and unhelpful when trying to prevent self-harming?

- Do you have a history of self-harm?

- Do you struggle with personal relationships or identify as having Borderline Personality Disorder [BPD]?

If yes, then I would like to invite you to take part in my Doctorate Thesis Research.

What would it involve?

- You would be invited to complete two short questionnaires and take part in a semi-structured interview lasting approximately one hour which will be audio-recorded. Interviews will take place at a date and time convenient to you.

- Confidentiality is assured and you will not be identified in any part of the research.

How can I find out more?

- Your healthcare worker will ask if you would be interested in taking part in the research.

Thank you,

Julia Noble

Counselling Psychologist in Doctoral training

This research has been reviewed by Greater Manchester West NHS Ethics Committee.
Appendix AM

Participant registration form

Thank you for your interest. If you wish to take part in this study then please complete this form below and I will contact you by phone to arrange a time and place to meet.

Name:

DOB:

Organisation where I heard about research:

Contact telephone number (if applicable):

Contact email address (if applicable):

*Please indicate a response to these questions below (delete as appropriate):*

1. I have a history of self-harm: **YES** | **NO**
2. I struggle with personal relationships: **YES** | **NO**
3. I think I have borderline personality disorder: **YES** | **NO**
4. I have read the information provided and I am happy to be contacted by telephone to arrange a meeting:  **YES | NO**

5. I consent to the researcher leaving a message letting me know they have tried to reach me if I am unable to answer the phone call:  **YES | NO**

6. I have read the information provided and I am happy to be contacted via email to arrange a meeting:  **YES | NO**

Please pass this completed form to your healthcare professional who discussed this research with you, or put in the research box at the organisation.

Please note this personal information will be held on a password-protected folder and destroyed on completion of the research. It will not be passed on to any third party.

**Name of healthcare professional who informed you about this study:**
Appendix AN

Participant Information Sheet

An investigation into how individuals who self-harm and struggle with personal relationships or self-identify as having Borderline Personality Disorder [BPD] perceive interventions to prevent self-harm

Participant Information Sheet

You are being invited to take part in a research study as part of the thesis for the Professional Doctorate in Counselling Psychology. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Thank you for reading this.

Who will conduct the research?

Julia Noble (julia.noble@postgrad.manchester.ac.uk), Trainee Counselling Psychologist.

School of Environment, Education and Development, The University of Manchester, Oxford Road, Manchester, M13 9PL

Title of the Research

An investigation into how individuals who self-harm and struggle with personal relationships or self-identify as having Borderline Personality Disorder [BPD] perceive interventions to prevent self-harm.

What is the aim of the research?

The aim of the research is to look at what people who self-harm and struggle with personal relationships or feel they have BPD think about activities to try and stop self-harm. No previous research exists asking people who self-harm what they think about these activities, and whether they find them helpful or unhelpful.

Why have I been chosen?

You have been chosen because you are aged 16 and over, and have identified you have a history of self-harm and struggle with personal relationships or think you have BPD. If you decide to take part you will be one of 12-20 individuals taking part in the research.

What would I be asked to do if I took part?

If you decide to take part in this study then we will meet for approximately one hour. We will arrange a time and place convenient for you at the organisation or the University of Manchester. You will be asked to complete two short questionnaires. The first questionnaire will be about self-harm, and the second questionnaire will ask you to rate how helpful you imagine certain activities to be to prevent self-harm. If you are unsure about any of the questions you can ask the researcher to explain them. Then we will talk about your answers to the second questionnaire about activities to prevent self-harm. You do not have to answer any questions you do not want to. The meeting will only be you and the researcher unless you would like someone to be present. The meeting will be audio-recorded.
What are the possible disadvantages and risks of taking part?

You might experience mild discomfort at being asked about self-harm and your experiences of interventions. If this is the case we can stop at any point.

What are the potential benefits of taking part?

The results of this research will tell us more about what activities are helpful and unhelpful and why. It is hoped this could be used in the future to help people who self-harm and struggle with personal relationships choose or design activities which they find helpful.

What happens to the data collected?

The audio recording will be typed up into a document. Audio recordings will be deleted as soon as they are typed up. This will be used with data from the questionnaires and other participant’s data to look for general themes, to create a theory about what is helpful and unhelpful when trying to prevent self-harm.

How is confidentiality maintained?

All data will be anonymous and you will be assigned a code and a fake name. Confidentiality may be broken in the event you disclose serious harm to yourself or others. All documents and audio-recordings will be encrypted and kept in line with the Data Protection Act 1998. Only the researcher, supervisor and markers of the research will have access to the anonymous data. After five years all data will be destroyed.

What happens if I do not want to take part or if I change my mind?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide not to take part or change your mind about taking part, you are still free to withdraw up until the point of analysis (within three days of taking part in the interview) without giving a reason. This will not impact the quality of your current care and/or treatments.

Will I be paid for participating in the research?

You will not be paid for taking part in this research.

What is the duration of the research?

Approximately one hour.

Where will the research be conducted?

The research will take place in a quiet room at the organisation where you heard about this research or the University of Manchester, at a date and time convenient for you.

Will the outcomes of the research be published?
The findings from the research will be published in a doctoral thesis for The University of Manchester. It is hoped that the results might also be published in scientific journals. You will remain completely anonymous.

**Criminal Records Check**

The researcher has undergone a satisfactory Criminal Records Check. The researcher follows the ethical requirements for research as outlined by the Health and Care Professions Council and the British Psychological Society.

**Who has reviewed the research project?**

The project has been reviewed by Greater Manchester West NHS Ethics Committee.

**Contact for further information**

For further information regarding this research project please contact

Julia Noble *(Researcher)* julia.noble@postgrad.manchester.ac.uk

Dr Terry Hanley *(Supervisor)* terry.hanley@manchester.ac.uk

For further information about taking part in research please see information and contact details at:

http://www.northwestpeopleinresearchforum.org/

**What if something goes wrong?**

The researcher will provide you with a list of contacts for further support if you require help or advice following your participation in the research. If you have any concerns please do not hesitate to contact a member of the study team:

Julia Noble *(Researcher)* julia.noble@postgrad.manchester.ac.uk

Dr Terry Hanley *(Supervisor)* terry.hanley@manchester.ac.uk (0161 275 8815)

If there are any issues regarding this research that you would prefer not to discuss with members of the research team, please contact the Research Governance and Integrity Team by either writing to 'The Research Governance and Integrity Manager, Research Office, Christie Building, The University of Manchester, Oxford Road, Manchester M13 9PL', by emailing: Research.Complaints@manchester.ac.uk, or by telephoning 0161 275 7583 or 275 8093.

In the event that something does go wrong and you are harmed during the research you may have grounds for a legal action for compensation against the University of Manchester you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.
Appendix AO

Research journal extract

Thoughts for discussion regarding belief system. Is it that needs + beliefs about self-harm to create struggle + cannot seek help externally due to previous experiences + beliefs about others (because change always involves another in some respect). Maybe not.

Another way of thinking:
Self-harm is a result of internal struggle due to beliefs about others not feeling willing to seek help externally so manage if internally through the body.

12/01/2015 - Thoughts on decision to do things differently.

Name doesn’t really capture what going on - it’s not as much of a decision + seems more like an alternative path or change. The decision process seems just like ARRM bit.

Breaking the family state system?

2 participants who were talking about an alternative path to self-harm (CPFO & CPPO) had interventions which fulfilled all the different criteria (5 aspects).

Again? Why is it important therapy ends? No man is an island.
Appendix AP

NHS ethical approval

2 February 2015

Miss Julia Noble
University of Manchester
Ellen Wilkinson Building
Oxford Road
Manchester
M13 9PL

Dear Julia

Re: Research Governance Decision Letter

SPEAR/Trust Project Reference: 1380
Project Title: How do individuals who self-identify as having Borderline Personality Disorder [BPD] symptomatology perceive interventions to prevent self-harm behaviours?
REC No: 15/NW/0046

Further to your request for research governance approval, we are pleased to inform you that this Trust has approved the study and all REC amendments up to the date of this letter. Please note when contacting the R&D office about your study you must always provide the project reference numbers provided above.

Trust R&I approval covers all locations within the Trust; however, you should ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing your research. This letter also gives NHS permission, on behalf of Rotherham Doncaster and South Humber NHS Foundation Trust, to undertake the protocol specified research activities within the Early Intervention Service.

Please take the time to read the attached ‘Information for Researchers – Conditions of Research Governance Approval’ leaflet, which give the conditions that apply when research governance approval has been granted. Please contact the R&I Office should you require any further information. You may need this letter as proof of your approval.

We would like to point out that hosting research studies incurs costs for the Trust such as: staff time, usage of rooms, arrangements for governance of research. These are demonstrated in the enclosed proforma invoice. We can confirm that in this instance we will not charge for these. However we would like to remind you that Trust costs should be considered and costed at the earliest stage in the development of any future proposals.

You will need to contact us before any new researchers join your team as they will need Trust permission before they start work on the project.

A condition of approval is that you comply with the Trusts Argyll (Lone Working Policy) System (Contact Phil Moffett on 0181 277 1231) where appropriate.
It is your responsibility to contact us a week prior to the expiry date we have recorded for this project to let us know if you wish to extend it, as we will need to send a new approval letter. You will also need to let us know immediately if for any reason the project finishes earlier.

It is a condition of our Trust approval that on completion of this study we are in receipt of an end of study report summary and a copy of the Ethics letter confirming that they have closed the study, we will remind you of this nearer the time. You will also be asked to complete an audit form for each year your study is supported by this Trust (including the year of its completion) this approval requirement and failure or refusal to complete it may result in Trust approval being withdrawn.

By beginning your research you are agreeing to all the terms and conditions as stated within this letter.

May I wish you every success with your research and if you have any queries do not hesitate to contact the R&I Team.

Yours sincerely

[Signature]

Dr. Andy Mee
Research & Innovation Manager

cc: Research Governance Sponsor – University of Manchester
    Academic Supervisor – Dr Terry Hanley

Enc: Approval Conditions Leaflet
     Induction & ID Badge Information
     TrustTECH Leaflet
     Lone Working Policy
     Dummy invoice
Thank you for taking part in the research study today. The purpose of this research was to explore what individuals who self-harm and struggle with personal relationship or think they have BPD think about interventions to prevent self-harm. This is the first time this has been researched.

The information you provided today will be combined with other participants’ data, and findings from the study will be published in a thesis to the University of Manchester and possibly published in scientific journals. Your involvement will remain confidential and you will not be identified in any part of the research.

A summary of the main findings from the research will be included on the organisation’s website during summer/autumn 2016.

If you have any further questions about the research please contact:

Julia Noble
Julia.noble@postgrad.manchester.ac.uk

Or

Dr Terry Hanley (Supervisor)
terry.hanley@manchester.ac.uk

If you feel you require any support following your involvement in the research please contact: Helene Wickins (SAFA)
The following organisations also provide free counselling support:

**North Cumbria**

**Carlisle Eden Mind**

01228 543354 Mondays to Fridays between 9.30 and 4.30pm

www.cemind.org/

**South Cumbria**

**Forget-Me-Not Counselling and Support Services**

01946 328171 (**Monday:** 14:00 - 18:00, **Tuesday:** 09:00 - 21:00, **Wednesday:** 09:00 - 21:00, **Thursday** 10:00 - 17:30, **Friday:** 09:00 - 17:30, **Saturday:** 12:00 - 17:00)

http://www.forgetmenot.uk.com/

**All of Cumbria**

**Samaritans**

08457 90 90 90

http://www.samaritans.org/
Thank you for taking part in the research study today. The purpose of this research was to explore what individuals who self-harm and struggle with personal relationship or think they have BPD think about interventions to prevent self-harm. This is the first time this has been researched.

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terry.hanley@manchester.ac.uk

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The following organisations also provide free counselling support:
Beacon Counselling
0161 440 0055 or 0161 285 1827 anytime
http://www.beacon-counselling.org.uk/index.php

Gaddum Centre
0161 834 6069 (Monday–Friday 9am–4.30pm)
http://www.gaddumcentre.co.uk/

Samaritans
08457 90 90 90
http://www.samaritans.org/
Appendix AR

Properties and dimensions of the category beliefs about others

<table>
<thead>
<tr>
<th>Properties</th>
<th>Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position relating to others</td>
<td>less than – more than</td>
</tr>
<tr>
<td>Others level of trustworthiness</td>
<td>trustworthy – not to be trusted</td>
</tr>
<tr>
<td>Level of support from other</td>
<td>supportive – unsupportive</td>
</tr>
<tr>
<td>Others judge me</td>
<td>positively – critically</td>
</tr>
</tbody>
</table>

*Conditional statement.*

Participants’ earlier life experiences formed their beliefs about others.

Participants compared themselves to others and felt they were worth less. They believed others were not to be trusted, judged critically, and were unsupportive.
Appendix AS

Properties and dimensions of the category beliefs about self

<table>
<thead>
<tr>
<th>Properties</th>
<th>Dimensions</th>
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</thead>
<tbody>
<tr>
<td>Future expectations</td>
<td>change – fixed</td>
</tr>
<tr>
<td>Attitude towards self</td>
<td>judging – compassionate</td>
</tr>
<tr>
<td>Evaluation of self</td>
<td>positive – negative</td>
</tr>
<tr>
<td>Receiving care</td>
<td>worthy – unworthy</td>
</tr>
<tr>
<td>Expression of emotion</td>
<td>expression – denial</td>
</tr>
</tbody>
</table>

*Conditional statement.*

When participants were engaged in a cycle of self-harm they described their beliefs about themselves to be fixed and life unlikely to change. They judged themselves critically and believed they contained no positive aspects, therefore they were unworthy of care, and they did not allow themselves to communicate their distress to others.
Appendix AT

Properties and dimensions of the category multiple purposes of self-harm

<table>
<thead>
<tr>
<th>Properties</th>
<th>Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>How I want to connect to reality</td>
<td>grounding - distancing</td>
</tr>
<tr>
<td>How I feel about others knowing</td>
<td>seek help – hidden from others</td>
</tr>
<tr>
<td>Intensity of emotional build-up</td>
<td>low – high</td>
</tr>
</tbody>
</table>

*Conditional statement.*

Participants all used self-harm to change how they were feeling when they were in a state of high emotion. Participants described how particular types of self-harm were used for different purposes. The type of self-harm often matched the trigger and the underlying belief.
### Appendix AU

Unstoppable mind-frame category – selection of quotes from participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Unstoppable Self-harm mind-frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul</td>
<td>I’ve held it in and held it in. But last night was just [pause] errr it had to come out. I have to do it. Just to feel better [laugh] Researcher: Right Paul: That's no such talking you can do to do that. That's self-harm yeah.</td>
</tr>
<tr>
<td>Janet</td>
<td>But if I’ve made up my mind and I’ve got my plan, then nothing on earth will stop me. It’s just fate. And that's what’s saved my life when I’ve hanged myself or when I’ve overdosed. Everything, the logic goes out of the window Researcher: So the logic Janet: There’s no logic</td>
</tr>
<tr>
<td>Nicola</td>
<td>I just think if that's your way of coping then, then nothing’s gonna, I don’t think, in that frame of mind, looking back, nothing would have stopped me doing it. Like at the time, no matter if there was list not to do it, even if I was really feeling that bad then I would do.</td>
</tr>
<tr>
<td>Amy</td>
<td>Yeah you’ve already gone past that point. At the point where kind, of, my self harm kind of kicked in would be at the point where I would kind of be kinda hysterical kinda of crying and really kind of thinking that you know, umm, I’m not a good person, you know, life is not worth it, and so then to kind of almost have a list of things that are positive for me I’ve already in my own mind, [pause] dismissed that by the time I’ve got to the self harm level, so potentially [pause] if you would show me a list of things, that I potentially, what positive about me at that point I wouldn’t I wouldn’t Realaser: Mean anything? Amy: Yeah. Mentally I would be like no, I wouldn’t accept it because I’ve already got low in myself at that point, its already gone past that.</td>
</tr>
<tr>
<td>Kimberly</td>
<td>It's like a junkie shooting up for the first time, feels like that, how I can describe it. Its, you’re in this, sort of, tense, stressed state where you feel like that you have no control over anything</td>
</tr>
<tr>
<td>Laura</td>
<td>Laura: Yeah when like, its heightened and the adrenalinics kicking it, and you just think, you know what, it doesn’t matter about anything else, you know, same as like suicide, you just think like doesn’t matter about any other reasons or anybody else. It’s just about me, you don’t think mentally</td>
</tr>
<tr>
<td>Name</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| Laura | *Researcher: It sounds like it just gets so much*
|       | *Laura: Yeah it takes over*
|       | *Researcher: In that moment is anything helpful?*
|       | *Laura: No*
| Karen | *I’ll go on it again when I get home even though I’m totally knackered. It’s just something I do*
|       | *[Later…]*
|       |   *I dunno, it set me off. And then everything spiraled out of control, and I’ve been on and off my cross trainer all day and stung, because I thumped myself that hard in my stomach and I dunno I just. I’ve had enough today.*
| Sheila | *This, it feels like it’s something that’s done to me rather than something inside of me that I can control.*
| Rebecca | *I try and always explain its like, if you’ve watching a video on the fastest, or you fast-forward it, and that's how it, my mind works like when I’m unstable. It’s sort of really fast and I don’t get a minute to process which feeling I am feeling, because they are all happening at the same time [later…]*
|       |   *It could become something that could just spiral out of control where I’d be able, I’d be snapping then.*
| Lisa | *Oh yeah it’s like a wave coming on you, you know it’s coming on you and you’ve just got to ride it out.*
|       | *[Later…]*
|       |   *When you are annoyed, you are annoyed, and you are at that point of no return, and you need to get your anger out. So I think when you get to that point there is not much you can do about it.*
| Dawn | *It started off badly I had self harmed and also taken an overdose, and the nurses that were looking after me weren’t very, they were all right but they weren’t very on the ball, and they left me in the cubicle with the sharps bin and closed the curtains. So then I had self harmed again with something that I fished out of the sharps bin because I was in a really bad way.*
| John | *If I haven’t managed to intervene in the process before the top of the hump. Then there is nothing that will stop me self-harming. I just, I’m completely unable to prevent it.*
Appendix AV

Properties and dimensions of the category environmental change

<table>
<thead>
<tr>
<th>Properties</th>
<th>Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Known</td>
<td>old – new</td>
</tr>
<tr>
<td>Protected</td>
<td>safe – unsafe</td>
</tr>
<tr>
<td>Level of stimulation</td>
<td>calm – busy</td>
</tr>
<tr>
<td>Participation</td>
<td>enforced – voluntary</td>
</tr>
</tbody>
</table>

*Conditional statement.*

Under conditions of a new environment which was either enforced or voluntary, but felt safe and calming, participants experienced a shift in thinking creating the possibility to do things differently.
Appendix AX

Properties and dimensions of the category physiological change through medication

<table>
<thead>
<tr>
<th>Properties</th>
<th>Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose and type</td>
<td>too much – no noticeable effect</td>
</tr>
<tr>
<td>Communication with medicator</td>
<td>open - dismissive</td>
</tr>
<tr>
<td>Monitored</td>
<td>vigilant – unobserved</td>
</tr>
</tbody>
</table>

*Conditional statement.*

Under conditions where the communication with the medicator was open, and individuals were prescribed a dose and type of medication which felt to be just at a correct level to alleviate symptoms, and they were monitored for side effects participants felt medication could be the ignition promoting a change away from self-harm.
Appendix AY

Properties and dimensions of the category interactional change

<table>
<thead>
<tr>
<th>Properties</th>
<th>Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related position</td>
<td>outsider – insider</td>
</tr>
<tr>
<td>Physicality</td>
<td>present – real located elsewhere – virtual reality</td>
</tr>
<tr>
<td>Other’s belief in me</td>
<td>hopeful – hopeless</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>trusted secret knower - broadcaster</td>
</tr>
<tr>
<td>Other’s see me as</td>
<td>individual – patient</td>
</tr>
<tr>
<td>Other’s feelings towards me</td>
<td>caring – indifferent</td>
</tr>
<tr>
<td>Other’s stance</td>
<td>curious – directing</td>
</tr>
<tr>
<td>Pacing</td>
<td>fast – slow</td>
</tr>
<tr>
<td>Level of experience</td>
<td>experienced – inexperienced</td>
</tr>
</tbody>
</table>

*Conditional statement.*

Under conditions where another experienced individual who was an outsider to the current situation was physically present, and could be trusted with secrets, went at the participant’s pace using a curious stance to try and understand the participant as an individual, because they cared and were hopeful about the participant’s future, then interactions with others helped individuals challenge their automatic thought patterns and take an alternative path.
Appendix AZ

Properties and dimensions of the category decision to do things differently

<table>
<thead>
<tr>
<th>Properties</th>
<th>Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness</td>
<td>full – lack of awareness</td>
</tr>
<tr>
<td>Evaluation of previous coping</td>
<td>reconsidering – reconfirming</td>
</tr>
<tr>
<td>Self-agency</td>
<td>recognition – denial</td>
</tr>
<tr>
<td>Motivation for change</td>
<td>high – non-existent</td>
</tr>
</tbody>
</table>

*Conditional statement.*

Under conditions where a participant gained awareness of their situation and its impact on others they care about, they evaluated previous self-harm, leading to reconsidering of existing patterns, and a recognition of partial agency, and control over the situation. If individuals were motivated for change they looked for alternatives to self-harm. During this process barriers resulted in self-harm as usual.
Appendix BA

Properties and dimensions of the category interventions that work

<table>
<thead>
<tr>
<th>Properties</th>
<th>Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>individualised – generic</td>
</tr>
<tr>
<td>Speed of access</td>
<td>instant – delayed</td>
</tr>
<tr>
<td>Frequency</td>
<td>consistent – unpredictable</td>
</tr>
<tr>
<td>Length</td>
<td>short-term – long-term</td>
</tr>
</tbody>
</table>

*Conditional statement.*

Under conditions in which an individual decided to seek help, if they experienced an intervention matching their need to self-harm at the point when emotion was building (instant), which was consistently available for the long-term the intervention could be used instead of self-harm.
Appendix BB

Physical grounding category - selection of quotes from participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Physical grounding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul</td>
<td>I walk 10 miles a day with weight.</td>
</tr>
<tr>
<td>Janet</td>
<td>-</td>
</tr>
<tr>
<td>Nicola</td>
<td>So I kinda, when I go for a walk, that's my time out and then I can realise then that problems really aren’t that big, and I’ve made them big and they are really not that big.</td>
</tr>
<tr>
<td>Amy</td>
<td>Yes I have done that, and I’ve kind of tried to take myself out of the zone to calm myself down and to go for a walk which does help, if again if, it does help if you are almost in control of what you are feeling.</td>
</tr>
<tr>
<td>Kimberly</td>
<td>It’s going to be, distracting myself with my hands, because it’s physically. It’s something I can actually physically feel, and for me that’s distracting my brain.</td>
</tr>
<tr>
<td>Laura</td>
<td>Sometimes I can’t be bothered and I just feel lazy, but when I’ve done it, it’s been helpful, just getting a bit of fresh air or doing a bit of tidying.</td>
</tr>
<tr>
<td>Karen</td>
<td>Some days when I’m really not feeling great and I’m feeling really down all I want to do is be at home on my cross trainer, anywhere rather than at work or thinking about anything else. It just helps me focus.</td>
</tr>
<tr>
<td>Sheila</td>
<td>With exercise the endorphins make the difference.</td>
</tr>
<tr>
<td>Rebecca</td>
<td>I distract myself by cleaning and I clean from getting up to going to bed.</td>
</tr>
<tr>
<td>Lisa</td>
<td>-</td>
</tr>
<tr>
<td>-------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>Dawn</td>
<td>I’d be much better, knocking down a wall with a sledgehammer. And something that’s really real, and concrete, and physical.</td>
</tr>
<tr>
<td>John</td>
<td>If I am feeling vulnerable and I’m aware that there is likely to be a trigger that could cause me to self harm, if I go swimming I’m much more likely to be able to deal with that trigger without crossing into self-harm, than if I hadn’t gone swimming.</td>
</tr>
</tbody>
</table>
Appendix BC

Properties and dimensions of the category the sunset of self-harm

<table>
<thead>
<tr>
<th>Properties</th>
<th>Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternative interventions in place</td>
<td>working – inadequate</td>
</tr>
<tr>
<td>Evaluation of seeking help</td>
<td>helpful – unhelpful</td>
</tr>
<tr>
<td>Stance towards change</td>
<td>flexible – rigid</td>
</tr>
</tbody>
</table>

Conditional statement.

When individuals had evaluated other coping mechanisms, apart from self-harm, as working, and their overall experience of seeking help was positive, and they viewed their future as unknown but they felt adaptable to be able to deal with changes, then self-harm drastically reduced, and individuals entered into a more definite path away from self-harm.