

# **Experiences of Adults who Disclose Self-harm to Non-professionals**

Emily Jane Higgins

Submitted in accordance with the requirements for the degree of  
Doctor of Clinical Psychology (D. Clin. Psychol.)

The University of Leeds

School of Medicine

Division of Psychological and Social Medicine

May, 2020

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

This copy has been supplied on the understanding that it is copyright material and that no quotation from the thesis may be published without proper acknowledgement.

The right of Emily Jane Higgins to be identified as Author of this work has been asserted by her in accordance with the Copyright, Designs and Patents Act 1988.

© <2020> The University of Leeds and <Emily Jane Higgins>

## Acknowledgements

Firstly, I would like to thank the 10 participants who gave up their time to share their personal stories with me. It was a privilege to listen to your experiences and I am so grateful that you decided to take part.

Thank you to my supervisors Professor Allan House, Dr Cathy Brennan and Dr Rachael Kelley for your vast knowledge, continued support and feedback throughout this project. Thank you to Battle Scars and Jenny Groves for your valuable involvement and advice.

I would like to say a huge thank you to my Mum and Dad for your unconditional love and unwavering belief in me, without which I would not be the person I am today. Thank you Mum for providing emotional support, kind words of encouragement and for reading every page of this thesis! Thank you Dad for being a constant source of joy, light relief and humour. I feel so lucky to have you both as parents. Thank you to my brother and chief word-cutter Jordan, you always have time for me and have helped me throughout my training.

Thank you Luke for your endless love, support, words of wisdom and cups of tea. We have shared similar experiences and I am grateful we have been there for one another throughout the last few years. I look forward to the next chapter of our lives together and the many adventures to come!

Finally, I want to thank the beautiful, kind and intelligent women who I have completed my training with, you all inspire me and it was a pleasure to go on this journey together. I never expected it to be so much fun!

## ABSTRACT

**Background:** Research suggests that self-harm is often a private behaviour and many individuals do not disclose their self-harm. People who feel unable to disclose their self-harm have less opportunity to seek support. There is a paucity of research on adult self-harm disclosure experiences, with most existing studies recruiting adolescents.

**Aims:** This study aimed to understand the expectations and experiences of adults who self-harm when they disclose to non-professionals.

**Methods:** Ten participants (aged 26-51) were recruited through the NHS and a third sector organisation. Semi-structured interviews were conducted and data was analysed using thematic analysis.

**Results:** Four themes were identified; 'The insular nature of self-harm', 'Imagined versus reality', 'Self-preservation' and 'New ways of relating'. Participants described self-harm as an insular behaviour, which created an inherent tension when considering disclosure; a social process. There were risks associated with self-harm disclosure, including stigma and losing control. Participants carefully considered the decision to disclose, experiencing high levels of ambivalence about disclosing and spending extended periods rehearsing potential disclosures. In reality, disclosure experiences were sometimes very different, with participants describing a range of positive and negative responses. Making such risky personal disclosures meant self-preservation was key, both during and after a disclosure. Participants found new ways of relating to their disclosure recipients and evaluated future potential disclosures depending on the response received. Most participants had experienced negative responses, which caused distress and curtailed future disclosures, highlighting a need for improved public awareness of supportive responses to disclosures of self-harm.

**Discussion:** This study highlighted the personal risks and highly variable responses people experience when disclosing self-harm to a family member, friend or colleague. Helpful ways of responding to self-harm disclosures were highlighted by participants in this study and guidance could be published so that non-professionals can be informed and prepared for having conversations about self-harm.

## Table of Contents

Acknowledgements .....	3
<b>ABSTRACT .....</b>	<b>4</b>
List of Tables.....	8
List of Figures .....	9
<b>CHAPTER ONE: INTRODUCTION .....</b>	<b>10</b>
Summary .....	10
Definitions of Self-Harm.....	11
Methods of Self-Harm.....	12
Rates of Self-Harm.....	12
Gender and Self-Harm .....	14
Definition of Disclosure .....	16
Rates of Self-Harm Disclosure and Chosen Recipients .....	17
The Decision to Disclose .....	18
Outcomes of Disclosure .....	19
Disclosure Models.....	20
Mediating Mechanisms of Outcomes .....	22
Self-Harm Disclosure Research .....	23
Barriers to Self-Harm Disclosure.....	24
Factors that may Prompt Disclosure .....	25
Deciding who to Disclose to .....	27
Self-harm Disclosure Responses and Outcomes.....	29
Positive Experiences .....	29
Negative Experiences.....	30
Limitations of Existing Studies .....	32
Addressing the Limitations of Previous Studies .....	34
Possible Clinical Implications.....	34
Research Aims/Questions .....	36
<b>CHAPTER TWO: METHOD.....</b>	<b>37</b>
Research Design.....	37
Methodological Approach.....	37
Participants.....	40
Sampling strategy.....	40

Inclusion Criteria.....	42
Exclusion Criteria.....	42
Ethical Considerations .....	43
Ethical Approval .....	43
Informed Consent.....	43
Confidentiality/Anonymity .....	43
Data Protection.....	43
Harm to Self .....	44
Harm to Others .....	44
Involvement of People with Personal Experience .....	45
Recruitment Procedure.....	47
Interview Procedure .....	48
Data Analysis .....	49
Quality Checks .....	52
Quality check of transcriptions .....	53
Research supervision.....	53
Audit trail .....	53
Situating the sample .....	53
Grounding in examples .....	53
Researcher Reflexivity .....	54
<b>CHAPTER THREE: RESULTS.....</b>	<b>58</b>
Participant Demographic Information .....	58
Pen Portraits .....	58
Qualitative Results .....	61
Brief Description of Thematic Map and Links Between Themes .....	63
Theme 1: The Insular Nature of Self-Harm .....	63
Disconnected .....	64
Concealing self-harm .....	65
Theme 2: Imagined versus Reality.....	67
Expectations .....	68
Ambivalence .....	72
Rehearsing.....	74
Relationships .....	76

Responses and Impact .....	79
Theme 3: Self-Preservation .....	85
Control .....	85
Distancing .....	89
Theme 4: New Ways of Relating .....	92
Perceptions Changing Over Time .....	92
Co-creating a Language .....	93
Advice from the Participants.....	95
<b>CHAPTER FOUR: DISCUSSION .....</b>	<b>103</b>
Revisiting Research Aims .....	103
Summary of Findings .....	103
Discussion of Findings .....	104
The insular nature of self-harm .....	104
Imagined versus reality .....	107
Self-preservation .....	113
New ways of relating .....	116
Strengths and Limitations .....	117
Strengths.....	117
Limitations .....	118
Clinical Implications .....	119
Future Directions for Research .....	122
Personal Reflections.....	122
Conclusion .....	123
<b>REFERENCES.....</b>	<b>124</b>
<b>APPENDICES .....</b>	<b>142</b>

**List of Tables**

Table 1 - Examples of generating codes.....	51
Table 2 - Advice from participants to other people who self-harm and worry about disclosure.....	96
Table 3 - Advice from participants for health professionals.....	99
Table 4 - Helpful ways of responding to self-harm disclosures that emerged during coding.....	101



**List of Figures**

Figure 1 - Thematic Map.....62

## CHAPTER ONE: INTRODUCTION

I start this chapter with a short summary, before outlining definitions, methods and rates of self-harm. Next I define disclosure and outline the general disclosure process, prior to providing some disclosure models. I then summarise the existing literature on self-harm disclosures, including the limitations and how I have tried to address these. Finally, the clinical implications of the research and the research questions are outlined.

### Summary

Self-harm is a major public health concern with considerable adverse consequences (Cleaver, 2014; Mental Health Foundation, 2006). Research indicates that those who attend hospital after an episode of self-harm often repeat the behaviour, with 15% to 25% returning to the same hospital following a repeat episode within a year (Carroll et al., 2014). It is a clear risk factor for suicide, with over 50% of individuals who have died by suicide having a history of self-harm (Carroll et al., 2014). It is associated with increased mortality and adverse psychosocial outcomes (Bergen et al., 2012). Furthermore, it results in substantial health and social care costs (Sinclair et al., 2011).

Research findings indicate that many adults who self-harm do not seek professional help (Nada-Raja et al., 2003). Few studies have investigated whether people who self-harm disclose to non-professionals, such as partners, family or friends. Studies that do explore this have typically explored self-harm disclosures in online forums (Lewis & Baker, 2011; Lewis et al., 2012), the difference between disclosers and non-disclosers on significant factors, such as self-harm characteristics and motivations (Armiento et al., 2014), or the disclosure experiences of adolescents, findings which may not be applicable to an adult population (e.g., Klineberg et al., 2013). Little is known about why adults who self-harm disclose to other people, what this process entails, and the implications of making a disclosure.

This research aims to understand the expectations and experiences of adults who self-harm when they disclose to non-professionals. This will provide new insights into the process of disclosing self-harm to others, the responses received and the impacts for the person who discloses. Investigating this under-researched area will help facilitate informed efforts to support positive self-harm disclosures.

## Definitions of Self-Harm

There are several different, often contradictory, self-harm definitions in the literature (Hawton et al., 2012), which makes comparison between studies difficult (Ougrin et al., 2015). In the National Institute for Health and Care Excellence (NICE) guideline CG133 ‘Self-harm in over 8s: long-term management’, self-harm is defined as “any act of self-poisoning or self-injury carried out by an individual irrespective of motivation” (NICE, 2011, p.4). This is the definition most used in research conducted in the United Kingdom (UK; Hawton et al., 2003). NICE guidelines (2011) clarify that the self-harm definition does not include accidental harm or harm resulting from alcohol, drug use or eating disorders.

In contrast to the definition above, the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5; American Psychiatric Association (APA), 2013), divides self-harm into two categories. These are Non-Suicidal Self Injury (NSSI) and Suicidal Behaviour Disorder (SBD). NSSI is defined as “the deliberate destruction of one’s own body tissue with no suicidal intent” (McAndrew & Warne, 2014, p.570). Researchers make a distinction between behaviours in which bodily injury is the intended purpose of one’s behaviour (e.g., cutting) and those in which it is an unintentional side effect (e.g., Binge-drinking alcohol; Nock, 2010). SBD is defined as attempted suicide within the previous two years, and does not include NSSI (APA, 2013). However, this distinction has received criticism as views on suicidal intent can differ between health professionals and service-users (Hawton et al., 2012; Kapur et al., 2013). There is on-going debate as to whether a person’s intent during self-harm can be reliably measured, as it can be assessed inaccurately as well as being subject to recall bias (Brunner et al., 2014; Kapur et al., 2013; Ougrin & Zundel, 2009). In addition, suicidal intent can be ambiguous, as individuals who self-harm can describe an uncertain attitude towards death (Andover et al., 2012), and suicidal and non-suicidal intent and behaviour can coexist within the same individual (Ougrin & Zundel, 2009). It would be helpful to have more consistency in definitions of self-harm, as the various terminologies creates confusion regarding which specific construct is being investigated (Messer & Fremouw, 2008). Better international agreement regarding definitions of self-harm would help advance research (Ougrin et al., 2015).

For this study, I have chosen the term ‘self-harm’ and used the NICE (2011) definition as it is comprehensive, capturing self-poisoning as well as self-injury, and does not differentiate self-harm based on suicidal intent. However, when making

reference to other studies I have used the authors chosen terminology and definition (e.g., NSSI, self-injury.)

### **Methods of Self-Harm**

Cutting is the most common method of self-harm reported in the community-based literature (Brunner et al., 2014; Klonsky, 2011; Madge et al., 2008) with approximately 70-90% of individuals who self-harm using this method (Nock, 2010). Other acts of self-harm include self-inflicted burns, interference with wound healing, hair pulling, hitting objects, swallowing objects, attempted hanging or drowning, traffic related injuries, and carbon monoxide poisoning (Royal College of Psychiatrists, 2010). Self-poisoning 'overdose' is the second most common method by which people harm themselves, after cutting (Hawton et al., 2002; Madge et al., 2008; Moran et al., 2012). However, in the UK self-poisoning is around four times as common among people who attend hospital for self-harm as cutting or other injury (Bergen et al., 2010). This may be because some methods of self-harm are more medically serious and require medical attention (McManus et al., 2019). The method used could therefore influence disclosure decisions about self-harm in that decisions about whether to disclose are taken away to a degree when a person is physically unwell because of the method used and requires medical help. It could be assumed that for less medically serious methods individuals have more choice over whether to disclose, and perhaps individuals who have not disclosed may be more likely to use certain methods.

Research has shown that it is common for people who self-harm to switch between different methods (Kapur et al., 2013). In a large multi-centre study of over 7344 individuals attending hospitals in England, 1234 repeated self-harm and a third of these individuals switched methods, over an average of 9-months follow-up. People who cut themselves were most likely to change methods, usually to poisoning (Lilley et al., 2008). A more recent study found that over an average of 30-months follow-up, 23% of people repeated self-harm and one-third of them, often rapidly, switched method (Owens et al., 2015). Method of self-harm is therefore often fluctuating and unpredictable.

### **Rates of Self-Harm**

Across Europe, the UK has one of the highest rates of self-harm (Madge et al., 2008). Self-harm is one of the most frequent causes of hospital admission (Royal

College of Psychiatrists, 2010). In England, annually there may be over 200, 000 presentations for self-harm to Accident and Emergency departments (Hawton et al., 2007). However, it is widely recognised that self-harm rates are higher than those reported by hospital admission statistics (Hawton et al., 2002), which highlights the problems in assessing prevalence rates by hospital data only. Self-harm often occurs in adults in the community and does not come to the attention of clinical services or other helping organisations (Borges et al., 2010). Therefore, self-harm presentations to hospital can best be described as the “tip of the iceberg” in self-harm behaviour (Hawton & Rodham, 2006, p. 135). The fact that hospital figures do not reflect patterns of self-harm in the community suggests that many people are self-harming but potentially not disclosing their self-harm and not seeking support.

Recent figures from a multi-centre study of self-harm found that between 2000 and 2012, in five emergency departments across England, the overall age-standardised rates of self-harm were 36.2 in males and 44.1 in females per 10, 000 people in the population (Geulayov et al., 2016). A primary-care patient cohort study across the UK, found estimated annual rates of self-harm were 18.5 and 28.9 (males and females respectively) per 10,000 patients (Carr et al., 2016). However, these figures are likely to be underestimated as evidence suggests that self-harm is often a private behaviour and many people who self-harm do not present to services (Ogden & Bennett, 2015).

In terms of self-harm prevalence across the lifespan, research suggests that self-harm often begins during adolescence with the age of onset reported to be around age 13 or 14 (Klonsky & Muehlenkamp, 2007; Muehlenkamp et al., 2012). However, self-harm stretches beyond the boundaries of adolescence (Chan et al., 2007), with some people who first self-harm in adolescence continuing into adulthood. Estimates indicate that 12–38% of young adults report lifetime histories of NSSI (Gratz et al., 2002; Hamza et al., 2012; Klonsky & Glenn, 2009). There is some variation in the distinction between adolescents, young adults and adults, but the World Health Organisation (WHO; 2009) defines adolescents as individuals in the 10-19 age range and young adults are usually defined as individuals between the ages of 18-25. Studies using adult community samples have found a lifetime prevalence of 2.7% (Nock, 2008) and 5.9% (Klonsky, 2011).

Evidence suggests that some people self-harm for the first time in adulthood. For example, Heath et al., (2008) found that early adulthood is a period of increased onset of self-harm. Recent research investigating rates of self-harm by age found that although rates were highest among adolescents, self-harm was still a substantial problem among

adults (Carr et al., 2016). In the 25-34 age group incidence rates were 15.1 and 16.7 (males and females respectively) per 10,000 primary-care patients. In the 35-44 age group incident rates for males and females were 11.8 and 15.3 per 10,000, respectively. Although rates seem to decrease with increasing age, these rates suggest that self-harm is still occurring among adults and therefore self-harm among adults needs greater understanding.

Prevalence and incidence rates likely vary across studies because self-harm is defined differently which effects the number of eligible participants for each study, meaning study populations are not consistent. This will fluctuate depending on whether the definition of self-harm includes just suicide attempts, all suicidal and non-suicidal self-harm behaviours, or just non-suicidal self-harm. Other factors that can account for the varying rates include the age range of participants, the period over which self-harm is investigated (e.g., lifetime, previous year), where the sample is selected from (e.g., community, hospital), data collection method (e.g., anonymised, self-report, interviewer administered; Ougrin & Zundel, 2009), and survey type (e.g., cross-sectional, retrospective or prospective). Muehlenkamp et al. (2012) found that questionnaires that ask about self-harm behaviour using a 'yes/no' response option found considerably lower self-harm rates than questionnaires that detailed particular behaviours, which could account for the large difference in self-harm rates across studies. There is also limited literature relating to the self-harm behaviours of people from different communities and cultures, such as those from LGBTQ communities, older adults and BAME communities (Adler & Adler, 2007).

Self-harm is difficult to measure precisely, as estimates are only based on reported incidents, and due to the often private nature of self-harm (Duffy, 2006), many people do not disclose their self-harm. Rates based on acts of self-harm reported to health care services hugely underestimate the actual numbers of people engaging in self-harm. Therefore, these estimated rates do not reveal the true scale of the problem (Long et al., 2013).

### **Gender and Self-Harm**

Self harm is typically portrayed as behaviour that is engaged in by young, white, middle class females (Chandler et al., 2011). Brickman (2004) argued that a portrayal of the "typical self-injurer" first arose during the 1960s from literature which depicted and interpreted self-cutting as feminine. Self-harm was described as a white "problem" of

teenage girls who were labelled “delicate cutters” (Brickman, 2004). Brickman (2004) claimed that this narrative continues, despite research evidence that self-harm is undertaken by a diverse range of people. These assumptions are still widely accepted and reproduced in research, popular media and by the medical profession (Chandler et al., 2011). Research has often been carried out on predominantly female samples, which reinforces the narrative that self-harm is a female behaviour (Abrams & Gordon, 2003; Alexander & Clare, 2004). Therefore, self-harm in males is either overlooked or thought to exist in only certain male populations, such as prisoners (Chandler et al., 2011). Hence, knowledge and understanding of male self-harm is limited (Gratz & Chapman, 2007).

Research findings on gender differences in the rates of self-harm are mixed. Females are commonly reported to engage significantly more in self-harm (Madge et al., 2008; Moran et al., 2012; O'Connor et al., 2009). However, some hospital studies have found rates of presentation at hospital for self-cutting were higher for men than for women (Hawton et al., 2004). More recent hospital studies have found 44% of people presenting with self-harm were male (Cooper, et al., 2013), and between January 2008 and December 2009 in a hospital in Manchester, 41% of all hospital reported self-harm incidents were by men (Dickson, et al., 2011). Although these figures suggest that the majority of people who self-harm are female, they indicate that male self-harm needs further recognition (Chandler et al., 2011).

A meta-analysis including 122 studies explored gender differences in the prevalence of NSSI (Bresin & Schoenleber, 2015). The findings suggested that women were 1.50 times more likely than men to report engaging in NSSI, which is a small effect size (Chen et al., 2010). The results were based on a large number of studies that had used diverse samples. Therefore, the study provides evidence that women are slightly more likely to engage in NSSI than men. The age of the sample was not related to the size of the gender difference. This contrasts with previous research that has found larger gender differences in adolescents who self-harm, with females being four times more likely to self-harm than males (Hawton et al., 2002). The meta-analysis also found that the gender difference was more pronounced in clinical samples as opposed to community samples (Bresin & Schoenleber, 2015). One explanation for this finding may be that men who self-harm may be less likely to seek out treatment, leaving them underrepresented in clinical compared to community samples. There appears to be conflicting evidence as to whether there are gender differences in relation to self-harm

and studies which have found self-harm to be more common among females have tended to focus on adolescents, specific methods of self-harm, such as cutting or clinical populations (Sornberger et al., 2012; Whitlock et al., 2006).

Positioning self-harm as a gendered issue may mean that men who self-harm are marginalised and less likely to disclose and seek support with their self-harm. Although there is a lack of research exploring gender differences in self-harm disclosures, there is a wider literature, which suggests men are less willing to disclose mental health difficulties generally and are at increased risk of suicide (John, 2017; Lynch et al., 2018). Research has identified many possible reasons for this, including perceived stigma (Clement et al., 2015; Rothì & Leavey, 2006), gender socialisation (Rickwood et al., 2007) and masculine ideals, which may inhibit men from disclosing and seeking help with mental health difficulties (Gonzalez et al., 2005; Nam et al., 2010).

### **Definition of Disclosure**

Being able to disclose self-harm to other people may be helpful for the recovery process. Research has shown that disclosure of personal and meaningful information can be therapeutic and helpful (Frattaroli, 2006; Lyubormirsky et al., 2006). The human need of individuals to confide in others has long been acknowledged in the psychological literature (Buckley, 1986). Disclosure as a concept can have varied meanings. Jourard (1971) proposed one of the first definitions of self-disclosure as the “act of making yourself manifest, showing yourself so others can perceive you” (p.19). This definition includes verbal and nonverbal ways in which people can convey aspects of themselves to others, although many authors refer only to verbal disclosure (e.g., Chaudoir & Fisher, 2010).

Disclosure may be voluntary or involuntary. Any form of communication may reveal something about the self, but with voluntary disclosure one individual intends to deliberately reveal something personal to another (Derlega et al., 1987). Self-harm disclosures may include both voluntary and involuntary disclosures. For example, if an individual decides to tell a family member about their self-harm, the disclosure is voluntary as a deliberate choice has been made. However, sometimes people who self-harm may be confronted by others who have noticed their injuries. In this case questions about wounds from others may trigger someone who self-harms to disclose even if they had not made a deliberate decision to do so (Rosenrot & Lewis, 2018).



Disclosure is not an all-or-nothing act. Early social penetration and incremental exchange theories (Altman & Taylor, 1973; Levinger & Snoek, 1972) highlighted how disclosure can progress in both depth and breadth within relationships. Depth refers to the personal nature of information disclosed, and breadth refers to the amount of content shared. According to this perspective, people reveal more about themselves as their relationship and affection for one another develops over time (Greene et al., 2006). However, many researchers have rejected the simplistic idea that the development of relationships always follows a linear pattern, with growing openness of self-disclosure (Altman et al., 1981). Other theories acknowledge that relationships might exhibit cycles of openness and closedness, or that some relationships may never progress toward increased openness (Altman et al., 1981).

### **Rates of Self-Harm Disclosure and Chosen Recipients**

Research has consistently found that a significant amount of people do not disclose their self-harm to others (Evans et al., 2005; Whitlock et al., 2006; Williams et al., 2013). Some studies have shown that up to 30-56% of people have never disclosed their self-harm to anyone (Armineto et al., 2014; Evans et al., 2005; Martin et al., 2010; Michelmore & Hindley, 2012; Nixon et al., 2008; Whitlock et al., 2006). Of those who have disclosed most people have only disclosed their self-harm on one or two occasions (Armineto et al., 2014), and this is often to informal sources (e.g., friends and family) rather than formal sources (e.g., medical and mental health professionals).

Research findings suggest that professional help-seeking among people who self-harm is particularly low (e.g., Whitlock et al., 2006). A systematic review investigating help-seeking among adolescents who self-harm found that between one third and one half of adolescents had not sought professional help (Rowe et al., 2014). Estimates of rates of adults who self-harm and have sought professional help have been as low as one in five (Nada-Raja et al., 2003). Although many people who self-harm do not disclose, for those that do it may be more likely that disclosures are made to non-professionals, such as family, friends or partners. Existing research seems to support this idea, for example a review investigating help-seeking for self-harm in a large sample of participants under the age of 26 found that most participants sought help from their social networks rather than professionals (Michelmore & Hindley, 2012). For young people this is commonly their peers, however little is known about how and to whom adults who self-harm make disclosures. Despite some evidence that only around

half of individuals who self-harm ever disclose their behaviour there is a lack of research aimed at understanding self-harm disclosure, such as why people decide to disclose or not, and the outcomes of choosing to disclose (Ammerman & McCloskey, 2020).

### **The Decision to Disclose**

When individuals decide to disclose, they need to consider who to disclose to, what to say, how to say it and where to disclose (Greene et al., 2006). Decisions are required about both the form and content of disclosure. In terms of the form of disclosure, there is the mode of disclosure to consider and whether this is face-to-face, through another channel of communication, such as social media, or through a third party (Greene et al., 2003). Timing is also important, such as whether disclosures are planned or spontaneous, and more nuanced decisions about which point in a conversation to disclose. As well as disclosing verbally, individuals may disclose non-verbally. For example, disclosures can be made symbolically, particularly if information is difficult to express verbally. This may be particularly true of self-harm, as a systematic review of non-suicidal reasons for self-harm has shown that one reason for self-harm may be as a ‘personal language’ (Edmonson et al., 2016). It can be understood as a ‘way of communicating the pain within’ (Harris, 2000, p.167), highlighting the interpersonal influence of self-harm.

The content of the disclosure, including what to disclose and how much to share also needs to be considered. Disclosures can differ in terms of the duration and emotional content expressed (Chaudoir & Fisher, 2010). For example, disclosers may share their emotions associated with their behaviour or talk about their experiences in a detached way. Evidence also suggests that most people hide experiences or feelings from significant others. This may be because the content is considered ‘taboo’ (Roloff & Ifert, 2000), too difficult to reveal (Derlega et al., 2000), too burdensome for the recipient to worry about (Burton Denmark et al., 2012; Hom et al., 2017), or merely private information (Petronio, 2002; Burton Denmark et al., 2012). Disclosure decisions depend on carefully weighing up the benefits and risks to the discloser and the disclosure recipient (Omarzu, 2000). Little is known about how adults who self-harm go about making these important disclosure decisions.

## Outcomes of Disclosure

Research suggests that disclosure of personal information can be associated with a range of positive outcomes, including increased psychosocial adjustment (Talley & Bettencourt, 2011), improved coping (Smyth et al., 2001), relational outcomes such as increased intimacy and trust and social contextual outcomes, such as reduced stigma (Laurenceau et al., 2005). Disclosure therefore has the potential for wide reaching effects (e.g., Beals et al., 2009; Smith et al., 2008).

However, when people disclose information that is not easily shared, and that society may stigmatise, they risk particularly negative outcomes. Stigma has been described as, ‘a mark separating individuals from one another based on a socially conferred judgment that some persons or groups are tainted and “less than”’ (Pescosolido et al., 2008, p. 431). The stigma surrounding self-harm may contribute to some people’s reluctance to disclose. The concept of self-harm can be hard for others to understand as it contradicts the human tendency to pursue pleasure and avoid pain (Walsh, 2007). Goffman (1963) identified 3 types of stigma: “abominations of the body”, “blemishes of individual character” and “stigma of race, nation and religion” (p.14). People who self-harm may be stigmatised on at least two accounts for having both physical injuries on their bodies, in a society that is becoming increasingly fixated on body image, and for the type of person they are assumed to be. For example, a common myth about self-harm is that the behaviour is attention-seeking, and used for secondary gain (Klineberg et al., 2013; Maple et al., 2019), therefore people who self-harm may be perceived as ‘attention-seeking’. The evidence that many people who self-harm rarely disclose highlights the inaccuracy of this myth (Evans et al., 2005; Whitlock et al., 2006; Williams et al., 2013). The stigma and misunderstanding around self-harm likely prevent people from disclosing.

Whilst there is limited research exploring outcomes of self-harm disclosures, research that has investigated the disclosure of other stigmatised topics, such as HIV status or homosexual sexual orientation, has found that continued concealment leads to increased feelings of guilt, distress and worry (Cepeda-Benito & Short, 1998; Pachankis, 2007). Individuals who do not disclose their stigmatised identity may feel socially isolated and have a negative self-image (Kelly, 2002). Equally, disclosure is associated with a more unified sense of self and increased feelings of self-acceptance (Kelly, 2002; Pachankis, 2007). However, not all disclosure experiences are alike, and some disclosures may result in negative psychological outcomes (Ullman, 2010). The

benefits of disclosure depend somewhat on the reactions of the disclosure recipient (Greene & Faulkner, 2002). For example, the disclosure recipient may offer practical or emotional support, which may enhance the discloser's self-worth (Beals, 2003). However, negative consequences may occur, and the discloser may feel unheard or rejected (Kelly, 2002).

Disclosing stigmatising information about oneself is likely a complex process because it has the potential for both benefit and harm. Research suggests that selective disclosure, by only disclosing to certain people, may serve to maximize benefits (e.g., social support) whilst minimising risks (e.g., stigmatising responses; Bos et al., 2009). However, selective disclosure infers that individuals still need to conceal their behaviour in particular contexts, which may cause distress (Pachankis, 2007). Furthermore, although selective disclosure may be beneficial for individuals with a stigmatised identity or behaviour, it may have adverse consequences for society. Research shows that interpersonal contact and familiarity lead to a reduction in stigma (Pettigrew & Tropp, 2006). Therefore, if people who self-harm conceal it, there will be less opportunity to challenge other people's attitudes towards self-harm. There are clearly difficult decisions to be made about self-harm disclosure and the potential for both positive and negative consequences for the person who discloses, but little is known about the self-harm disclosure experiences of adults living in the UK.

### **Disclosure Models**

Several theoretical models have attempted to bring together the different elements of disclosure discussed above (decisions, outcomes) and have also considered additional factors that influence disclosure experiences (e.g., Omarzu, 2000; Greene et al., 2006). Although these models have not yet been applied to understanding self-harm disclosures, they may offer a useful framework for understanding self-harm disclosures. Greene et al. (2006) presented a self-disclosure model that encompasses background factors such as culture, social network and individual differences of the discloser and disclosure recipient, including, personality, gender and attachment style. The discloser considers their cultural context, social norms and their access to appropriate people to disclose to. Proximal factors are implicated including the assessment of the current situation, for example privacy of the location where the disclosure will happen. The model highlights individuals' self-reported motivations for disclosure. Consistent with attribution theories, reasons for or against disclosure can reflect a self-focus, other-

focus, relational-focus or situational-focus (Manusov & Harvey, 2001). For example, self-focused reasons for disclosure include the catharsis of talking, self-clarification and seeking support (Biddle et al., 2013). Self-focused reasons for non-disclosure include loss of privacy, lack of control and rejection. Disclosure decisions may also be influenced by the recipients own willingness to disclose, highlighting the reciprocity of disclosure interactions (Dindia, 2000). This may be particularly relevant in the context of self-harm and it could mean that people might be more willing to disclose to other people who have experience of self-harm or mental health difficulties more broadly.

A more recent model is the Disclosure Process Model (DPM; Chaudoir and Fisher, 2010) which was developed to ascertain when and why disclosures may be helpful, especially for people with stigmatised identities (e.g., HIV-positive, mental health problems; Pachankis, 2007). The DPM model highlights the significance of the disclosure outcome in determining the helpfulness of the disclosure. The reactions of both the discloser and discloser recipient affect the likelihood of future disclosures (Chaudoir, 2009). When disclosures create positive outcomes and increase wellbeing, future disclosures are likely to increase. However, when disclosures lead to adverse outcomes future disclosures are likely to decrease. Supporting this, research has found that people with HIV who reported a positive recent disclosure experience were more likely to disclose subsequently within the next 6 months (Chaudoir, 2009). Furthermore, they were more likely to report increased social support, fewer communication problems, and less adverse thoughts about HIV during their subsequent disclosure experience.

Although recipients' reactions to disclosures are important, disclosure research fails to fully consider the role of disclosers (Chaudoir and Fisher, 2010). Recent theory suggests that one of the most significant influences of an individual's willingness to disclose is the expected reaction of the disclosure recipient (Chaudoir & Fisher, 2010; Derlega et al., 2011; Sprecher & Hendrick, 2004). Therefore, the discloser's expectations are important in the disclosure process. The discloser's goals, the way in which they communicate, and their ability to cope with the recipient's response, also affect the process and outcome of disclosing. While previous research has identified different goals that may guide disclosure decisions, such as relationship development, social control and self-clarification (Omarzu, 2000), consideration has not been given to how these goals affect what happens next in the disclosure process and how this influences outcomes.

The DPM makes a distinction between approach and avoidance goals of the

discloser. Approach goals are focused on pursuing a rewarding end-state, whereas avoidance goals are focused on avoiding a punishing end-state (Carver, 2006; Gable & Berkman, 2008). The model postulates that these goals shape the disclosure process and result in different disclosure experiences and outcomes. Chaudoir and Quinn (2010) found that people with stigmatised identities with approach goals for their initial disclosure reported more positive responses from the disclosure recipient and greater psychological wellbeing. Individuals with approach-focused goals may be better adept at communicating information about themselves and, in turn, garnering a positive reaction from their recipient. Further, research suggests that approach and avoidance goals influence the environmental stimuli that individuals attend to (Strachman & Gable, 2006). For example, individuals with approach goals are likely to be attuned to signs suggestive that the recipient is supportive and empathetic. In contrast, disclosers who expect social rejection may interpret neutral signs as rejecting (Strachman & Gable, 2006; Kaiser et al., 2006).

### ***Mediating Mechanisms of Outcomes***

The DPM proposes that disclosure can lead to various outcomes through three types of mediators; alleviation of inhibition, changes in social support, particularly when the disclosure recipient is receptive and changes in social information (Maisel & Gable, 2009). Researchers have previously identified alleviation of inhibition as the predominant mediator. This is derived from the literature on written disclosure (Pennebaker, 1995), which suggests that individuals benefit from disclosure as they express previously inhibited thoughts and emotions. Disclosure can greatly enhance wellbeing because it is an essential prerequisite to obtain social support. Individuals who keep parts of themselves concealed, while being protected from social rejection, do not have the opportunity to receive support from others. An absence of social support may be particularly damaging for individuals with behaviour that is especially disruptive to their lives, for example self-harm. Changes in social information refers to what happens when a discloser chooses to disclose. When people decide to disclose, the information they share can alter perceptions and actions of both the recipients and the disclosers, a change that shapes the way that they relate to each other and their wider social context (Petronio, 2002).

Below is a summary box outlining what the disclosure literature and disclosure models collectively suggest is important when exploring disclosure experiences.

### **Summary Box 1: Important aspects of disclosure**

- Disclosure may be voluntary or involuntary.
- Disclosure is not an all-or-nothing act; disclosures can progress in terms of depth and breadth.
- Little is known about who adults who self-harm disclose to. Some evidence suggests people selectively choose who to disclose to.
- The form of the disclosure is important, whether this is face-to-face, through another channel of communication such as social media, or through a third party.
- Timing is important, such as whether disclosures are planned or spontaneous, and more nuanced decisions about which point in a conversation to disclose.
- Disclosures can be made symbolically as well as verbally. Method may be implicated in disclosure decisions because some methods are more visible than others, some methods may mean disclosure is more likely or necessary.
- The content of the disclosure, including what to disclose and how much to share needs to be considered. Disclosures can differ in terms of the duration and emotional content.
- Disclosers' expectations are important.
- Disclosers' goals and motivations are important.
- Disclosure outcomes are important for future disclosures.
- Many people who self-harm do not disclose and there are many barriers to self-harm disclosure.

### **Self-Harm Disclosure Research**

Although considerable research has focused on disclosure in the context of a range of stigmatised issues and other distressing events, research on personal experiences of self-harm disclosure is a comparatively new area (Gayfer et al., 2018). I have organised the existing literature using sub-headings that relate to key factors that were highlighted in the disclosure literature as being important. I have reviewed the self-harm specific literature with these key elements of disclosure in mind. Some of the studies reviewed in this section explored attempted suicide disclosure rather than self-harm disclosure, however the definitions overlap, and the findings are still relevant. I will highlight limitations of existing studies at the end of this section and then outline how my study addresses these.

## **Barriers to Self-Harm Disclosure**

The existing literature on self-harm disclosure has begun to provide a useful understanding of important elements of self-harm disclosure. Research has identified several barriers to self-harm and suicide attempt disclosure (Frey et al., 2018; Klineberg et al., 2013; Long et al., 2015; Rosenrot & Lewis, 2018). Klineberg et al. (2013) investigated self-harm disclosure experiences from the first-hand perspective of an ethnically diverse sample of thirty adolescents, aged 15-16, providing new insights into the disclosure process and awareness into the sociocultural context of adolescent's self-harm. Thematic and content analysis found that participants felt reluctant to disclose their self-harm due to a fear of being judged negatively by their peers. Other barriers reported included fear that the disclosure may be shared, uncertainty about responses, and a belief by some individuals that their self-harm was not a serious problem. Supporting this, research that investigated help-seeking in a school-based survey of 15-16 year olds found that participants often described self-harm as something they did on the spur of the moment and it was therefore not considered important enough to disclose (Fortune et al., 2008). Some participants described self-harm as something they chose to do and reported that they were worried about disclosing their self-harm because others may try to prevent them from doing it (Fortune et al., 2008).

Other research has identified barriers that include external barriers, such as anticipated or real societal stigma and internal barriers, such as fear and internalised stigma (Frey et al., 2018; Long et al., 2015). It appears that individuals can internalise public stigma, leading to feelings of failure, which can prevent them from disclosing. A recent qualitative interview study explored barriers and responses to the disclosure of NSSI among seventeen Canadian University students, aged between 18 to 22 years (Rosenrot & Lewis, 2018). Shame was a prevalent theme, with participants identifying shame as either a barrier that prevented them from disclosing, or as an intense feeling that they experienced during the disclosure experience. Participants also reported being concerned about the impact disclosing their NSSI would have on others. Supporting this finding, Frey et al. (2018) explored the decision-making process for disclosing suicidal ideation using audio-only interviews with a sample of 40 adult survivors of a suicide attempt and found that worrying about the effects of disclosing on others was a barrier to disclosure. Linking back to attribution theories referenced in the disclosure literature (Manusov & Harvey, 2001), barriers therefore may reflect self-focused reasons for non-



disclosure (e.g., fear of being rejected) or other-focused reasons for non-disclosure (e.g., worrying about the impact the disclosure will have on others).

Maple et al., (2019) explored suicide attempt disclosures with 31 adult survivors of a suicide attempt. Two themes related to barriers to disclosure were ‘hard to reach’ and ‘needing to find the words’. Some participants had a social network that they could have accessed help from, but they were not able to talk about their experiences while they were in crisis. The inability of participants to share their thoughts and feelings led to them masking their pain, which in turn made it difficult for others to recognise that they were struggling. Sometimes, hiding their pain was intentional to avoid disclosing due to discomfort, at other times it felt essential because of what they described as an inability to share. When participants were unable to find the words to describe their experience, they remained silent and did not disclose.

### **Summary Box 2: Barriers to disclosure**

- Both external and internal barriers
- Fear of negative judgment
- Fear the disclosure may be shared
- Uncertainty about other’s responses
- Belief that self-harm is not a serious problem
- Worry that others will try to prevent self-harm
- Anticipated or real societal stigma
- Internalised stigma
- Shame
- Worrying about the impact the disclosure will have on others
- Inability to talk about self-harm
- Inability to share

### **Factors that may Prompt Disclosure**

Several studies have investigated whether people who self-harm and choose to disclose can be differentiated from people who self-harm but do not disclose. For example, Armiento et al. (2014), focusing only on NSSI, explored factors contributing to disclosure including NSSI characteristics, NSSI motivations and psychosocial factors via a questionnaire survey of 268 Canadian University students. Results showed that 57% of participants had never disclosed their NSSI to anyone. For those who had disclosed, 74% had disclosed only to a non-professional. Logistic regression analyses showed that high severity of NSSI, pain experienced during NSSI, relational motivations for NSSI, higher friendship quality and higher suicidal ideation were all

significantly associated with an increased probability of NSSI disclosure. Frequency of NSSI and number of methods of NSSI were not significantly associated with disclosure. This has important implications and suggests that individuals with more severe NSSI and higher suicidal ideation may be more likely to disclose their NSSI to others. This contrasts with research that has found higher suicidal ideation is associated with decreased disclosures (Apter et al., 2001; Horesh & Apter, 2006). However, these studies focused on disclosure of suicidal behaviour rather than self-harm.

Factors influencing self-harm disclosure were also explored by Ogden and Bennett (2015) using an online anonymous survey with 25 predominantly female participants aged 19 to 45 years old. For some participants, self-harm was used to communicate symbolically, using non-verbal means, when they found it hard to verbally communicate their distress. One theme was ‘thresholds for change’, which related to factors that seemed to prompt a disclosure and help-seeking. Thresholds for change included decreased physical and mental health, seeing the future and public reactions. For example, for some participants it was the reaction of their children noticing their scars that prompted disclosure. Various functions of self-harm were identified which were linked to the decision to disclose. Self-harm served the function of validating distress, gaining control, releasing overwhelming emotions, self-punishment and self-care. In these cases, self-harm was a private act and participants’ ability to keep self-harm concealed signified self-reliance. This study demonstrated that when self-harm enabled effective management of the private self, the public self was one of self-sufficiency. However, when managing the private self was no longer effective, the public self became one of communication, thereby initiating disclosure.

Frey et al. (2018) found several motivations for disclosing suicidal ideation and behaviour to friends and family, for example seeking help, sharing personal information and informing others for logistical reasons (e.g., if needing to go into hospital). Most participants conducted an informal cost–benefit analysis before disclosing. Each benefit and cost was not weighted equally because one benefit could be valuable enough to override several costs of disclosure. Similarly, one cost, such as the perceived risk of societal stigma, could override numerous potential benefits. One benefit that prompted disclosure was motivation fulfilment in that the goal for disclosing would be achieved. Other benefits that prompted disclosure were being an advocate for attempt survivor needs or educating others about the experience.

**Summary Box 3: Factors that may prompt disclosure**

- High severity of self-harm
- Pain experienced during self-harm
- Relational motivations for self-harm
- Higher friendship quality
- Higher suicidal ideation
- Decreased physical and mental health
- Public reactions (e.g., children noticing)
- Seeing a different future
- Seeking help
- Sharing personal information
- Informing others for logistical reasons (e.g., if needing to go into hospital)
- Wanting to advocate for others
- Wanting to educate others

**Deciding who to Disclose to**

Several qualitative studies that have explored self-harm disclosure experiences have reported findings related to decisions about who to disclose to. Armiento et al. (2014) found that friends and partners were the preferred disclosure recipients for NSSI, with 73% of disclosers choosing to disclose to a friend and 58% disclosing to a partner. Supporting this, participants in a different study highlighted the important role of friends in providing support, with many participants having chosen to disclose their self-injury to friends in the first instance (Long et al., 2015).

Long et al. (2015) recruited a community sample from Northern Ireland of 10 adult participants, aged between 19 and 42, who had self-injured. Semi-structured interviews were conducted, and data was analysed using principles from grounded theory. One theme from the data related to selectively choosing who to tell. Participants described disclosure to be a carefully considered decision. One participant described disclosing inappropriately to be like “letting a bag of feathers go in the wind” (Long et al., 2015, p. 938). Participants felt that it was inappropriate and unhelpful to disclose self-injury to family members, due to their close emotional involvement. Although this study focused on help-seeking generally rather than specifically disclosure of self-harm, it emphasises some important issues in disclosure decisions. A more recent study also found that participants reported being concerned about the impact disclosing their NSSI

would have on others. Participants reported being particularly worried about the emotional burden disclosing their NSSI would place on their family (Rosenrot & Lewis, 2018). Supporting this, recent research has found that individuals worry that self-harm disclosure could put other people at risk by either overburdening them or triggering their own emotional distress (Sheehan et al., 2019).

Frey et al. (2018) explored participants' reported decisions regarding to whom they should disclose. One important factor was the presence of a confidant. Most participants who had disclosed suicidal ideation or behaviour reported having one individual with whom they felt safe talking about suicide. The confidant was most frequently an individual who had previously had a helpful response to a past suicide disclosure. The participants felt able to disclose because they believed the confidant would react empathically, but also display the emotional stability necessary to manage their own emotions while offering support. Participants who could not identify a confidant reported disclosing less often and were most likely to disclose to individuals who knew about their previous suicidal behaviour, often due to involuntary disclosure. Finally, some participants reported disclosing to an individual to seek help, simply because they were in close proximity when the participant experienced suicidal ideation.

The findings from these studies highlight the complexity of disclosure-related decisions. Other-related reasons for non-disclosure are usually implicated, in that participants often did not want to disclose to family because of the worry it would cause them (Manusov & Harvey, 2001). These findings seem to fit with previous disclosure research which suggests that disclosure decisions depend on weighing up the benefits and risks to the discloser and the disclosure recipient (Omarzu, 2000). The participants in these studies seemed to endorse selective disclosure, by carefully choosing who to disclose to, in order to maximise benefits whilst decreasing risks (Bos et al., 2009).

#### **Summary Box 4: Deciding who to disclose to**

- Friends are often the chosen disclosure recipient
- Partners can also be preferred disclosure recipients
- Disclosure is a carefully considered decision
- Selectively choosing who to tell is helpful
- Potentially harder to disclose to family members due to their close emotional involvement
- Participants worried about the emotional burden disclosing to family members would cause
- Presence of a confidant is important
- Decisions are based on how potential recipient has responded in the past
- Disclose to people that are available and in proximity

## **Self-harm Disclosure Responses and Outcomes**

### *Positive Experiences*

Recent qualitative studies have investigated the risks, benefits and outcomes of disclosure from the perspectives of adults who have self-harmed (Rosenrot & Lewis, 2018) or attempted suicide (Frey et al., 2017; Maple et al., 2019; Sheehan et al., 2019). In Frey and colleagues' (2017) audio interview study many participants reported positive responses that reinforced feelings of worthiness. Three subthemes identified were 'seeking to understand by asking questions', 'being present' and 'projecting strength and stability'. When asked about the ideal way to respond to suicide disclosure, many participants stated the need for open-ended non-judgemental questions, as opposed to blaming questions. Questions such as "how were you feeling?" were thought to convey a genuine desire to understand from friends and family. Being present referred to not only the type of questions asked by others but also the willingness to hear honest answers to those questions, even when the information is upsetting. This directly related to increased feelings of belongingness among suicide attempt survivors. Projecting strength and stability referred to participants' desire to avoid being a burden to friends and family. Many participants expressed gratitude for others who were capable of hearing about their suicidal behaviour without becoming overwhelmed by it. Supporting these findings, in Rosenrot and Lewis' (2018) study participants reported that the willingness of disclosure recipients to talk openly about NSSI, without judgment, seemed to support the disclosure experience. Most participants were able to recall at least one positive self-harm disclosure experience, that promoted understanding, compassion and acceptance.

In Sheehan et al's (2019) study participants acknowledged how suicide-related disclosure could benefit them through increased social support and strengthening of relationships. Participants described how some disclosure recipients were flattered that they had been trusted with such sensitive personal information. Other benefits of disclosure were gaining access to treatment, maintaining personal safety, opportunities for self-reflection, enhanced coping strategies and personal recovery. Participants also described how disclosure could benefit others by providing suicide psycho-education, reducing stigma and allowing suicide attempt survivors to help peers who may be

struggling with similar difficulties. This study had a more representative sample than previous studies as more males participated and participants were from a range of ethnic backgrounds. The study focused solely on identifying specific benefits and risks of disclosure. The authors suggested future research could explore in detail the process that people engage in while making a disclosure decision, the consequences of disclosing and the key components of a successful disclosure experience.

A key theme from Maple and colleagues' (2019) study was 'Finding a lifeline', which related to positive help from family members or friends following a suicide attempt disclosure. Participants frequently described one key person as a lifeline who helped them survive and recover from the experience. Some family members acted as buffers to prevent others' stigmatising reactions by stopping other people from saying hurtful things. This highlights how social support can be helpful for the recovery process.

### *Negative Experiences*

Klineberg et al. (2013) found that many participants had negative experiences when they disclosed their self-harm to peers, which reinforced their wish to keep self-harm concealed. Participants reported receiving shocked reactions and stated that others were more concerned with the physical injuries, rather than offering emotional support. In Rosenrot and Lewis' (2018) study the responses participants received varied, with some being harmful, leading to invalidation and anger. Many participants reported that their NSSI disclosures were met with silence and avoidance, with disclosure recipients failing to take any action and NSSI never arising in subsequent conversations. It appears that NSSI seems to not only silence people who self-harm but also significant others who may not know how to appropriately respond. Supporting this, a theme from Maple and colleagues' (2019) study 'Needing to find the words' also related to family members responses to disclosures. It was suggested that some family members may not communicate because they either cannot find the words or fear negative consequences.

Other negative responses include unsupportive reactions, stigma, unwanted treatment (e.g., hospitalisation), re-traumatisation, lack of privacy and lack of understanding from others (Sheehan et al., 2019). Research has shown that misunderstanding from others after a self-harm disclosure can cause people who self-harm to retreat further into their self-harming behaviours and perpetuate a vicious cycle of shame (Long et al., 2015). Unhelpful reactions can include both perceived overreactions and underreactions. To describe overreactions participants used phrases

such as “hovering” and “sleeping with one eye open” (Sheehan et al., 2019, p.15). Overreactions from others usually led to increased secrecy. Conversely, underreactions that were dismissive were perceived to be unhelpful. It seems that other people may struggle to find the right balance when responding to self-harm disclosures.

Three themes relating to negative suicide attempt disclosure responses and outcomes were reported by Maple et al. (2019). These were ‘attention seeking’, ‘stigma’ and ‘harsh judgements’. Participants talked about a range of negative reactions following their disclosure that impacted their willingness to disclose in future. Participants were particularly concerned about the assumption that suicide is attention-seeking or selfish. Some participants decided to end relationships with people who reacted in a hurtful way. Judgemental reactions included criticism, name calling, or blaming the individual who had attempted suicide.

In Frey and colleagues’ (2017) study every participant reported having at least one negative experience after disclosing suicidal behaviour. Many negative experiences related to stigmatising statements, such as blaming the suicide attempt survivor for hurting other people. The reactions contributed to participants’ ongoing feelings of worthlessness and a sense that they are a burden. Another way in which responses to suicide disclosure were perceived as negative was when the focus was initially on the impact of the behaviour on friends and family members rather than on the suicide attempt survivor. Several participants described how others reacted by focusing on what the attempt survivors were doing to them, which further exacerbated attempt survivors’ feelings of being a burden to significant others.

The research findings from studies on self-harm disclosures raise some significant issues in relation to responses to disclosure. The findings suggest that individuals who can disclose self-harm to others may not be receiving the social support they require (Rosenrot & Lewis, 2018). Research has found that rejecting responses can increase psychological distress (Chaudoir & Fisher, 2010) and may predict worse outcomes than not disclosing at all (Ullman, 2010). For example, one study found that misunderstanding from others caused participants to retreat further into their self-harm behaviours (Long et al., 2015). In this case disclosing was detrimental and harmful. The disclosure literature also suggests single disclosures can influence the likelihood of future disclosures (Chaudoir & Fisher, 2010). If adults receive stigmatising responses or responses of silence, avoidance or overreactions they may be less willing to disclose again in the future resulting in a lack of support.

### Summary Box 5: Responses and Outcomes

#### Positive Experiences

- Reinforce feelings of worthiness and belongingness
- Seeking to understand
- Open-ended, non-judgemental questions
- Being present, willingness to hear honest answers
- Projecting strength and stability
- Increased social support
- Strengthening relationships
- Gaining access to treatment
- Maintaining personal safety
- Opportunities for self-reflection
- Enhanced coping strategies and personal recovery
- Benefits others through raising awareness, providing education and reducing stigma

#### Negative Experiences

- Shocked reactions
- Others concerned with physical injuries rather than offering emotional support
- Silence and avoidance
- Feeling ignored
- Unsupportive reactions, overreactions, underreactions
- Stigma
- Unwanted treatment (e.g., hospitalisation)
- Re-traumatisation
- Lack of privacy
- Lack of understanding from others
- Others assuming self-harm is attention-seeking/selfish
- Judgemental reactions – blaming, name calling, harsh responses
- Feelings of worthlessness after disclosure
- Feeling like a burden after disclosure

#### Limitations of Existing Studies

The limited number of studies to date are constrained in both their sampling and their focus. In terms of sampling, the existing literature that focused specifically on self-harm disclosure experiences has mainly explored the experiences of adolescents or University students who have disclosed self-harm (e.g., Armiento et al., 2014; Evans et al., 2005; Fortune et al., 2008; Klineberg et al., 2013; Michelmore & Hindley, 2012). It is difficult to differentiate the self-harm disclosure literature between adolescents,



young adults and adults as there are no agreed upon standard definitions. However, there are broadly three categories under consideration. Those who are legally defined as children and adolescents and they use different health services and often access education. This group may be under the age of 16 or 18 depending upon the country and exact circumstances. There is then a transitional group who are not obviously adult and are still on a developmental trajectory, socially and perhaps biologically, and not obviously children. These are often called ‘Young People’ or ‘Young Adults’. There are variable definitions but typically this group of people are between the ages of 16-25 or 18-25 (WHO, 2009). Finally there are ‘adults’ who are in a stable stage of adulthood. The self-harm disclosure experiences of adolescents and University students may not be as relevant to an adult population. For example, they may be more likely to involve disclosures in peer groups, education settings, or involve parents.

In addition, many of the studies have been conducted outside of the UK and have used a restricted definition of self-harm that make distinctions based on suicidal intent (e.g., Rosenrot & Lewis, 2018). For example, recent qualitative studies exploring experiences of adult suicide attempt disclosures in the United States (Frey & Fulginiti, 2017; Frey et al., 2017; Frey et al., 2018; Maple et al., 2019; Sheehan et al., 2019) exclude disclosures of self-harm behaviours without suicidal intent, which may result in different disclosure experiences. Furthermore, a lack of culturally diverse samples have been recruited with several of the study samples consisting of only Canadian University students, so the results may not generalise to individuals with different ethnic backgrounds or those not attending University (e.g., Armiento et al., 2014; Rosenrot & Lewis, 2019). Previous studies have tended to have homogeneous samples of predominantly young females, with very few males participating (Klineberg et al., 2013; Rosenrot & Lewis, 2018). It may be that there are differences in the disclosure experiences of men and women. Research suggests this could be the case as one study found 69% of men had never disclosed self-harm compared to 53% of women (Armiento et al., 2014), suggesting potentially that there may be more barriers for men.

In terms of focus limitations, some studies have investigated help-seeking more generally rather than disclosure experiences specifically (e.g., Long et al., 2015; Ogden & Bennett, 2015). It may be that people disclose their self-harm for other reasons than seeking help and these disclosure experiences could differ. Other studies have focused on certain aspects of disclosure experiences, for example disclosure decisions (Frey et al., 2018) or others’ reactions to disclosure (Frey et al., 2017), rather than taking a broader approach to understanding self-harm disclosure experiences. The existing

studies fail to explore the detailed disclosure process in depth and certain elements of disclosure that research has shown is significant are missing. For example, participants' expectations prior to disclosing, the mode of communication used to disclose and the emotional content expressed (e.g., Rosenrot & Lewis, 2019).

### **Addressing the Limitations of Previous Studies**

It is important to explore the experience of self-harm disclosure from the perspective of adults who self-harm. Previous research has begun to explore this but there are obvious gaps. This study aims to build on the limited research in the field of adults disclosing self-harm to non-professionals. I have used a broader definition of self-harm, which is common to self-harm research in the UK. I have explored disclosure expectations and experiences of both men and women and recruited participants with a wider age range than previous studies. It may be that adults have different disclosure experiences to adolescents, for example their disclosure recipients may be more likely to be partners, they may be more concerned about their self-harm being apparent in intimate relationships, disclosure recipients may be less likely to be parents, work is a different environment to school and colleagues may respond differently to school peers and adults may have different social communication styles. Furthermore, adults who self-harm may have begun self-harm before adulthood, and so may have a longer history of self-harm and therefore a broader range of disclosure experiences over time, or a longer history of not having disclosed their self-harm to draw upon.

I have recruited a more diverse sample than previous studies with participants that have used various methods of self-harm. I have also explored how others' responses to self-harm disclosures may have changed over time and how participants' perceptions may have changed as the disclosure literature suggests that disclosure is a dynamic evolving process. Furthermore, I have taken a broader approach to understand self-harm disclosures by exploring the overall experience as opposed to specific aspects of disclosure. I have used the disclosure models outlined to inform my interview topic guide and explore the different elements of disclosure in detail. The findings from this study will provide new insights into the process of disclosing self-harm to others, the responses received and the implications for the person who discloses.

### **Possible Clinical Implications**

Research suggests disclosing is the first step in the recovery process, as one

aspect of getting help for self-harm is being able to tell others about it (Hasking et al., 2015). Research has highlighted the role the disclosure process may play in helping people stop self-harming. For example, Whitlock et al. (2015) found that among University students who had self-injured, disclosing their self-injury, and having a conversation with someone about it was a significant predictor of students being able to stop self-harming over time. Research has also highlighted that those who disclose their self-harm to non-professionals, and receive a positive response from the disclosure recipient, are more likely to seek support from formal sources, including health professionals (Nada-Raja et al., 2003; Wu et al., 2012). Although simply telling somebody about self-harm and actively seeking help with it are possibly separate actions with different motivations (e.g., social support/versus treatment), research findings suggest that non-professionals may be in a unique position when it comes to offering support to somebody who self-harms. Research indicates that non-professionals are the preferred disclosure recipients for people who self-harm (e.g., Armiento et al., 2014; Evans et al., 2005), therefore it is important to improve understanding of these disclosure experiences. By increasing awareness and understanding of disclosure experiences it may be possible to support positive self-harm disclosures.

Media mental health campaigns such as ‘time to talk day’ symbolise a nationwide push to encourage people to talk more openly about mental health, with the underlying assumption that the conversation in itself will be helpful (Rethink Mental Illness, 2020). However, there is limited guidance to explain why, how or in what circumstances these conversations might be helpful. The latest campaign ‘Britain get talking’ launched on ITV and involved popular programmes being paused for a minute of silence to encourage viewers to talk to each other about mental health (ITV, 2020). This shows that people are beginning to talk more openly about mental health problems in the media and on social media platforms, however, there seems to be a paucity of conversations around self-harm. This makes me wonder if and how these conversations happen within family and friendship groups, or among colleagues and what these conversations look like. Currently we know very little about self-harm disclosure experiences amongst adults in the UK. The research findings will result in improved understanding of the potential benefits of disclosing and overcoming barriers to disclosure. Furthermore, it may assist professionals to support people they work with to disclose self-harm to significant others or provide support for non-professionals who may be unsure how to respond to somebody else’s self-harm disclosure. It is important to prepare non-professionals with effective ways to respond to self-harm disclosures.

Supportive responding may help to decrease distress, encourage increased understanding and acceptance and improve relationship quality (Chaudoir & Fisher, 2010). The findings from this study will highlight what is and is not helpful when talking to other people about self-harm.

### **Research Aims/Questions**

The aim of the research is to understand the expectations and experiences of adults who self-harm when they disclose to non-professionals. The research questions were developed to address the gaps in the existing literature and are as follows:

- 1) What influences the decision to make a disclosure about self-harm to a non-professional?
- 2) What are the expectations of those who consider disclosing self-harm to a non-professional?
- 3) What are the experiences of adults who disclose self-harm to a non-professional – both at the time and following disclosure?
- 4) For those who disclose self-harm to a non-professional, what are the impacts on the individual who discloses?
- 5) What are the barriers to disclosing self-harm to a non-professional?

## CHAPTER TWO: METHOD

I begin this chapter by outlining the selected research design and justifying the chosen methodological approach. Next, I discuss the participants and sampling strategy before outlining ethical considerations. I then describe the recruitment procedure and interview procedure. Finally, I summarise the quality checks used during data analysis prior to providing a reflective statement.

### **Research Design**

The aim of the study was to gain an understanding of participants' self-harm disclosure experiences. As the research was exploratory, I chose qualitative research methods and gathered data through face-to-face semi-structured interviews with 10 participants who had self-harmed. I analysed the data using Thematic Analysis (TA) as outlined by Braun & Clarke (2006).

### **Methodological Approach**

Qualitative research methods are commonly used when exploring, describing and interpreting the personal and interpersonal experiences of participants (Smith, 2015). An attempt is made to understand a participant's worldview or unique frame of reference (Smith, 2015). Due to a lack of research on adult self-harm disclosure experiences I chose a qualitative approach to give a voice to views which have seldom been heard. This enabled the development of insight and understanding into participants' self-harm disclosure experiences.

I chose semi-structured interviews as the data collection method. Semi-structured interviews are conducted conversationally with one participant at a time and employ open-ended questions, often accompanied by probing and follow-up questions (Newcomer et al., 2015). The discussion can meander around the topics on the interview guide, rather than strictly adhering to questions in a specific order. The advantages of semi-structured interviews are that they can raise unexpected issues. As there is limited research on self-harm disclosure experiences I thought this would be particularly useful and I did not want to restrict topics of conversation. Another benefit of face-to-face interviews is that I could build rapport with participants and observe their non-verbal communications. This meant it was easier for me to monitor participant well-being, which was particularly important when investigating potentially sensitive or distressing

content. Other methods of data collection, such as questionnaires would not have allowed for participant experiences to be explored in-depth and clarification of responses would not have been possible. Conducting focus groups would have been potentially uncomfortable for participants due to the private nature of self-harm and the difficulties in talking about self-harm that were highlighted in the introduction.

The use of qualitative research methods also has drawbacks. The data depends on the participant's capacity to reflectively determine aspects of their own experience and to put this into words to effectively communicate their experiences to the researcher (Polkinghorne, 2005). Furthermore, people may only have partial awareness, rather than complete access, to their own experiences. The conversion of reflective awareness into language might not fully describe the experience, particularly if the person's perspective is articulated sometime after the experience occurred (Polkinghorne, 2005). Research quality is also more dependent on the individual skills and ability of the researcher (Anderson, 2010).

I used TA as a framework to analyse the data. TA is a method for identifying, analysing and reporting patterns 'themes' within data (Braun & Clarke, 2006). A theme depicts something important about the data in relation to the research questions and represents some level of meaning within the data set. TA can provide a rich and thorough examination of personal lived experiences, and hence is appropriate to explore self-harm disclosure experiences. TA is particularly valuable when investigating topics that have not been as extensively researched (Braun & Clarke, 2006), as is the case for this study. Furthermore, TA has been viewed as a foundation of qualitative analysis as it provides essential skills that are transferrable to many other forms of qualitative analysis (Braun & Clarke, 2006). As this was my first major independent research project using qualitative methods, I thought that TA would be a suitable and accessible method of analysis to utilise. Although TA seemed like the natural fit for my research I considered alternative methods of analysis, including Grounded Theory (GT; Charmaz, 2000; Glaser & Strauss, 1967). However, I felt that TA offered more advantages. GT is concerned with social processes and aims to develop a novel theory underlying these, which is relevant to the research due to disclosure being a social process and the understudied nature of self-harm disclosures. However, in order to generate a theory that is 'grounded' in the data, GT is associated with a prescribed analytical approach that dictates the method of data collection and analysis, whereas TA is more flexible. GT utilises theoretical sampling, which necessitates that the researcher analyses interviews to decide what data to collect next, prior to conducting further interviews.

(Charmaz & Belgrave, 2007), and due to practical constraints this was not feasible.

Braun and Clarke (2006) suggest that in contrast to other qualitative approaches such as Interpretative Phenomenological Analysis (IPA) (e.g., Langridge, 2004; Smith, 1996), GT (e.g., Charmaz, 2000; Glaser and Strauss, 1967), and discourse analysis (e.g., Potter and Wetherell, 1987; Wetherell, 1998), TA is not wedded to any pre-existing theoretical framework, meaning it can be used flexibly. However, for evaluative purposes, it is important to identify a theoretical underpinning, as this often guides what knowledge is explored, how it is explored and how the findings are interpreted (Braun & Clarke, 2006; Terry et al., 2017; Kivunja & Kuyini, 2017).

Braun and Clarke (2006) suggest that TA can be both a realist and a constructionist method. Realist methods assume that reality is 'out there' and discoverable through the research process (Terry et al., 2017). The language participants use is believed to capture their direct experience of reality, which exists independently of being studied. Whereas constructionist methods assume that there is no external reality discoverable through the research process, rather multiple versions of reality are created through research (Terry et al., 2017). Constructionist methods explore the ways in which events, realities, meanings and experiences are constructed in a range of societal discourses. Equally, Braun and Clarke (2006) suggest that TA can be a contextualist method, which is somewhere between the realist and constructionist methods. Contextualist methods assume that reality is 'out there' but access to it is always mediated by sociocultural meanings, along with the participants' and researcher's interpretations. Participants' words provide access to their specific version of reality and research produces interpretations of this reality. Contextualist methods therefore recognise how people make sense of their lived experiences whilst acknowledging how the broader social context influences those meanings. As a Psychologist in Clinical training (PICT) I believe that individuals cannot be separated from their social context and will always be influenced by this. Therefore, I felt the contextualist method fit with both my aims of wanting to immerse myself in participants' accounts, whilst also understanding these in a wider social context; working both to 'reflect reality and to unravel the surface of reality' (Braun & Clarke, 2006, p. 81).

The versatility and accessibility of TA made it an appropriate method of analysis for this research project. TA has sometimes been perceived as a research approach of lower quality; however, several authors argue that other qualitative analyses, including

IPA and GT, have TA at their core (Braun & Clarke 2006). I have used a version of TA, recently termed 'reflexive TA' by Braun and Clarke (2019), which emphasises researcher subjectivity, organic and recursive coding processes and the importance of deep engagement with the data. The researcher is seen as active in making decisions about analysis. Hence, despite TA being a flexible approach, several areas must be considered with regard to data analysis, which I have outlined later under the sub-heading 'Data Analysis'.

## **Participants**

Participants were adults, aged 18 years or over, with a history of or current engagement in self-harm. As most previous research had recruited adolescents or young adults (e.g., Rosenrot & Lewis, 2018), I chose to recruit participants who were 18 years of age or over and recruited a wider age range than previous studies (e.g., Ogden & Bennet, 2015; Rosenrot & Lewis, 2018). This fits with the open and exploratory approach to the research and enabled me to explore the experiences of adults who are likely to have different disclosure experiences (e.g., to work colleagues, children etc). I specifically chose to focus on adults aged 18 or above because around this age people's social connections tend to change with people moving into the world of work, University, or independent living away from parents. Therefore, disclosures around self-harm may change in terms of who they are too. Furthermore, research suggests that early adulthood is a period of increased onset and high rates of self-harm (Heath et al., 2008), so it did not make sense to exclude younger adults from the research. I did not specify an upper-age limit as some previous self-harm disclosure studies have focused on University students between the ages of 18-22 (e.g. Rosenrot & Lewis, 2018) and I aimed to recruit adults of different ages. Adult participants were more likely to be able to reflect on a greater number of disclosure experiences over their lifetime than adolescents, enabling me to explore differences across these experiences, the different contexts in which they occurred and disclosure experiences over time. I have provided demographic information and brief pen portraits of participants in the results chapter.

## **Sampling strategy**

The number of participants to be included in qualitative research is difficult to determine. There is limited guidance on what sample size is required for an interview study (Guest et al., 2006; Emmel, 2013). However, one approach is to continue



interviewing until theoretical saturation, where data analysis no longer generates new themes (Glaser, 1965). Sandelowski (1995a) stated that determining an adequate sample size is also dependent on researcher judgement. The sample size needs to be ‘manageable’, in that it is small enough that the researcher can carry out a detailed data analysis, but large enough to provide ‘a new and richly textured understanding of experience’ (p. 183).

Previous TA studies have found that around 6-12 interviews are sufficient for reaching data saturation (Ando et al., 2014; Guest et al., 2006; Isman et al., 2013). Braun & Clarke (2013) also originally provided guidance about adequate sample sizes based on the type of data collection and the size of the study. For small research projects, it was recommended that 6–10 participants are interviewed. However, in more recent work Braun and Clarke (2019) question the usefulness of the term ‘saturation’ when applied to TA and the underlying assumptions that inform ‘data saturation experiments’ (p. 5). They argue that although the concept of theoretical saturation is consistent with a realist approach to research, whereby codes are believed to exist within the data and emerge through the analysis, the concept is not consistent with the assumptions of reflexive TA, which emphasises the subjective role of the researcher in interpreting and generating meaning. They now encourage researchers to tolerate uncertainty and acknowledge that meaning is created through interpretation and not excavated from data. Therefore, judgements about when to stop data collection are subjective and cannot be fully determined prior to data analysis. As I began data analysis after I had collected the data, it was not possible to determine when I may have reached data saturation. Therefore, the sample size was subjectively determined, considering various issues as recommended by Braun and Clarke (2019) including, the breadth and focus of the research questions, the data collection method used, the desired diversity of the sample, the demands placed on participants, the depth of data likely generated from each participant, the scope and purpose of the project and the pragmatic constraints of the project. Taking these considerations into account, it was decided that a sample size of 10-15 would be adequate to generate themes, whilst remaining feasible.

I decided not to restrict the population of interest to only those who had disclosed their self-harm. Although the main research aim was to explore self-harm disclosure experiences I also felt it was important to explore barriers to self-harm disclosure. It was predicted that not all participants would identify with the word ‘disclosure’, or that some participants may not feel that they had disclosed their self-harm to a non-professional. Therefore, non-disclosure was not an exclusion criteria and

participants who could not identify a specific disclosure experience were still able to participate in the study.

### **Inclusion Criteria**

To be eligible for semi-structured interviews participants had to:

- 1) Be 18 years of age or older.
- 2) Have self-harmed, according to the study definition “any act of self-poisoning or self-injury carried out by an individual irrespective of motivation” (NICE, 2011, p.4).
- 3) Be identified as having capacity to consent to participate.

### **Exclusion Criteria**

Potential participants were excluded if, for any reason, it was deemed inappropriate to recruit them to the study, for example, due to personal circumstances or significant risk to themselves or the researcher. I asked gatekeepers within services to apply these exclusions, and for self-referrals to the study I made an informal assessment judgement but realise with retrospect I was not explicit in how I did this.

I chose a convenience sampling approach to select participants for the study. Whilst this is often seen as the least rigorous qualitative sampling technique (Marshall, 1996; Sandelowski, 1995b). I chose convenience sampling due to the possibility of only recruiting a limited number of participants due to the private nature of self-harm and the difficulties people face in disclosing. However, if more than 15 participants wanted to take part in the research I would have selectively chosen who to interview in order to get a diverse sample. Preceding studies had very few male participants (e.g., Long et al., 2015), therefore I wanted to recruit a more even mix of male and female participants. If a limited number of males contacted me about the study I planned to target the recruitment strategy and approach Andy’s Man Club, which is a group of men who meet to discuss their problems in a bid to reduce male suicide. However, I did not instigate this part of the sampling strategy as enough men decided to take part in the study. I also aimed to get diversity on other participant characteristics such as, age and ethnicity, by keeping the sampling strategy as broad and inclusive as possible.

## **Ethical Considerations**

### ***Ethical Approval***

Ethical approval was sought and granted from the National Health Service (NHS) Yorkshire & The Humber - Leeds East Research Ethics Committee (Ref 19/YH/0137). The research was also approved by the relevant NHS Research and Development departments. Confirmation of ethical approval can be seen in Appendix A.

### ***Informed Consent***

I provided participants with clear information about the study and gave them the opportunity to ask questions, ensuring informed consent. The participant information sheet (PIS; Appendix B) notified participants about the context of the research and the possible usage and implications of the findings. I gave participants time to make an informed decision about taking part in the research before they signed the consent form (Appendix C). Furthermore, I informed participants about their right to withdraw their contribution, up to four weeks after being interviewed, without suffering any negative consequences.

### ***Confidentiality/Anonymity***

I audio-recorded interviews with participants' permission in private locations, such as rooms in community venues. The PIS documented how participant information would be used following the interview. At the beginning of the interview, I informed participants about the usual rules that apply to clinical work with regards to confidentiality. These applied equally to the research and meant that participants could expect their personal details to remain confidential within the research team. The only occasion when confidentiality could be broken, and information passed onto a third party, would be in the event of the participant disclosing that they or somebody else was at serious risk. Furthermore, I informed participants that if they did not wish to answer specific questions then they could refrain from doing so. I also notified participants that direct quotes may be used in the research; however, any identifiable data was removed during transcription and I gave participants pseudonyms to protect their identity.

### ***Data Protection***

I password protected all electronic data, such as audio files and transcripts, and stored them on the secure University server, where they will remain until completion of my doctoral studies. The data will then be transferred to a different secure drive via

encrypted USB, in anticipation of my personal drive being suspended with the completion of my studies. The secure University server is administered by the Doctorate in Clinical Psychology course research coordinator, who will delete the files three years from the completion of the project. I hand delivered audio recordings to an approved University transcriber on an encrypted USB to safeguard the data. The transcriber was employed by the University and required to sign a confidentiality agreement in line with General Data Protection Regulations (GDPR).

I separated consent forms and paper-based data containing names and email addresses from other paper-based data (e.g., anonymised transcripts). The two separated types of paper data were stored in locked filing cabinets at the University, in a locked office. Paper-based data will be sent for destruction, three years after completion of the project.

### ***Harm to Self***

I interviewed participants during working hours in sensible locations and informed a reliable third party of my whereabouts and the estimated duration of each interview. In the community venues where I interviewed participants, I informed the person working on reception when I had arrived and the approximate time I would be finishing the interview and signing back out. These control measures minimised the risk to my personal safety.

Hearing stories of disclosing self-harm had the potential to be distressing. I am trained to work with people in distress and used to hearing information that is upsetting. I had access to supervision during the research process and ensured that there was enough time between each interview to reflect on the emotional impact of conducting the interviews.

### ***Harm to Others***

It was important to minimise risks to participants. Initially, to understand the potential risks I reviewed relevant literature involving participants who self-harm. It could be assumed that recalling events of self-harm will cause distress and increase risk amongst participants, however studies exploring this suggest this may not be the case. For example, Biddle et al., (2013) collected data from four studies on self-harm and suicide. Participants were asked to complete a visual analogue scale that measured their emotional state before and after their interview, with 50-70% of participants reporting a post-interview improvement. Many participants also described the ‘cathartic’ value of talking. Conversely, around 18-27% of participants reported a lowering of mood due to

discussion of difficult issues they were avoiding, although they expected this distress to be temporary and offset by a desire to contribute to research. An increase in distress did not therefore necessarily indicate an adverse experience. Furthermore, a meta-analysis of 18 studies investigating whether asking about suicide-related content resulted in changes to participants' level of distress, suicidal ideation, or suicidal behaviour found significant pre-post reductions in levels of suicidal ideation for those exposed to suicide-related content (Blades et al., 2018). In experimental study designs, participants in the suicide-related exposure condition were significantly less likely to report a suicide attempt after research participation compared to controls. Overall, the findings of these studies suggest that participation in self-harm research is not associated with increased risk and may in fact offer benefits to participants.

Although research suggests involving participants in self-harm research is unlikely to increase risk of distress, suicidal thoughts or behaviour, it was still essential to develop a risk management protocol for this purpose (Appendix D). The risk protocol outlined steps to be followed if a person was deemed at risk. During the interviews I monitored emotional responses and was alert to signs of distress. As I am training to be a Clinical Psychologist, I am appropriately placed to monitor and intervene with emotional distress. Although some participants did become upset during points in the interview, they reported feeling comfortable enough to carry on and research shows that some participants derive benefit from bringing closure to their account (Biddle et al., 2013).

In practice, no significant risk issues arose during the project. However, if any participants had felt they required confidential support for issues raised in the interviews they would have been signposted to relevant services.

### **Involvement of People with Personal Experience**

Several groups of people with personal experience were involved in the development of the research. I had three separate meetings with Everybody's Voice, Personalities in Action and the founder and Chief executive of Battle Scars to gain feedback. Everybody's Voice is a mental health service-user and carer group that works with the Doctorate in Clinical Psychology course at the University of Leeds. Personalities in Action are the involvement group for the Leeds Personality Disorder Clinical Network; members of this group have personal experience of self-harm. Battle Scars is a third-sector organisation and support group for people who self-harm.

The groups provided feedback on participant documents such as, the PIS, consent form and recruitment advert, as well as the interview topic guide. The groups were consulted about recruitment plans and offered suggestions of services to recruit from. The groups provided positive feedback including:

- They liked the photograph on the recruitment advert, as they thought it would put people at ease to know who they were meeting with.
- They thought the layouts of the documents were clear and the format was good.
- They thought the research made sense, had a clear purpose and was important.
- The groups liked that there was no upper age limit for participation and thought it was important to ask adults about self-harm disclosure experiences as this is likely to be different to adolescent experiences.

The groups also provided suggestions for improvement, which were all implemented, including:

- It was suggested to make anonymity plans clearer on the information sheet.
- It was suggested to give participants the option to be interviewed once more if they realised after the interview they had forgotten something important that they wanted to share.
- It was recommended changing the wording 'We' to 'I' on the PIS. It was felt that the wording 'we' could imply that other people may also be interviewing or may suggest two interviewers interviewing together. They thought making the PIS personal was important.
- People thought it would be helpful to state on the PIS that a short de-brief would be offered at the end of interviews to check that participants felt okay before leaving.
- People highlighted points of repetition in the participant facing documents.
- People stated that they wanted to know more information about the long-term advantages of the research such as, benefits/impacts on services more broadly.
- The founder of Battle Scars helped to develop the interview topic guide and suggested participants should be given a clear choice at every stage, and it should be made clear to them that they do not have to answer any questions they feel uncomfortable about.
- The founder or Battle Scars suggested not to interview in participants own homes, as originally planned, as this may feel intrusive.

## Recruitment Procedure

Participants were recruited from:

1. Battle Scars support group: A third sector organisation, that has been a registered charity in England and Wales since February 2018. The community group aims to support anybody affected by self-harm.
2. Two NHS Trusts in the North of England (details withheld to ensure participant anonymity).

Participants identified through NHS services were given an advert about the study by a clinician and asked if they would like to speak to a researcher about the study. Those that agreed were then given two options. Either, they could contact me (lead researcher) directly to discuss the study, or if they gave permission for their contact details to be passed on to the research team a clinician would complete a consent to contact form with them. The consent to contact form was then sent to me so that I could contact the potential participant to talk about the study in more detail, send them the PIS either by post or email, and answer any questions they had before they decided if they would like to participate in the study. For participants identified through Battle Scars, the group facilitator advertised the study to their members via the recruitment advert. People who were interested in taking part were then able to contact me using the contact details provided on the advert.

The recruitment advert was also displayed in waiting areas in the various services and community groups so that people interested could contact me directly without having to speak to a clinician in the service about the research. Once potential participants had contacted me I then liaised with them directly via email or telephone. I sent the PIS and consent form to participants either via post or email, and encouraged them to read these documents prior to our meeting. If participants still wanted to take part after reading the information sheet and consent form then a date, time and interview location was mutually agreed. The interviews were conducted between 8<sup>th</sup> July 2019 and 18<sup>th</sup> November 2019. At the beginning of each interview I gave participants another opportunity to read the information sheet. They were then able to ask any questions about the research. Subsequently, participants read the consent form and signed their initials to evidence that they agreed to take part in the research.

## **Interview Procedure**

I conducted semi-structured interviews using the interview topic guide (Appendix E) that was developed from the disclosure literature and feedback from supervisors and groups of people with personal experience. The interview questions aimed to elicit data that expanded on previous studies that have explored self-harm disclosure experiences. For example, I asked participants about other's responses changing over time, to get a sense of how disclosure may change over time and is not a fixed experience. I also asked participants how they made sense of past disclosure experiences in the present (e.g., 'How do you make sense of the experience now?'). As I interviewed adults with a broader age range than previous research (e.g., Rosenrot & Lewis, 2018), it was possible for some participants to reflect on past disclosure experiences and make sense of them in new and complex ways, with retrospection. This fits with the contextualist method I adopted and the assumption that the meaning participants attribute to experiences will be influenced by their current social context (Terry et al., 2017).

The interview topic guide focused on expectations and influences on disclosing self-harm, experiences of disclosing, and responses and impacts of disclosing self-harm. If participants had not disclosed to certain non-professionals, I explored their reasons for this and their expectations of self-harm disclosure. The interviews were conversational in style, which allowed participants to talk about the things that mattered to them. The use of a flexible topic guide enabled participants to tell their stories and bring up unanticipated issues and lines of inquiry. I started the interviews with some easier questions to help participants feel comfortable and settle into the interview and to explore their social contexts, which fits with my theoretical beliefs about conducting research, that individual's interpretations will be influenced by their social context.

During the data collection phase, I endeavoured to create interview conditions that minimised the potential for distress. I made sure to schedule interviews that allowed adequate time to establish rapport with participants at the beginning of the interview and allowed participants ample time to share their experiences. Once interviews were completed, time was taken to check participants' well-being and participants were able to engage in less formal conversation before leaving the interview location. I offered participants the opportunity to be contacted once the thesis was completed and given a summary of the main findings of the research.



Participants were offered various interview locations, including mental health hubs and various Universities across the North of England, or the location of the service they had been recruited from. Reimbursement was offered for any travel expenses to the interview location. Interviews lasted between 36 and 110 minutes, with the average interview length being 69 minutes. After each interview I wrote my reflections down, describing my sense of how the interview had gone, how the person presented during the interview, and action plans for how to improve future interviews. I then referred to my personal reflections when analysing the data. Interviews were transcribed verbatim. I transcribed three of the interviews and the remaining seven interviews were transcribed by an approved transcriber.

### **Data Analysis**

Before data analysis began I removed participants' identifiable information and assigned each participant a pseudonym and unique identification number. I printed out the interview transcripts in their entirety to enable me to manually analyse the data using TA.

In TA, themes within data can be identified in either a deductive or inductive way (Braun & Clarke, 2006). A deductive approach is driven by the researcher's theoretical interest in the topic and the researcher uses previous literature and theory to guide the analysis. Alternatively, with an inductive approach the researcher codes the data without a pre-existing coding framework, so the themes identified are strongly linked to the data (Braun & Clarke, 2006). In later papers, Braun and Clarke (2019) state that their approach was not intended to be a prescriptive set of stages or either/or choices between different ways of coding. As stated previously, the interview schedule was informed by pre-existing literature within the topic area, which could be considered a deductive approach. However, there was a need for a conversational interview style and analysis to match, therefore a predominantly inductive approach to data analysis was used. While I tried to stay as close as possible to the participants' perspective and lived experience, I recognised that my own experience, perspective and knowledge will have impacted the nature of coding and theme generation. I reflected on this during data collection and analysis and will cover this in a later section under the sub-heading 'researcher reflexivity'.

Another decision to make before analysing the data, is whether themes will be identified at a semantic or latent level (Braun & Clarke, 2006). When analysing data at a

semantic level, interpretation of meanings are taken explicitly and the researcher does not look beyond what the participant has said for an underlying meaning. A latent approach to analysis attempts to identify the underlying meanings and assumptions that underpin the data collected from participants. In Clinical Psychology training there is a strong emphasis on interpretive understanding, which would make using a purely semantic approach to identifying themes difficult. Therefore, although I aimed to stay close to the participants' own understandings as would be the case in a semantic approach, the responses were also thought about at a latent level, therefore I used a combination of both approaches.

Braun and Clarke (2006) developed guidelines of how to conduct TA, which is useful for researchers using the method for the first time. They propose a series of six phases which are supposed to be a flexible, dynamic process as opposed to a linear set of steps (Braun & Clarke, 2019). The first phase involved me familiarising myself with the data set. I did this by reading and re-reading the transcripts and by listening back to the audio-recordings to immerse myself in the data and to check for any inaccuracies in the transcripts. During this phase I actively read the transcripts searching for meaning and made notes about areas of interest (see Appendix F). I had discussions with my supervisors to share preliminary ideas about the data and shared some transcripts with them that we discussed together. I felt a temptation to rush into coding but made sure I spent adequate time immersing myself in the data as Braun and Clarke (2006) state how important this phase is as it forms the basis for the rest of the analysis.

In phase two of the analysis I began identifying codes and organising data into meaningful categories. The transcripts were worked through line by line and coded manually by writing codes directly on the transcripts next to the text they referred to. Codes were generated from interesting aspects of the data and data that was pertinent to the research questions. As suggested by Braun and Clarke (2006), I kept the context surrounding the codes and coded the data for as many potential themes as possible. I then collated codes together by keeping them in a separate word document and copying extracts of data from individual transcripts that fit under that code.

Table 1: Examples of generating codes

Extract	Code allocated
<i>“she’s really good... I told her all sorts before and like I know she’s confidential. So, like I think before this whole self-harm thing came out I’d kinda tested out other stuff, so she never told anybody stuff that I told her”</i>	Shared information before
	Trusts that information will remain confidential
	Testing the waters
<i>“It is kind of a mental trick that I do sort of rely on quite a lot as a way to articulate something to myself; I imagine having the conversation in which I tell someone else, I don’t as much these days imagine that that conversation will happen, after that experience... allow that to feed that much into the relationship with a real person, I think I’ve sort of got myself convinced at the time that this was preparation and I can kind of spot when I’m doing that, I’m less convinced by that now”</i>	Practice articulating experiences
	Imagine having disclosure conversation
	Changed expectations
	Imagining conversations as preparation
<i>“I don’t know why really why I haven’t broached it, I guess as a parent it’s really hard to be completely honest with your child about things that might worry them”</i>	Role as parent
	Hard to be completely honest with child
	Worry about impact of disclosure on child
<i>“I knew she’d supported me with different things in past so . . . I didn’t think she’d judge me”</i>	Been supportive in the past
	Expectations set based on past behaviour
	Not wanting to be judged

Phase three involved organising the coded data into potential themes that described the data more broadly. I considered the relationship between codes, themes and different levels of themes and organised codes into pre-liminary overarching themes and sub-themes. Codes were grouped into meaningful categories, for example, ‘testing the waters’, ‘practice articulating experiences’ and ‘imagine having disclosure

conversations' were initially categorised as 'planning'. Once the initial categories were produced, these were further considered and given a pre-liminary theme name. For example, 'planning' was later re-named 'rehearsing'.

In phase four I reviewed themes and checked that the themes and sub-themes related well to each other but also to the raw data set. I read the collated data extracts for each theme to check that they formed a coherent pattern. I discarded themes if there was not sufficient data to support them or they did not accurately capture the meanings evident in the data set. Reviewing also identified when themes could be collapsed into each other if there was considerable overlap, or when themes should be separated because they captured something distinct. For example, pre-liminary themes of 'role-switching', 'mutual sharing and helping' and 'worry about disclosure recipient' were collapsed into a broader sub-theme of 'relationships'.

In the fifth phase, I further refined the themes and agreed on a name for each theme with my supervisors. For example, I felt that 'expectations', 'rehearsing' and several other pre-liminary themes were about how disclosures are often imagined, but do not always turn out as expected in reality, therefore this overarching theme was named 'imagined versus reality'. It was important to ensure that the theme names were concise but captured the story of the data.

The sixth and final stage of the analysis involved production of a report summarising the themes that have been generated from the data. Throughout the analytic process I shared and reviewed the data, codes and themes with my research supervisors to ensure that the themes were refined and provided a clear and succinct account of the data, with interesting examples used to support themes. The report formed the results chapter of the thesis.

### **Quality Checks**

Braun and Clarke (2019) state that quality reflexive TA is not ensured by following procedures 'correctly' or about 'accurate' coding and attaining consensus between different coders. They state that quality TA comes about from the researcher's reflective engagement with the data and their reflexive and thoughtful engagement with the analytic process. To try to ensure quality of the research, I took some actions that were recommended by Elliot, Fischer and Rennie (1999), which I have outlined under the following headings.

### ***Quality check of transcriptions***

I listened to the audio recordings to ensure that the transcripts were an accurate representation of the audio data. This process also enabled me to begin familiarising myself with the data set.

### ***Research supervision***

I had regular research supervision and held discussions with my supervisors, all of whom are experienced researchers, to identify and refine themes from the data. My research supervisors read a proportion of the transcripts and we discussed different ways of coding. Differences between researchers can bring a greater depth of understanding and nuance to the analytic account as each member of the research team will naturally interpret the data slightly differently (Armstrong et al., 1997). It was helpful to have these discussions to further deepen my understanding of the data set.

### ***Audit trail***

I kept a reflective journal throughout the research process. I documented important decisions made throughout the research process and my thoughts, feelings and assumptions about self-harm disclosures and the participants that I interviewed. This was particularly important to monitor personal influences on data collection, analysis and interpretation.

### ***Situating the sample***

Situating the sample requires the researcher to describe the participants and their life circumstances so that the reader has an idea of who took part in the research and some context surrounding the participant that may be relevant to understanding the findings. This also fits with the contextualist theoretical position that informed the research (Braun & Clarke, 2006). For this purpose, brief pen portraits have been provided of each of the individuals who took part in the research.

### ***Grounding in examples***

Providing examples of the data allows for an appraisal of the understandings reached by the researcher and gives the opportunity for the reader to reach different interpretations. At each stage of the data analysis, the codes and themes that were generated were grounded within the raw data of the transcripts.

## **Researcher Reflexivity**

Personal reflexivity involves the researcher reflecting on themselves to consider how they may have influenced the research (Treharne & Riggs, 2014). Being a reflexive researcher involves acknowledging how one's research is informed by one's personal situation, privileges, aspects of identity and experiences (Willig, 2013). Elliot, Fischer and Rennie (1999) termed this 'owning one's perspective'. I will write about how I came to research self-harm disclosure experiences, so that the reader has transparency around how my background, influences and current context may have influenced the research process and findings.

I am a 27-year-old white British female living in West Yorkshire with my partner. I was brought up in Bradford and lived with my parents and brother. I completed a four-year undergraduate master's degree in psychology in the West Midlands. I am currently training to be a Clinical Psychologist and have experience of mental health problems within my own family.

When I qualify as a Clinical Psychologist I am not sure what area I want to work in, however I knew for my thesis I wanted to research a topic that would be clinically relevant. In previous placements, whether it has been with children, adults, older people or people with learning disabilities I have worked with people who self-harm. This initiated an interest and a desire to increase my understanding of self-harm, with the hope that as well as improving my research skills through conducting the thesis, I could also improve my clinical practice, as self-harm is something I will continue to encounter throughout my career.

Before getting onto training I worked as a health care support worker and spent time working on a Psychiatric Intensive Care Unit. Here I was shocked to see people engaging in severe forms of self-harm and witnessed the impact this had on staff who were fairly unfamiliar with patients due to the high turn-over on the ward. Staff, driven through fear and wanting to keep people safe, often responded to self-harm in restrictive ways and the culture on the ward was controlling and risk averse, which led to people being under close observation and their freedom being limited. In my clinical practice I am interested in systemic ideas and people's relationships. I began to wonder how self-harm is discussed within families and what family and friends' responses may be, and the impact this has on the person who discloses. This curiosity and desire to understand motivated me to research self-harm disclosure experiences among non-professionals. I was aware I was taking an unfamiliar position of researcher as opposed to PICT and that

my style would have to be adapted. I kept a reflective journal throughout the research process and made notes after each interview to refer to when analysing the data. This, along with the use of supervision contributed to my reflexivity.

Aspects of my identity and prior experience influenced the research process in several ways. When conducting the first couple of interviews I noticed that I tended to reflect back what participants said and validate their feelings, as I would in my clinical work. In my role as a PICT I am used to summarising what clients say and then interpreting further things which are left unsaid. At times during the interviews, through providing reflections and summaries I tended to ask questions that were leading, for example in an early interview I said to a participant “That sounds like a tough decision. I’m wondering was it a planned decision, it sounds rather than just a spontaneous thing where you just came out with it, you said you could trust her so it sounds like you planned to tell her”, as opposed to saying “tell me more, what happened next”, which would have been less leading. Although it was discussed with my supervisors that validating participants’ feelings may be useful to help develop a rapport with participants and put them at ease, it was something I needed to be conscious of to make sure I retained my role as researcher and gathered the information required without being leading.

My dual identity as a PICT and researcher influenced how participants responded to me. For some participants, the fact that I was a PICT meant that they felt more comfortable opening up to me about their self-harm disclosure experiences because they assumed I had prior experience of talking about self-harm, so would be non-judgemental and not shocked by what they shared. This is indicated in the following quote from one participant; “*You won’t be shocked; you’ve probably heard loads of stuff.*” In some ways, this was true as my experience as a PICT means I have heard many personal and distressing stories, and these interviews felt similar to my clinical work. However, usually I would have developed a therapeutic relationship with an individual before exploring these experiences, whereas in the research interviews I was unfamiliar with the participants and had to choose carefully which threads of the conversation to follow. It is possible that I may have closed some avenues of conversation down because I wanted to ensure that the person continued to feel safe and contained.

Although some participants felt more able to share their experiences because I am a PICT, I was aware that others had experienced negative encounters with NHS professionals, including Psychologists, which may have made them more apprehensive

to share their experiences with me. This is demonstrated in the following quote from one participant; *“I know that the NHS is stretched.. but I think it’s important for the person who is being interviewed, that they are not sitting there, and the professional is looking at the clock ‘right yeah your ten minutes is up’, people who work as professionals in that industry have to be in it because they care and they are passionate about it, not because they want to pay their bills at the end of the month and I have come across a few like that.”*

My age and gender also influenced the research process. For example, I found that participants who shared more similarities with me, either in age or gender, tended to be more open in discussing their experiences. Sawyer et al. (1995) suggested that if interviewers are matched with a participant’s demographic variables (e.g., gender, age, social class, ethnicity, race and values etc.) it can lead to the participant feeling more comfortable disclosing sensitive information, which can increase the researcher’s understanding of the participant’s perspective. One interview I did with a male participant, particularly stood out because of the dynamic between us. I noticed that he spoke about his experiences in a detached way, which led to me probing less and avoiding exploring certain areas because he seemed uncomfortable. I sensed that he felt anger that he did not feel comfortable expressing during the interview because I was a younger woman. He apologised for swearing when describing his experiences and tried to reassure me that he only inflicts his anger upon himself and never towards others, especially women. I tried to encourage him to use his preferred language to express himself, however he remained guarded. Whereas, for other participants the fact that I was a young female I felt enabled people to feel more comfortable describing their experiences because they had preconceptions that I was from a younger generation that perhaps speak more openly about mental health difficulties, including self-harm. This is demonstrated in the following quote; *“they are of a generation that just like sort of suck it up and won’t talk about things.”*

Finally, from reflecting on the interviews and reading the transcripts I noticed that I responded more empathically to participants that were more open about talking about their disclosure experiences. This was particularly evident for participants that spoke about the emotional aspects of their experiences and who expressed emotion in the room. Some participants spoke in a detached matter-of-fact way about their experiences, possibly to protect themselves and to stop themselves becoming overwhelmed, or because they did not feel comfortable in the interview. In these interviews it was sometimes difficult to feel as connected with the participant and as a



result the interviews may have had more of a superficial feel as I potentially explored their experiences in less depth.

In this section I have attempted to outline some of the ways in which I have influenced the research process. I will now outline my interpretation of the findings.

## CHAPTER THREE: RESULTS

I begin this chapter by providing some information about the participants, including brief individual pen portraits to give relevant context to the findings. I then present the results of the thematic analysis along with direct quotes from the participants to demonstrate the themes described. The quotes have been edited for readability and minor hesitations have been removed.

### **Participant Demographic Information**

Participants were aged between 26-51 (mean age: 37 years), which is a wider age range than previous studies (e.g., Ogden & Bennet, 2015; Rosenrot & Lewis, 2018). Five male participants and five female participants took part in the research. Nine participants described their ethnicity as White British and one participant as White Other.

### **Pen Portraits**

#### *Hannah*

Hannah was 33 at the time of the interview and living at home with her parents. She was in full time employment. Hannah had told a few close friends about her self-harm, but not her parents. Hannah had begun attending a support group for people who self-harm and had started to talk more openly about her self-harm. Hannah described feeling nervous leading up to the interview but afterwards was pleased that she had taken part. She reported that she had initially panicked that she had shared too much but then felt glad that she was able to help with the research.

#### *Ben*

Ben was 30 at the time of the interview and living with his partner. He was a musician and writer and used his public platform to talk openly about mental health and self-harm. Ben grew up in a household where self-harm was visible and he had relatives and friends who had self-harmed. He began self-harm as a teenager, and his self-harm progressed in severity as he became an adult. Ben was articulate during the interview and described his experiences clearly. As he was open about his self-harm, he tended to describe his experiences in general as opposed to specific disclosure conversations.

***Becky***

Becky was 33 at the time of the interview and had been wanting to get more involved in research. She was a volunteer for a charity, after giving up work a few years prior due to a health condition. Becky lived alone and enjoyed being outdoors. Becky began self-harm in school and reflected on various disclosure experiences throughout her teenage years and adult life. Becky was very open in the interview about her experiences. She often described specific disclosure experiences in detail using emotional language to portray how she felt. Becky was honest and thoughtful throughout the interview.

***Martin***

Martin was 50 at the time of the interview and lived alone, although was in regular contact with his partner. Martin had a health condition which affected how much he was able to do in his spare time. However, he engaged in various groups and activities. Martin wanted to participate in the research to give a male perspective on self-harm disclosure. Martin had self-harmed for many years and kept his self-harm very private, only disclosing to his partner by not hiding his self-harm. Martin's interview was the shortest in length, but he was still able to reflect on some of his disclosure experiences.

***Jane***

Jane was 29 at the time of the interview and lived on her own. She had completed a University degree and was employed. She enjoyed reading, researching and writing, but stated that she had many varied hobbies. Jane described herself as an introvert, with not many friends living locally, although she had friends and family in other cities. Jane started self-harm around the age of 14 but described it as infrequent until she started University. Jane described how most of her friends and family knew about her self-harm but felt she had been 'outed' more than she had chosen to disclose. In the interview Jane was very thorough in describing her experiences.

***Adam***

Adam was 26 at the time of the interview and a PhD student. He lived with friends and enjoyed playing sports. Adam began self-harm in his first year at University and then had a four to five-year gap without self-harm, before starting again. He had

told most of his close friends about his self-harm but none of his family members. Adam was reflective in the interview and described his disclosure experiences in detail. He came across as open, friendly and honest during the interview.

### ***Matthew***

Matthew was 27 at the time of the interview and lived on his own. He was engaged in long distance learning courses. He had local friends that he enjoyed spending time with. Matthew started self-harm when he was a child and had disclosed to several friends but was careful about who he disclosed to. Matthew's parents knew about his self-harm as a teenager but were not aware that he still self-harmed. Matthew worried about disclosing his self-harm in future relationships. During the interview Matthew was calm and thoughtful in reflecting on his experiences.

### ***Anne***

Anne was 51 at the time of the interview. She had completed a PhD and was employed. Anne started self-harm in her early twenties after a traumatic event and then had a 30-year gap, only starting self-harm again last year. She had told various friends about her self-harm but not her family. Anne was open during the interview and shared personal experiences about her self-harm and mental health difficulties. At points during the interview Anne became emotional, but felt able to continue. Anne was honest and open in the interview. She shared that she was glad this research was happening as she felt there needed to be more information available that applied to adults who self-harm.

### ***Wendy***

Wendy was 48 at the time of the interview and lived with her husband and children. Wendy had been self-harming for over 30 years before telling anybody and had grown up in a country where self-harm was never spoken about. Wendy decided to tell her friends and family over a short period of time and now everyone in her social network knows about her self-harm. Wendy was knowledgeable about self-harm and has supported other people who self-harm. During the interview Wendy was engaging and articulate in describing her experiences. She was able to reflect on a vast number of disclosure experiences.

### ***Peter***

Peter was 42 at the time of the interview and lived alone. Peter was unemployed and enjoyed walking. He described himself as an introvert. Peter started self-harm as a

child, after a traumatic event in his life, but only recently recognised his behaviour as self-harm. Peter had a less common method of self-harm, which left no visible marks. Peter had only disclosed his self-harm to one friend, when he was asked outright about it, and none of his family knew. Peter shared that he finds it hard to talk about his self-harm and articulate his experiences. Peter was warm and engaging throughout the interview.

## **Qualitative Results**

This study aimed to investigate the expectations and experiences of adults who self-harm when they disclose to non-professionals. Participants reflected on a wide range of disclosure experiences and described different types of self-harm disclosure. These included planned disclosures, disclosures initiated by others, face-to-face disclosures, disclosures using social media sites, text messaging and more subtle disclosures where participants decided to stop concealing their self-harm, but did not initiate a conversation about it. Participants also reflected on a range of motivations for disclosing their self-harm including, not wanting to feel alone and isolated with self-harm, feeling shameful about concealing their self-harm, wanting to be ‘known’ and authentic in their relationships, needing to know if others self-harm and wanting support from others.

In this section, four overarching themes will be presented which relate to the research questions outlined in Chapter 1. The four overarching themes are ‘The insular nature of self-harm’, ‘Imagined versus reality’, ‘Self-preservation’ and ‘New ways of relating’. Figure 1 demonstrates visually in a thematic map, the themes and sub-themes and represents the dynamic interactions between the overarching themes.

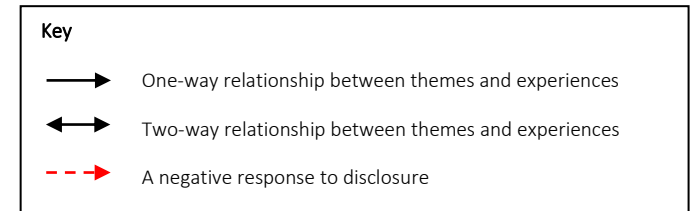
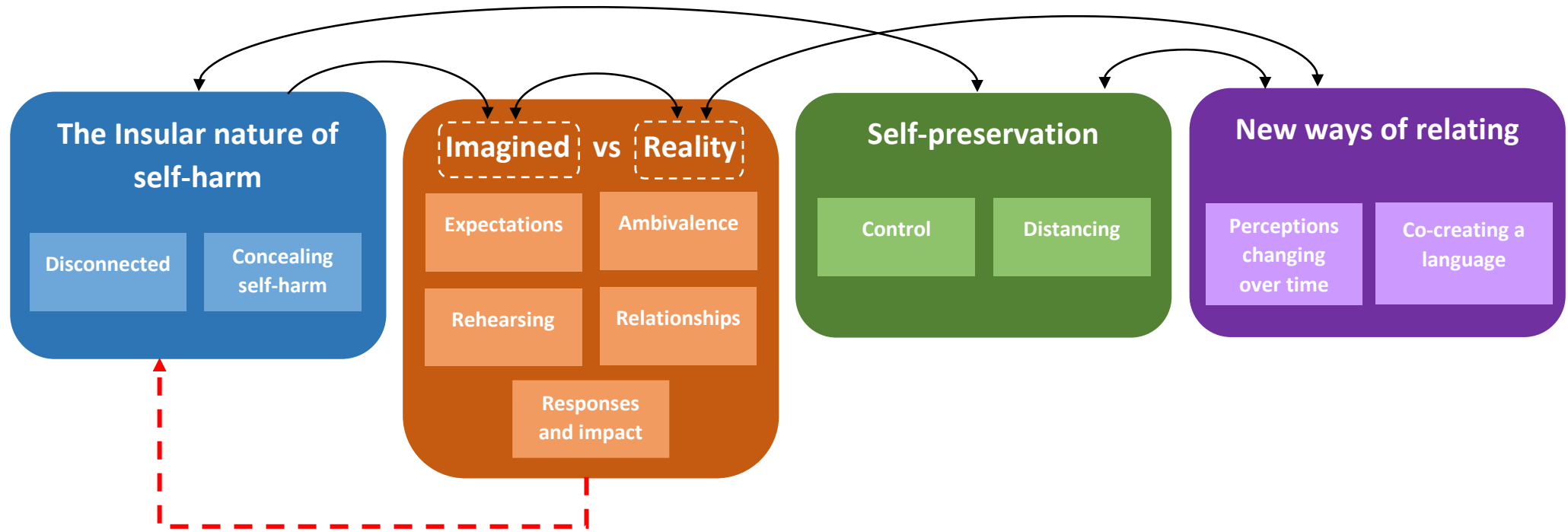


Figure 1. Thematic Map

### **Brief Description of Thematic Map and Links Between Themes**

It was evident from the interviews that many participants felt alone and isolated with their self-harm, which led to the development of ‘The insular nature of self-harm’ theme. The ‘Imagined versus reality’ theme captured how participants spent a long time imagining their disclosures, but they often turned out differently in reality. Due to the insular nature of self-harm it was difficult for participants to accurately imagine their disclosure experiences and hence ‘The insular nature of self-harm’ theme influenced the ‘Imagined versus reality’ theme. The ‘Imagined versus reality’ theme included the responses participants received from others following their disclosures. A negative response to disclosure led to participants feeling more disconnected after disclosure and reinforced the insular nature of self-harm. When participants disclosed their self-harm they often used strategies, such as distancing, to protect themselves and limit damage to the self. This led to the development of the ‘Self-preservation’ theme. The self-preservation strategies used by participants maintained the insular nature of self-harm demonstrating how these themes interacted. After disclosing their self-harm participants found ‘New ways of relating’ to their disclosure recipients, which was the final theme. There was a relationship between the ‘New ways of relating’ and ‘Self-preservation’ theme, because participants sometimes continued to use self-preservation strategies to have ongoing conversations about their self-harm. Each of the themes and sub-themes will be described in more detail using illustrative examples from participants.

### **Theme 1: The Insular Nature of Self-Harm**

This theme captured something about the act of self-harm itself as well as the implications for the disclosure process. Participants reflected on the nature of self-harm as a private behaviour that left them feeling alone and disconnected. The fact that self-harm is often so private runs counter to disclosure which is an interpersonal process. Hence, there is an inherent tension in the act of self-harm disclosure, whereby a very personal experience is being shared interpersonally. This theme had two sub-themes, ‘Disconnected’ and ‘Concealing self-harm’.

***Disconnected***

Participants felt disconnected from other people due to the private and insular nature of self-harm. Participants described how they felt disconnected from others prior to disclosure:

*“Self-harm feels really kind of insular, it feels like a world by yourself pretty much and you lock yourself away and self-harm and you don’t tell anyone and no one else in the world does it; it’s just you.” (Adam)*

*“It’s sort of a closed kind of closet feeling.” (Anne)*

Some participants wanted to keep their self-harm private and did not feel a need to talk about their self-harm:

*“It’s kind of unspoken, I just feel like it’s something that doesn’t need to be spoken about, for me it’s a very private thing, it’s always been my secret.” (Martin)*

Whereas for other participants feeling disconnected and isolated with their self-harm was what influenced them to disclose:

*“I definitely felt very isolated with regards to my self-harm and I didn’t want to be alone with it anymore, so I told my friend.” (Becky)*

Whilst receiving a supportive response resulted in one participant feeling less disconnected, receiving an unsupportive response, after disclosing to some friends at University, left another participant feeling rejected and more disconnected:

*“This is what I get from telling people, from telling close friends, to just kind of break that a little bit was, kind of yeah, it was just making the world a little less insular and it really helped.” (Adam)*

*“It was like my first time away from home, I felt a bit like a failure, like rejected and stuff, things like that because I’d lost quite a few friends just by being open about self-harming.” (Matthew)*

Although many participants described the insular nature of their self-harm, one participant did not talk about having the same hidden, insular reality the other participants experienced, either from those around him or internally. Self-harm had been normalised in his social context, which he felt had influenced him to be open in disclosing his self-harm to others and his disclosure experiences were different because of this:

*“I suppose I was brought up in a household where self-harm and especially big scars on the body were almost cool. My [relative] who raised me...was a beautiful man; he was covered in them: massive scars from self-harm and it almost felt like a kind of rite of passage, a coming of age.” (Ben)*



### *Concealing self-harm*

Almost all participants spoke about ways in which they concealed their self-harm from others, maintaining the insular nature of self-harm, through either hiding or lying about their self-harm. Concealing self-harm was a constant pressure and part of many of the participants' experiences. Some participants concealed their self-harm for many years prior to disclosing. For participants who had disclosed their self-harm to some people in their social network, they still concealed it in other aspects of their life, such as at work or in certain relationships. Moreover, some participants continued to conceal their self-harm from significant people such as their closest friends and family. Participants often experienced an inner tension as they had a desire to keep their self-harm private, but also perceived lying and secrecy to be shameful. Concealing self-harm made participants feel disconnected in their relationships because they could not be authentic and lying to conceal self-harm disconnected participants from their own values. Participants described the secretive nature of self-harm, particularly among adults:

*“I think it’s very much something that isn’t talked about in the adult population and isn’t seen; I think it’s hidden a lot. I think people who self-harm can be very secretive about it, and I don’t think that’s necessarily very healthy. I think that can be self-feeding.” (Anne)*

Participants spoke about how adult self-harm is also concealed in the media. If self-harm is represented in the media it is framed as a teenage female phenomenon, which may make it more difficult for adults, particularly males, to be open about their self-harm:

*“No one ever talks about self-harm and it seems like depression and anxiety’s like this nice thing, not nice but it’s like consumable for people to understand and take on but we stop that conversation as soon as we start going down self-harm like no one ever talks about self-harm on radio or TV and if they do they frame it within, like a teenage girl kind of thing.” (Adam)*

*“Self-harm in the context of 14-year-old girls seems to be fairly well publicised but actually anybody who makes it out of their teens and still self-harms is seen as a bit crackers.” (Anne)*

Most participants concealed their self-harm at work, even if they disclosed their self-harm in other areas of their lives. Some participants described work as a gossipy

environment and also worried about being discriminated against if their self-harm was discovered:

*“Once I went back to work I eased off using my arms because I don’t think work would be supportive.” (Anne)*

*“I am very careful to not let anyone at work see.” (Jane)*

Participants described the internal conflict and shame they felt about lying and creating stories to explain away their injuries in order to keep their self-harm concealed:

*“There wouldn’t be no benefit of telling him [brother], but the benefit to me would be not to lie to him, cos at the moment it’s a lie, it’s the shame, I don’t like it, don’t like it, but it’s the easiest way to cover it up.” (Peter)*

Participants who regularly told pre-planned lies about their injuries, reflected on an incongruence they experienced between the type of person they believed they were and their behaviour, which did not match their beliefs and values. In some cases, this disconnect influenced their decision to disclose their self-harm:

*“To carry that secret with you and all the lies and all the crap that comes with it... that’s a really nasty side of it... the whole thing didn’t sit well; you know all the hiding and the lying and all the deception... It really didn’t match with where I was and what, you know how I felt about life and myself so that was the big catalyst at that point.” (Wendy)*

Participants also spoke about the frustration in concealing their self-harm because they were not able to self-harm in the way they wanted to:

*“I always had to make sure there was a way to hide it, you know I used to cut under my watch and stuff like that cause I wear my watch all the time...it was really frustrating, you know I was really frustrated that I couldn’t cut the way I wanted to cut to get the benefit out of it.” (Wendy)*

Participants described the many situations in which they had felt forced into telling a lie when they were questioned by others about their injuries. In these cases, participants had an instinctive reaction to a situation where they may get ‘outed’:

*“I think I said something really instinctive. I said I cut myself shaving when I don’t shave my legs so like what a stupid thing to say. I’d lied but there was no kind of pre-plan to the lie. It was just like, you can’t just turn round and say, ‘oh, yeah, I cut myself; I self-harm.’ You can’t do that... but at the same time you can’t just ignore it and not say anything cause, you know it’s just a weird thing to do. So, I think an instinctive*

*made up lie came into my head that was clearly implausible, but it kind of bated it away.” (Adam)*

Some participants who were not in intimate relationships wondered about future relationships and the prospect of feeling disconnected to a partner through not being truthful:

*“Thinking into the future, I feel like dating would be hard because at what point would you raise it... I’ve got a strong feeling you can’t lie in a relationship because it’s not a relationship if you’re not fully truthful, but then it’s like when, how early into that relationship do you bring it up; would they still want to be with you after they know that.” (Matthew)*

This theme captured reasons as to why someone may or may not disclose their self-harm. There appears to be a push and pull of external and internal factors. Feeling disconnected because of the insular nature of self-harm may serve as a barrier to disclosure but can also act as a prompt for disclosure. Sometimes participants disclosed to others to feel less alone and more connected. Receiving a positive response made participants feel less disconnected but an unsupportive response left participants feeling more disconnected. Concealing self-harm through telling lies, challenged participants’ internal sense of self, disconnecting them from their values and pushing them to disclose, with the hope that this would bring their behaviour more in line with their values, helping them to feel congruent. The insular, often hidden nature of self-harm made it particularly difficult to disclose and is important to understanding disclosure and the risks that disclosing entails.

## **Theme 2: Imagined versus Reality**

The insular nature of self-harm highlighted the tensions that existed when participants considered disclosing their self-harm. Due to these tensions, participants invested lots of time and energy in imagining disclosures. The fact that participants spent so long imagining their disclosures, shows how important the decision to disclose was. However, the reality of disclosure experiences did not always match participants’ expectations. The effort participants devoted to concealing their self-harm and the insular nature of self-harm, meant that imagining disclosing was an anxiety inducing experience for many participants.

As self-harm was concealed in the media, as well as by participants, it was not perceived to be part of everyday conversations and hence it was difficult for participants to predict how other people would respond and how disclosure experiences would pan

out in reality. Therefore, participants felt ambivalent about the decision to disclose and had uncertain and conflicting feelings. Participants deliberated self-harm disclosures, considering their own expectations, rehearsing disclosures, considering their relationships and imagining what others' responses to their self-harm disclosure would be. This theme had five sub-themes: 'Expectations', 'Ambivalence' 'Rehearsing', 'Relationships' and 'Responses and impact'.

### ***Expectations***

Deciding to disclose self-harm was often a complex process. Participants discussed how they engaged in long and careful deliberation about self-harm disclosure regardless of whether they actually made a disclosure. This was an ongoing process, with some participants having deliberated for years prior to disclosure. Deliberation often occurred prior to a self-harm disclosure however, participants would repeatedly go through this process when considering disclosing to someone new.

When thinking about disclosing their self-harm, participants reflected on their own expectations and others' predicted response. Participants' expectations were informed in various ways. Some participants' expectations were set by how they viewed self-harm and how they felt about themselves. Participants talked about self-harm not being 'normal', and worried how other people would perceive them:

*"I spent at least 20 years self-harming not knowing if it had a name, I didn't even know if anybody else did it, it made it even more secret and more private and I don't dare speak to anybody about this. You're thinking you know this isn't normal. I shouldn't be doing this stuff, but I need to do it."* (Wendy)

*"I was a bit anxious about telling her [friend] before this, you don't know how somebody's going to react do you, purposely causing yourself harm, cause it's well, it's not seen as a normal thing to do."* (Matthew)

As participants had a feeling of 'abnormality' they had low expectations about other people being able to understand their self-harm, and this often acted as a barrier to disclosure:

*"I'm very careful who I choose to talk about it with because most people aren't equipped to talk about this sort of thing, therefore what's the point."* (Martin)

*"That's what puts me off ever telling, that's always been a worry about telling people that they don't get it and stuff."* (Hannah)

Not expecting other people to understand their self-harm, some participants felt most comfortable disclosing to other people in self-harm support groups, who they

deemed were more like them. There was a sense that knowing other people who self-harm lessened the feeling of abnormality, and this being a potential benefit of disclosure. Participants spoke about how being around others who self-harm challenged their own stigmatising views about self-harm:

*“Being around other people who self-harm in some ways helps, just reduces my urge to self-harm, because you feel that bit less isolated and that bit less freaky and that actually they do have completely different educational backgrounds; they have different ages, different jobs and they’ve all come to it for various reasons.” (Anne)*

*“Just to go into a space where people were talking about something that was so private where people just chatted about it was really nice. I think the first time I went, there was only one other guy there but he was like a similar kind of age, and then the rest, there was just people from so many different walks of life and there was something about that that was really helpful.” (Adam)*

For some participants initially being open in a self-harm support group and having a positive experience encouraged them to be more open about their self-harm in other relationships. This initial positive disclosure transferred to subsequent disclosures in their social network:

*“To say stuff out loud for the first time was really useful and yeah, that kind of gave me the confidence to tell my friends... cause it’s almost like practicing speaking about it and once you’ve said it out loud a few times it’s not as jarring.” (Adam)*

However, for other participants this did not transfer across to other relationships. These participants attended a self-harm support group in order to create a new social network so that they could talk about self-harm without having to disclose to their family and friends:

*“I’m very careful who I choose to talk about it with ... I would only sit and talk about it where there’s other people that self-harm or with people like yourself who are doing research on it.” (Martin)*

*“I mean as daft as it seems, the only one place I can talk openly, apart from obviously now, is when I go to Battle Scars.” (Peter)*

Participants had more positive expectations about other people who also self-harm and these disclosure experiences tended to play out positively in reality. Whereas participants’ expectations about disclosing to people they already knew, such as family members, were based on a lifetime knowledge and experience of knowing them. However, participants had likely never held a conversation about self-harm with people

they knew because of its insular and private nature, so they had to guess family members' likely response based on how they had responded to other related issues. There was also perceived to be more to lose in these relationships if the disclosure did not go well:

*"It is a conscious choice not to [disclose], cos of how people react, for instance my brother, I daren't tell him, cos he would just panic, he would think it's all suicide attempts and one thing and another, I just know my brother and how he's reacted to things in the past, he will try and wrap me up in cotton wool and that would be absolute murder, it would make me worse."* (Peter)

*"I'd thought about telling my parents when I were younger..., but they'd not reacted well to stuff in the past, so I didn't know, didn't really feel comfortable."* (Matthew)

Some participants had expectations that others would react negatively, preventing them from disclosing:

*"I should be able to say what I'm doing, but I can't cos its assumptions, I assume how people will react to it and I don't know how they would react really but I assume they will react in a bad way and not accept it for what it is."* (Peter)

*"What stops me talking, because I don't like being judged and kind of looked down on."* (Martin)

Participants' expectations that others would react negatively were informed by stigmatising attitudes about self-harm that they believed others held. For example, some participants spoke about their expectations that others perceived self-harm to be attention-seeking. The insular nature of self-harm described earlier strongly contrasts with this stigmatising attitude:

*"People probably get the wrong impression about self-harming that its attention seeking and you want everyone to feel sorry for you, but it doesn't work that way you know and in the intense moment you are not thinking about anything, all you are thinking about is hurting yourself."* (Martin)

*"I think it's got a stigma behind it, people think it's just done for attention-seeking and all that...to me it's something, a label, as a failure, why do you do it, do you want the attention and stuff like that."* (Peter)

Both Martin and Peter had rarely disclosed their self-harm, suggesting that stigmatising attitudes believed to be held by others, can influence expectations and act as a barrier to self-harm disclosure.

However, although most participants had negative expectations of others' responses, some participants still disclosed their self-harm, when their mental health had deteriorated and they needed support or were less able to keep up pretences that everything was okay. In these cases, what was happening in reality meant the decision to disclose was taken out of participants' hands. It is likely that the fears they had prior to disclosing still existed, but these were outweighed by the need to disclose or the loss of their ability to keep their self-harm hidden:

*"I went through this stage where I was self-harming every day, rather superficially, to self-harming severely like needing skin grafts and blood transfusions, but not doing it as regularly so it would be like I'd do it after a few months and then have that really awful sinking feeling of right I've got to tell somebody now." (Becky)*

*"If anybody's illusions about who I am and how I am and how better balanced I am get smashed, stuff it, I'm not interested you know by that point I was beginning to really start struggling to stay alive so I don't care so I posted it." (Wendy)*

Where participants had disclosed their self-harm, many reflected on times when they received a different response to what they expected. For example, one participant spoke about how their expectations were inaccurate after posting about their self-harm on a social media forum. In this case, the real response was better than the participant's imagined response:

*"I can't remember exactly what I put... it said a few things without going into a lot of depth but the support that I got, I was not expecting that I was expecting a lot of silence... so the fact that I got so many comments... that's not what I expected at all... I even actually felt that somebody would tell me well you're a fraud then and I expected a bit of an attack... but in the end... It was quite a different reaction to what I was expecting." (Wendy)*

The outlined accounts highlight that participants had various expectations about disclosing their self-harm. Expectations were informed by how participants felt about self-harm themselves, family insights and how family members had responded to similar issues in the past and stigmatising attitudes that participants felt wider society held about self-harm. Participants tended to have more positive expectations of other people who self-harm and this influenced them to disclose in self-harm support groups. In some instances, despite low expectations participants still disclosed their self-harm when their mental health deteriorated, or their self-harm became more severe. This

allowed for certain participants to reflect on their expectations with hindsight and recognise that sometimes their expectations were not borne out in reality.

### ***Ambivalence***

Participants described experiencing conflicting feelings throughout the disclosure process. Participants felt ambivalent about the decision to disclose, who to disclose to and the response or action wanted. The ambivalence participants felt emphasised the complexity of self-harm disclosure decisions.

Most participants changed their minds many times prior to disclosing:

*“If I go back through my diaries, there are pages and pages of, ‘I’ll tell him tonight.’ ‘No, I won’t’.. or these are all of the reasons why he would’ve been the person to tell but these are all the reasons why it shouldn’t be now and actually I didn’t just do that with him. I spent a long time . . . weighing up various people.” (Jane)*

*“It is a lot of internal conflict, I mean I’ve not really sat down and discussed it with [friend] I keep meaning to and then back out... it’s the conflict and its weighing the pros and cons up.” (Peter)*

The hesitation participants felt about disclosing their self-harm seemed to stem from anxiety caused by uncertainty about the possible outcomes. Although participants imagined what disclosures would be like, in reality it was difficult to predict other people’s responses with any certainty. Even if disclosures had been carefully considered the worry about not being able to predict other people’s responses could prevent disclosure:

*“I think it’s like a lot of fear... and the not knowing like that’s all I can tell you... if I knew what they were gonna say back obviously you can’t know that in life.” (Hannah)*

One participant had a different experience to the other participants and did not feel ambivalent about disclosing his self-harm. His self-harm did not feel insular and he had perhaps had to do less imagining of what disclosing might be like because he openly talked about his self-harm to others. These experiences were based on having positive conversations about his self-harm and were therefore part of his wider reality:

*“Because of the sheer amount of people I’m open with about this from people I meet in passing; people I know very well; people who are very close to me: my mum, whoever, my partner’s parents... I wouldn’t even think twice about telling people about it. If anything, I’d just been brought up knowing that if you don’t talk about your problems they get worse and you have to just share it, and if people aren’t happy then they’re not*



*worth being around and it's a good filter in a way... I never really... deliberated or fretted about how I was going to articulate these problems, these experiences but I don't struggle with talking about stuff so for somebody else maybe it would be quite traumatic, you know kind of an anxiety inducing experience, but I don't find that."*  
(Ben)

The accounts outlined show the internal conflict most participants experienced when deciding whether to disclose their self-harm. Therefore, what influenced the decision to disclose was not static and participants were constantly engaged in weighing up the pros and cons of disclosure. Participants moved between deciding whether or not to disclose both in relation to individual people, but also more broadly, depending on how earlier disclosures had gone. Positive responses from people lead to imagining further disclosures in a more positive light. For example, Ben had experienced this early in life so his disclosures were expected to be more positive and were more routine through many different relationships and contexts in his life. Similarly, negative experiences had the opposite effect on future imagined disclosures.

It was difficult for participants to imagine what happened during the disclosure interaction ahead of time because they could not predict and control how people would respond and the questions they might ask. For some participants, this was an anxiety inducing element of their thinking around potential disclosures:

*"I was more thinking about what she were gonna ask me; cause once we started talking about it, 'Oh God, she's gonna ask all sorts here like."* (Hannah)

Whereas other participants did not allow themselves to pre-emptively think too much about this level of detail:

*"I didn't [think about what husband would say]. I didn't allow myself to think that at all. I was thinking more about how am I going to say the first sentence to get it out, I can't remember exactly what I said, only bits of it. I was in a state, I was in a right state... there were so many uncertainties and so many unknowns in the whole thing."*  
(Wendy)

Participants' experience of ambivalence continued throughout the disclosure process and some participants experienced further ambivalence post-disclosure about the responses and actions given by disclosure recipients:

*"I don't know, I think I probably did want her to keep asking but when she actually did it felt really uncomfortable. I don't think I was prepared for how I would feel."* (Becky)

Some participants also reflected on how it felt when others around them had not seemingly noticed obvious self-harm injuries. This could be considered a form of passive disclosure that went unnoticed. Participants had ambivalent feelings about this:

*“In some ways I wanted it to happen because it would force me to talk about it... but in other ways I really desperately did not want them to put me in that position cause I wasn’t prepared to talk about it so there was always this two sides of it, sometimes I thought, ‘Are you blind?’ there were times I was just like, ‘Are you people just so blind?’ on one hand, it was like that’s just weird; but then there was a bit of pride. It was like, ‘Ooh, I thought, this lie that I’m telling is quite good so I’ve managed to hide it again.” (Wendy)*

In summary, participants experienced ambivalence throughout the disclosure process about whether to disclose and who to, and what they wanted to happen afterwards.

### **Rehearsing**

As participants felt ambivalent about disclosing their self-harm they often rehearsed their self-harm disclosures, even when in reality they may not have disclosed their self-harm. This also gave participants the opportunity to explore their expectations through these rehearsals. The rehearsing often involved an interpersonal aspect and a ‘testing the waters’ where participants would try ascertain what reaction disclosing would elicit prior to telling people about their self-harm. Participants were cautious in how they did this and the outcomes of these ‘tests’ influenced their decision to disclose: *“TV sometimes has storylines with mental health stuff, so even if it’s not self-harm, I’ll sort of drop it into conversation to see their general opinions about mental health stuff to see if they’re a bit judgemental about it or not.” (Matthew)*

*“I told her all sorts before and like I know she’s confidential. So, I think before this whole self-harm thing came out I’d kinda tested out other stuff, so she never told anybody.” (Hannah)*

Some participants had only mentally imagined what disclosure conversations would be like:

*“I had spent a lot of time prior to that... kind of fantasising about who I would tell and how, and who would be the first to know, and if I would tell anyone, that was quite a constant thing.” (Jane)*

Quite often there was a mismatch between imagining the disclosure and the reality of actually disclosing. When participants had spent a prolonged time imagining

their self-harm disclosures, it was difficult for them to accept when the disclosure experience was different in reality. One participant talked about this when her mum initiated a conversation about self-harm, and she felt pushed into disclosing:

*“I’m not saying it was a terrible thing to have happened, but it definitely wasn’t how I wanted it to go . . . at the time I had it in my head that the first person to know would be one of my best friends and I had a rule that no one would know while I had open wounds, I had it in my head that it would be [friend] first because he was the one who’d shown the most interest; like he could maybe handle it, but I kept putting that off and then mum kind of took the choice away.” (Jane)*

Jane had since tried to notice more when she was building things up in her head and had tried to not let that influence her expectations too much:

*“It is kind of a mental trick that I do sort of rely on quite a lot as a way to articulate something to myself; I imagine having the conversation in which I tell someone else, I don’t as much these days imagine that conversation will happen, after that experience... allow that to feed that much into the relationship with a real person, I think I’ve sort of got myself convinced at the time that this was preparation and I can kind of spot when I’m doing that, I’m less convinced by that now.” (Jane)*

As well as mentally rehearsing and testing out other people’s responses, some participants spoke about active rehearsals they had made to disclose their self-harm:

*“I keep filling the forms out from Battle Scars saying I want to tell you this, fill it out and then... throw them in my drawer at home [then feel] shame, guilt, which then causes me to self-harm, I’ve gone to do summat and not done it, that is a big thing, I feel guilty every time I do it.” (Peter)*

*“I’d been thinking for ages cause I’d wrote a letter at one point... I were planning on just leaving it one day... let them read it...but then I decided not to cause I’d be panicking all day cause if a letter’s there and then they’ve seen it... or like if I don’t get any response I’ll panic even more, there was too many like ifs and buts and what ifs. I’ve still got the letter but only cause it took me forever to do it.” (Hannah)*

Participants spoke about times when they were not able to go through with their rehearsals due to uncertainty about what the outcome would be and this sometimes led to them feeling shame. Therefore, the ‘ideal’ disclosure was not just thwarted by others, but also by participants themselves. This sub-theme outlined how participants rehearsed their self-harm disclosures in a variety of ways and therefore demonstrates what an important decision self-harm disclosure was. Participants spent time repeatedly

rehearsing their disclosures as revealing something so personal about themselves was felt to be a significant risk. Self-harm disclosure felt risky because it was difficult for participants to predict how people would respond to a personal revelation of a behaviour that is so often concealed and not spoken about.

### ***Relationships***

When making self-harm disclosure decisions participants considered people in their social network to disclose to. Participants' expectations and imagined aspects of disclosure were different depending on the relationship they held with the person they were considering disclosing to. One aspect of the decision to disclose was based on whether the participants felt that disclosing their self-harm would make an existing relationship closer or influence the relationship negatively. Equally, when a relationship was already perceived to be supportive participants were more likely to disclose their self-harm. Several participants reflected on the significance of knowing their recipients for many years, trusting them and the relationships fulfilling multiple roles, all of which seemed to aid disclosure:

*“She’s been a very close friend for a long time, she’s actually my oldest friend in this country... and she’s helped me a lot with [spirituality] cause she’s into that spiritual stuff as well so we got quite close... cause apart from a friend she’s also a bit of a mentor. So, you know the relationship had quite a lot of aspects to it... because we discussed so many things in so much depth that made it easier to talk about another aspect.” (Wendy)*

*“He was very interested in the inner-workings of people... we would have long, deep chats about sort of setting the world rights.” (Jane)*

In these accounts' participants described how they expected, from their previous conversations, that a revelation around self-harm would be in keeping with their existing relationship and was likely to be positively responded to. One participant spoke about how his relationship with his partner became closer after he disclosed his self-harm and how being open about his self-harm was a way of vetting his relationships:

*“It’s made relationships closer with people, my partner in a sense. It’s one of many different filters that are not only there as filters but they kind of serve to keep people away that I don’t want in my life. People who are just going to be like, ‘Why would you do that?’ or just completely bereft at why somebody would do that. Most of my friends have self-harmed.” (Ben)*

Participants also spoke about mutual sharing and helping within relationships as an influencing factor to self-harm disclosure and as something that sometimes occurred during disclosure. Several participants selected people to disclose to who had themselves shared private information with the participant:

*“I told her. Cause she’s known stuff all along. We do talk a lot and I’ve helped her through a difficult time... she told me some like big stuff I haven’t told anybody else, so I think it’s kind of a bit mutual.” (Hannah)*

*“The people that I talk to about self-harm were people who I already knew had issues with their own mental health who I’d been supportive to so I felt they’d be more understanding, for example, one of my friends had difficulties, an eating disorder for years but I’d supported her so I didn’t feel she would be judgemental about my particular area of poor mental health.” (Anne)*

In these accounts’ participants imagined that the disclosure recipients would be understanding because they had shared personal information about themselves within the relationship. One participant spoke about a disclosure experience, where there was reciprocity, in which the person she was disclosing to disclosed something significant themselves, however, this was unexpected and not perceived to be helpful:

*“In that conversation she did end up revealing something that I didn’t know at the time, which was that at 17 she’d tried to kill herself and I think she did that as a sort of... I understand something of this... yeah that felt odd, I appreciate why she did it. I appreciate knowing but I wasn’t quite sure what to do with that information...it felt like that needed a deeper, bigger conversation and that wasn’t what we were having. I have kinda struggled with suicidal ideation, but I’ve never attempted so that was an escalation of what... it’s not a terribly nice thing to say but it did sort of feel like she’d undermined me.” (Jane)*

Participants also reflected on what it felt like to switch roles, when they viewed themselves as the one usually offering support and they found themselves in a situation where they required support:

*“Over the past 30 years I would say that on the whole I have given more support than I have asked for. I’m quite nurturing... I do things for people and that’s been very much a pattern and the way most of my adult life... and this time round I’ve really needed other people’s help.” (Anne)*

*“I very much define myself as someone who offers support to others so I would sort of vet people as to whether they could allow that role to switch.” (Jane)*

Participants described how difficulties in existing relationships were a barrier to self-harm disclosure:

*“When I were off work like mum weren’t very nice, we don’t get along very well to be fair anyway so that doesn’t really help but, I am just trying to make our relationship better for now without doing anything else like I think I’d need that first to tell them... I wouldn’t want to make the relationship any worse.” (Hannah)*

Participants also reflected on family and friends’ perceptions of their relationship and when there was a perceived mismatch in expectations around disclosure. Participants described what others thought it meant for their relationship if they had not disclosed by choice or had waited a long time to disclose:

*“Prior to that, our relationship had been made up mostly of gentle banter and crosswords... it wasn’t a particularly emotionally intimate relationship ... but the repeated, not just from her but from quite a lot of people, was, ‘Why didn’t you tell us before.’, I imagine other people’s feelings around it... came with a sort of undertone of, ‘Why didn’t you trust me?’ ‘Why didn’t you love me enough to’ . . .with some people like my grandma, like what in our relationship previously made you think that this was a conversation we could have... how have I misread this so badly... I didn’t think I had but it’s suddenly a lot of people seem to come out of the woodwork with, ‘Oh no, but I was always so supportive of you’ but no, that wasn’t our relationship... It became very much about what they thought their role was, you know as a parent, as a grandparent, rather than who we were as people.” (Jane)*

This example shows how hard it can be to imagine how other people will respond in reality due to the insular and concealed nature of self-harm and also because people are complex and do not always behave in predicted ways. Existing relationships were an important factor that influenced disclosure decisions and the dilemma for the person who disclosed was whether the disclosure would make the relationship closer or potentially damage it.

Many participants described worrying about the impact the self-harm disclosure would have on the recipient. This was particularly true for parent/child and sibling relationships where there was a close emotional attachment. Hence, when the potential disclosure recipient was someone the participant knew well, there were three different aspects that were imagined: how the person would respond to the disclosure, how their response would impact the relationship, and what the impact of the self-harm disclosure would be on the disclosure recipient. The last two were particularly important when the

person was someone the participant felt close to. Therefore, whilst disclosures to people participants were closest to could feel the safest as there was more chance of participants accurately predicting their response, these were also high-stake disclosures. Participants' expectations could have been overly positive and in reality the recipients' response or the impact on them or the resulting relationship could be worse than participants imagined. These worries acted as a barrier and meant that some participants kept their self-harm concealed from those closest to them:

*"I don't know why really why I haven't broached it, I guess as a parent it's really hard to be completely honest with your child about things that might worry them." (Anne)*  
*"I've just deliberately not told them [family] because, specially my mum, she worries enough." (Adam)*

However, sometimes participants did disclose when they felt the benefits of disclosure outweighed the worry caused. Post-disclosure, participants still worried but had strategies to try and minimise their worrying feelings:

*"There's times where I really struggle with like worrying that they're worrying about me or worrying that I'm a burden or worrying about our friendship because of it. But the benefit outweighs that." (Adam)*  
*"I think the problem was before that I told my housemates that I didn't want anyone else to know, and I think that affected our friendship quite badly because I was asking them to keep a big secret and then this time round... the way that I told [friend] was tell [name] which is his partner, like if you want to tell her that's absolutely fine; if anything I'd prefer you told her cause it's better for me if you tell her just because I'd worry less about you so you've got someone to speak to." (Adam)*

This sub-theme highlighted how participants' existing relationships could influence self-harm disclosure decisions, but also how self-harm disclosures could influence participants' relationships in both negative and positive ways. Participants were more likely to disclose in supportive relationships, where mutual disclosing occurred, and hence self-harm disclosure would be more in keeping with the existing relationship. Participants spoke about worrying about the impact a self-harm disclosure would have on their relationships and the disclosure recipient, particularly if this was someone they felt close to.

### ***Responses and Impact***

Participants that moved from imagining their disclosures to disclosing their self-harm in reality were able to reflect on a wide range of responses from others and the

impact these responses had on them. Participants also shared how the responses influenced their future imagined disclosure experiences. Most participants had several disclosure experiences so could compare different responses, highlighting what was helpful or unhelpful.

Almost all participants had at least one disclosure experience that they deemed negative and most spoke about several negative experiences. Participants often perceived experiences to be negative when the recipient's response did not match their expectation:

*“The first time that I told people was the people that I was living with and I think they were understanding and they got it but it was really hard as well cause they did stuff like took away knives. That's not what I wanted, like I know you're trying to help but that's not useful for me. So, I think that was kind of a negative experience really.”*

*(Adam)*

*“[disclosing to work colleague] she was more trying to direct me to other things that I might do instead of self-harming so, 'Have you thought about different strategies, you know have you thought about shouting into cushions, because I think that she wanted to make it better and I get the motivation but I wasn't really asking for that, I was just in distress.”* *(Anne)*

These accounts suggest that even when disclosure recipients may have good intentions and a desire to help, their responses can still be perceived as negative if they do not match the participants' hoped for outcome. This highlights how imagined disclosures sometimes turned out differently in reality. It shows that participants' expectations extended to the desired response they hoped for, which could be difficult for disclosure recipients to predict. It is probable that because of the insular and concealed nature of self-harm many people may not know what would be a helpful response to a self-harm disclosure.

Participants described experiences where they had imaged a positive response to their disclosure but in reality received an unexpected negative reaction:

*“One that's been quite difficult was actually the friend of mine who I knew self-harmed in the past and he knew I wasn't doing great and I told him that I was self-harming... and then he's just blanked me; he's completely ghosted me.”* *(Anne)*

Other responses that were deemed to be negative included responses that were cruel or hurtful, over-intrusive, dismissive and ego-centric, when the focus was initially on the impact of the behaviour on friends and family rather than the participant.



Many participants had experienced hurtful reactions from others, such as being called derogatory names or others implying that they were dangerous:

*“He [manager] didn’t say the word ‘self-harm’ but he said, about being a danger, he said do you feel like you’re safe to be at work and I said what do you mean, and he ignored me and said do you think you’re dangerous to be at work. That’s how he put it, he meant, he said both: like to me or people I were looking after... that made me not tell anyone else for ages.” (Hannah)*

*“She was saying that I should be locked up and that I carried a knife round with me, but I never did, and that I’d probably hurt other people because I were crazy.” (Matthew)*

These descriptions suggest that others can assume that if people can hurt themselves then self-harm is about the urge to hurt and this could be directed towards self or potentially others. This stigmatising attitude led to participants having a negative experience when they did disclose their self-harm. Other stigmatising attitudes that participants referred to was that self-harm is viewed as juvenile:

*“I can vaguely remember negative experiences of people saying, you know kind of infantilising this or like, ‘You’re silly, aren’t you silly’, you know this kind of thing, undermining that, I suppose. That would be a very negative experience... like eye-rolling, like, ‘What have you done now?’ like a nuisance; a silly burden that was doing something for attention and that I should grow up and know better.” (Ben)*

Many participants spoke about others reacting to their self-harm disclosure with shock and disgust:

*“She was appalled to be honest; she was utterly disgusted with what I’d just done and didn’t get it.” (Martin)*

*“I could see it in her face, like a mixture of shock and disgust, [it felt] like I had done the wrong thing, because like you can only rely on yourself the way it had always been.” (Becky)*

In the above extract, Becky described how after seeing her friend’s initial reaction she immediately regretted telling them. This disclosure experience happened when she was a teenager, but the powerful negative impact stayed with her:

*“Not long after I’d told her she started to distance herself from me and started hanging around with different people and then before long this other group of people, I remember one of them once got up in my face and called me a ‘freak’ and another one I remember him sitting behind me in a class calling me ‘chainsaw girl’ ...[it felt] like my stomach had*

*been ripped out and people were standing on it, it was so private, yeah it felt horrendous.”*  
(Becky)

This example highlights the ongoing negative impacts of a difficult disclosure experience and of moving from something very insular and private to something that is suddenly very public.

Participants also described responses that they found over intrusive and in some cases these responses caused participants to become more secretive with their self-harm:

*“They get too concerned and start being clingy and are constantly ringing me and texting me. If I don’t text back in a certain amount of time they end up phoning the police cause they’re concerned, because they link self-harm to suicide... it felt a bit over the top and a bit over-bearing and over controlling cause they were like well come and sleep at our house and stuff and I live in my own private accommodation and I’m quite happy to be in that space.”* (Matthew)

*“I felt like they were always watching me, I felt like I had to be even more secretive... I hid my blades better, I hid my diary better, I started like running the shower and self-harming then so they would think I was just in the shower.”* (Becky)

In contrast to this some participants described disclosure experiences that felt like an anti-climax and responses that they perceived to be dismissive. In some of these cases participants had quite positive expectations prior to disclosing, which were not met in reality:

*“I got zero reaction; I mean really zero reaction. It was obvious he wasn’t comfortable with it, but I was a bit surprised, cause it was quite a positive thing that I was telling him... I think I got discharged by psychology, I just kinda talked about it, the self-harm and what the psychologist thought... so it’s not like I went into depth about it... and he didn’t speak at all so it was like the conversation died...very suddenly, brutally.”*  
(Wendy)

*“Whatever he had to do to get me to talk he was gonna do... I eventually cracked and told him, his response was, ‘Oh, I thought you were ill, that’s not as bad as I thought it was going to be’ and then he got up, went to the loo, came back and started talking about a TV show! Just the whiplash of it really from him putting all this emphasis on like whatever your secret is we’re gonna stay here until you tell me, to oh that secret’s not good enough.”* (Jane)

Another participant provided an example of an ego-centric response when his mum was more concerned that she had not been involved rather than about his self-harm:

*“My mother, who’s very ill, I didn’t tell her about this while I was in hospital because I didn’t want her to catastrophise an already catastrophic situation. And she was really angry at me...she wasn’t upset about the fact that I’d done it to myself. She was upset that she wasn’t involved... which is quite an annoying reaction.” (Ben)*

The above accounts show that when participants had negative responses they often regretted disclosing their self-harm. There were also important ongoing impacts of these negative responses. For example, after a difficult experience some participants self-harmed again or changed how they self-harmed and participants became more cautious about disclosing in the future:

*“After those incidents I definitely self-harmed, and I’m not sure if it was around that time but it would of been about the right age where I went from using the pen knife to using blades instead and I started cutting on my arms.” (Becky)*

*“I’ve never really been as honest since then.” (Matthew)*

*“I hated it because a lot of me not being very well is that I often feel like a burden, and that just amplified that massively, so in that instance it really didn’t help at all telling people and it put me off big time telling anyone else, until five or six years later.” (Adam)*

Most participants had at least one positive experience of disclosing their self-harm. These occurred when the disclosure recipient’s response aligned with the participants’ expectations. Positive responses related to acceptance and the sense of relief participants experienced as a result. Many participants stated that their motivation for disclosing was simply to let the disclosure recipient know and they hoped that they would accept what they were told:

*“I just wanted people to know, and not to change; just to know.” (Adam)*

*“When I told other people things, like my friend I didn’t expect her to understand. Just more like to accept that that’s just what’s going on at the moment.” (Hannah)*

Some important factors for positive responses were being understanding, subtly checking-in, letting the self-harm exist without trying to fix it, allowing participants to instigate conversations on their terms, remaining in control, and asking participants

what they would find helpful (A table of responding in helpful ways is provided at the end of this chapter).

*“We’d gone on a date night... he brought it up because he started asking what happened to my arms and that kind of made it easy, just said that I’d struggled when I were younger, still struggling, and that I use self-harm to deal with stuff, and kept it simple... he gave me a hug... [it felt] amazing, it felt like he was just accepting me, I think for a long time part of me had felt that self-harm was all that I was, there wasn’t really anything else to me so him accepting the self-harm felt that he was accepting me.” (Becky)*

*“I showed her[friend] the message and she was amazing about it... she was like, ‘what do you want? Like what do you need from me?’ and I think that’s a really good question because she wasn’t trying to fix me or do anything. It was like, ‘is there anything that you need-want me to do differently or want me to do’ and I just said to her just keep doing what you’re doing. Like don’t change what you’re doing... it was really stressful at the time and it was like a relief of like quite a lot of pressure, so I got pretty upset but it was a big relief telling her.” (Adam)*

One participant acknowledged that talking about their self-harm, was still a difficult thing to do even upon receiving a positive response:

*“She was the only person that I didn’t need to hide the injuries from while everybody else, I had to make sure that it was all covered up and hidden and stuff. So, it was a bit of a relief it was quite a relief you know. I was still very embarrassed talking about it... but it was always on my terms she never pushed...she’d wait for me to say something.” (Wendy)*

These accounts highlight the power of recipient responses and the lasting positive and negative impacts disclosure recipients’ responses had on participants. For example, when participants had a positive disclosure experience they were more likely to continue talking about their self-harm and therefore had more opportunity to access support:

*“If you get a positive reaction, you get a nice accepting reaction, then chances are you’re gonna continue talking.” (Wendy)*

Participants spoke about wanting acceptance as opposed to wanting to stop self-harm and many participants continued self-harming after disclosing, even after positive experiences. One participant spoke about how their self-harm reduced after disclosure and they wondered whether this was as a result of disclosing:

*“I was probably self-harming every day at the time of telling them. Whereas now it’s probably more like once a week, once a fortnight, something like that. so, I don’t know if that’s a positive of like getting more help or telling them. It’s probably like a combination of everything really, to be honest. But I think that thing of like the world feeling really insular really kind of made the self-harm worse.” (Adam)*

The imagined versus reality theme highlights that self-harm disclosure was a complex process, involving lots of uncertainty. It was also not a single one off act, but more nuanced in terms of what disclosers wanted to disclose, who to, how they did it and what happened afterwards. For example, disclosures led to participants being asked more questions at a later date, disclosures were made to others without participants’ consent, and the impact on relationships could not always be predicted. This shows why participants spent lots of time imagining and deliberating about their disclosure experiences as there were many possible consequences. It also explains why participants felt so much ambivalence about the disclosure process because there were a lot of unknowns and the potential for negative impacts. The aspects of disclosure that participants imagined could, in reality, go better, worse or in the way participants had imagined.

### **Theme 3: Self-Preservation**

Self-harm disclosure could be a daunting process, whereby a previously insular and personal experience was shared in some way. Despite engaging in lengthy imagining and deliberation about disclosures, disclosure experiences were difficult to predict, with the potential for many different outcomes that could have long-lasting impacts. Due to this, participants’ efforts throughout the disclosure process were focused on self-preservation. Participants tried to protect themselves in various ways, such as implementing strategies to avoid unwanted disclosure interactions or if they did choose to disclose, implementing strategies during disclosure in an attempt to limit the potential for damage to self. These strategies fell under two main headings, ‘Control’ and ‘Distancing’, which are the two sub-themes presented below.

#### ***Control***

Participants spoke about a need for control over the disclosure process. Some participants felt they had more control than others, but all participants strived for this. Different factors affected how much control participants felt they had such as the visibility of their self-harm. Participants had a range of different methods of self-harm;

some participants' self-harm was visible, whereas others was not. The visibility of their self-harm influenced the amount of control participants had over their disclosure experiences. One participant's method of self-harm, which left no visible marks, meant that he had more control and had rarely disclosed his self-harm:

*"I mean you looking at me today, you wouldn't think I self-harm because there is no physical signs, I like it, because if I had a great big cut down my arm somebody could say 'oo what you done there', you can't say because the cat has scratched you each time, or the dog has bit you, whereas I'm not having to explain myself." (Peter)*

In contrast to this, participants with visible self-harm shared some difficult experiences where they were confronted by others and had no choice but to disclose, giving them limited ability to protect themselves from hurtful responses:

*"I got confronted once because I was stood in the queue for toilets and I have to disclose that I'm trans-gendering, female to male, so I presented as female at this time so I had a short-sleeved t-shirt on and this lady in front of me she had kids with her and she basically told me that, 'you should cover them disgusting things up!' and then pointed to my arms... I told her that they were part of life. I said if you'd been in a fire when you were a kid and you'd been burnt and then you've got to live with them burns for the rest of your life, would she tell that person that they've got to cover them burn scars up, because they don't look very nice... she was like 'That's different they've not chosen to do it themselves.' I was like, 'Well it's part of mental health so you can't choose to have a mental illness, this is how I've coped since I were ten-year-old... I'm not gonna cover myself up just because somebody doesn't agree with it.'" (Matthew)*

Confronted by a stranger Matthew had to defend and explain himself. Whilst he felt able to do this it was a negative experience for him, one that someone else in that situation could struggle to know how to respond to:

*"It made me a bit angry and a bit uncomfortable cause there were like other people around...what I was trying to do is make her think twice about judging somebody because there's other people that could've took that to heart and burst into tears and then gone and done themselves some further harm." (Matthew)*

Other participants had developed strategies to try and disguise the visible signs of their self-harm in order to protect themselves from unwanted attention and questions. One participant chose to have her scars tattooed over to regain control:

*"It is something I strategise about because I've got this tattoo and I'm saving up to get the rest tattooed over, just because that gives me a bit more control, if it's not the first*

*thing people see when they look at you, I find that reassuring so there's a lot of people who, cause I do have scars here, even if they notice, the fact that it's tattooed over is a signal not to make an issue kinda thing... I know from getting this tattoo that sometimes I forget they're there now, there's more freedom that comes with that." (Jane)*

However, in contrast to this another participant tried to regain control in a different way by reframing self-harm scars and searching for positive meaning:

*"When I see them [someone] showing them [scars], not covering up, being on whatever part of the body... legs, arms or whatever. I'll see that on somebody who's proud of themselves. I suppose in a similar way to when women get stretch marks and they've got tiger stripes, it's like re-framing it, I think it's a good, positive thing." (Ben)*

Another participant had a strategy to maintain control in case he was in a situation where children noticed his self-harm. In this example Matthew was aiming to protect himself and others, particularly children who he felt may not be mature enough to know about self-harm:

*"If I'm with friends that have got quite young kids, I'll cover my scars up cause it's not appropriate; or some friends I have approached before I went and asked what they'd prefer me to wear – cause they know their child's maturity level. So if they said it was okay to wear short sleeves I'd then be like well what do I say if your child asks about them scars, because some kids do, some kids don't, out of curiosity, and because I've never had kids I wouldn't know how to age-appropriately say something, so I'd have that discussion to have a bit of a backup if they ask." (Matthew)*

Some participants worried that their self-harm could leave permanent marks and what this would mean in future:

*"This time round it's probably worse, so I don't know if that's like a thing. I know it does worry me a bit when I see it in the mirror and stuff like that or like when I get out of the shower, it worries me a little bit that I might have done some permanent damage, and how that's gonna affect stuff." (Adam)*

Participants also spoke about the importance of feeling in control during the disclosure interaction and they tried to maintain control in various ways. For one participant this meant not becoming upset during the interaction if they disclosed their self-harm to their child. However, as they felt unable to talk about their self-harm without becoming upset, this acted as a barrier to disclosure:

*"I think it just helps to manage the situation at the time. If I'm wanting to do something that's already quite difficult for me and sharing something personal like that with*

*somebody, the calmer I feel the more in control I feel so, almost regardless of how it makes them respond, it makes me feel better that I can have the conversation and stop the conversation whereas if I am over-wrought and in floods of tears and sobbing, I'm sort of at the mercy of my own emotions then.” (Anne)*

Other participants tried to keep control by choosing certain modes of disclosure. For example, when disclosing to their friend one participant chose to disclose in a written message on social media, so they could control exactly what was shared. This way they were ensuring that they did not inadvertently say too much and leave themselves feeling exposed:

*“I wanted to have complete control of what I was gonna say, how I say it and the problem is like if I said it to him over the phone I'd be thinking about what I'd said and I'd be like did I say something that I didn't wanna say...stuff like that. Whereas if I'd written it down I could go back and look at it and be like this is what I said.” (Adam)*

Some participants shared difficult experiences where they felt they had not had control over the disclosure:

*“I think that's how it came out to my parents, that she'd [sister] read my diary and told them which, was again just like being called a freak in front of a load of people... that was way worse, seeing the upset on my parents face and knowing that I'd caused that was horrendous.” (Becky)*

It was also important that participants remained in control following a disclosure. This was particularly important when it felt like a coerced disclosure and participants described what it was like for information that was previously theirs alone to now be shared:

*“I resented them for knowing because I felt like they had stolen that information from me, it wasn't a happy place to be living for any of us.” (Becky)*

*“It had been mine and now I felt like it was kind of family property.” (Jane)*

Some participants had positive experiences post disclosure when the recipient respected their need for control and responded helpfully:

*“If it intensified to the point where I needed to actually start self-harming then I'd usually mention it and I think she [friend] worked out that I needed to have that control over it cause it seemed in a lot of stuff I was a control freak, in a lot of ways, so she'd worked that bit out that you know I needed to be in control of stuff, so she'd decided, right, okay I'm not going to say anything... unless you instigate a conversation.” (Wendy)*



In contrast, participants also spoke about situations post-disclosure where recipients had shared their personal information with others, and they had lost control over the information:

*“When they [parents] came to pick me up [from University] ... my only memory of that was feeling like again like I kind of lost control of the information. I’d told my parents because they needed to know and they needed to come and get me. I mentioned in the email please don’t fuss I’m having to tell a lot of people for the first time because of this. I’d had a counsellor for the previous year and I’d been open with her, but the whole process meant deciding how much to tell individual friends, and being quite deliberate about how much I told each person... but my parents because they have this thing that they don’t want to feel like they’re hiding things from family, so before I even had any say in it my grandparents knew on both sides; my uncle knew, it was halfway round my grandma’s church! and I wouldn’t have told those people.” (Jane)*

The control sub-theme captured that participants had a need for control throughout the disclosure process in order to protect themselves from potential harm. Feeling out of control at any stage during the disclosure process had a negative impact on the participants and left them feeling vulnerable. Experiencing a loss of control could also dissuade further disclosures. Therefore, retaining control over self-harm disclosures was paramount.

### ***Distancing***

This theme was most evident during the disclosure interaction itself. Participants commonly spoke about distancing themselves when disclosing as a form of self-preservation. The ways in which distancing was achieved varied but included; talking about self-harm as a thing of the past, sharing some aspects of self-harm but keeping other aspects private, the mode of disclosure and emotional distancing. This theme is in keeping with the insular nature of self-harm, as moving from something very private and hidden to an up close face-to-face conversation is a huge step, especially when it is difficult to predict and control how that conversation will go. Therefore, participants seemed to take smaller steps towards disclosing, which limited their vulnerability and potential for harm.

Most participants agreed that it was easier to disclose self-harm if referring to it as a thing of the past:

*“I didn’t self-harm, and that felt like a massive achievement that made me have more confidence because I could kind of describe it as a thing of the past. I think that the*

*older I get and the longer I've been doing it, it enabled me almost to be more vague so I could talk about it in the past tense... so distancing myself from it almost.” (Becky)*

*“There's a definite divide in my life and the most severe of all the cases of self-harm are before this kind of shift in the kind of way I was existing; and that after this point it was good, I'm doing really well. I turned it round. So, I can kind of talk about anything that was quite harrowing, horrible stuff I went through in a way where I feel safe that I'm quite distant, away from that... I think if I was still very f\*\*\*\*d up in the head it would be dangerous to talk about it with a lot of people because I'd feel like it may perpetuate that behaviour.” (Ben)*

Participants also distanced themselves by keeping disclosures vague, the conversations short and keeping some aspects of their self-harm private:

*“She asked how long it'd been going on for and when it had started and I fudged a lot of the details. I needed something of it to still be private.” (Jane)*

*“I remember telling him... I mean the whole conversation was no longer than ten minutes... it was quite short, which I was glad about to be honest.. I was not ready for a long conversation.” (Wendy)*

*“She would ask me if I was alright and ask me if I had done it again, which I wasn't keen on answering, it's one thing to tell someone you self-harm, it's another to kind of let them in on the injuries, on all the ins and outs of what it is exactly that you are doing.” (Becky)*

These descriptions show how there is a negotiation going on with self and within the relationship. There is a tension between keeping the information private and making it public; participants wanted connection but also privacy. Participants also created distance through their chosen mode of disclosure. Some participants chose to disclose their self-harm through more indirect modes. This was because they felt uncomfortable articulating their experiences or did not want to witness their recipient's initial response:

*“I kind of made this thing, I'm gonna tell my mate [name] who I do [sport] with, so I went to the library and I didn't know how he would react, so I didn't want to say it out loud. So, I just... wrote him a message basically, this long message, and just explained everything.” (Adam)*

*“Facebook Messenger! In words at a distance.” (Anne)*

One participant spoke of when they disclosed to their cousin and felt unable to talk about it further after disclosing because they needed distance from it:

*“I didn’t wanna stay there longer. I kinda like wanted to tell her and go. I stayed a little bit but we didn’t really move on to do summat nice, watch a film or something. Then in my head I was just thinking what’s she thinking. I didn’t directly want to ask her. I waited til I think I got home, oh no, I drove part-way home and it were just like nagging me, so I sent her quite a long text. She tried to ring me so I just put the phone down, ‘Don’t ring me. Can you just send me like a text cause I didn’t like want to talk about it more at that point.’” (Hannah)*

Some participants also disclosed in more of a passive manner because they were not ready to talk about their self-harm:

*“hence the t-shirts because then it was obvious, everybody could just glance and see whether I’d self-harmed or not so it’s like I’m not hiding it, but I can’t tell you yet. I can’t get the words out. It was really difficult for me” (Wendy)*

However, in later years Wendy reflected on how she changed her way of disclosing and preferred to have more direct conversations when disclosing her self-harm:

*“It was definitely face-to-face. I don’t think I would have told her that over the phone. I prefer these kinds of conversations to be face-to-face to be honest cause I just get the full image of what’s going on cause over the phone you don’t know if that person’s shocked or angry or whatever, I prefer to see how the person’s responding to it so I can figure out what to do.” (Wendy)*

Participants also distanced themselves during self-harm disclosures through emotionally distancing. Some participants’ disclosures were matter-of-fact and lacked an emotional element. In these disclosures’ participants did not share their feelings about their self-harm, instead they spoke about their experiences in a detached way:

*“I think when I’ve been able to be matter-of-fact about it, it’s been easier to discuss so it’s certainly been easier to broach the subject when I’ve not actually wanted to self-harm at that moment; when I’ve not been in a certain state of mental crisis so if I’m able to talk to somebody about it a bit more pragmatically, I think it makes things a bit less scary.” (Anne)*

*“Later on in my adult life, the self-harm became a lot more severe at the point I needed surgery on my left arm cause I’d cut through the muscle and so I was in hospital for a while, and in telling them friends, family about this it was very different, so I think it was very easy to dissociate from the fact that I’d done this to myself and be able to talk about it without any emotional attachment to it, feel like it was other and make light of it and also glorify it somewhat.” (Ben)*

He went on to say *“I suppose in terms of it being somewhat of a kind of rites of passage it feels like now is the post, sort of the period after. I can be quite matter-of-fact about it and yeah, I don’t really mind talking about it. I mean I’m quite surprised that there’s a kind of small amount of emotion that’s been stirred in me by talking about it with you.”* (Ben)

The self-preservation theme captured how although participants had a desire for understanding and closeness and hence disclosed, they also had a need for privacy and protecting themselves. Therefore, they disclosed their self-harm, but used strategies of control and distancing in order to protect themselves from feeling overexposed.

#### **Theme 4: New Ways of Relating**

This theme reflects what happened after participants had disclosed information about their self-harm to friends and family and how they negotiated new ways of relating once their personal information was shared. Participants reflected on how their experiences were not fixed and sometimes disclosure recipients’ responses and perceptions changed over time, as well as their own perceptions of previous disclosure experiences. Some participants continued to have conversations about their self-harm with their disclosure recipients and needed to find comfortable ways that enabled them to do this. This theme had two sub-themes, ‘perceptions changing over time’ and ‘co-creating a language’.

##### ***Perceptions Changing Over Time***

Participants reflected on how their disclosure recipients’ perceptions changed over time and the impact this had on them. The impact of self-harm disclosures on participants’ relationships was therefore not always initially apparent:

*“A few weeks later I got a text from him saying, ‘I’m really sorry I reacted like that. I didn’t know what to say...can I come and see you again. I’m ready to talk about it, so it still became a very important, learning curve for me again, I just need to be careful and give people time.”* (Wendy)

*“There was often upset for a few years, they [family] weren’t great at how they’d respond, they’d be upset obviously but they were angry as well which was really difficult, but my sister actually came up to me after the last time, and she has worked for [mental health charity] so she came and apologised to me and said that she’s not handled my self-harm very well in the past and she could see why it would have been painful for me and that she was sorry.”* (Becky)

Becky went on to describe what this experience was like:

*“[it felt] shocking, I felt like I could never be justified in being upset with them for the way they reacted because they were entitled to their reactions, but secretly I’d wish they wouldn’t do that or this hurt and for her to... almost validate what I thought about them... yeah that was good. Then I had a conversation with them and asked them how they thought they’d react if I was self-harming now and they said that they wouldn’t be as upset, they’d just accept it and it’s nice to think that my self-harm wasn’t going to upset them as much as it usually did.”* (Becky)

However, some participants described how their disclosure recipient’s responses had changed in more negative ways over time:

*“At first I thought she were understanding but now, like we do argue over it a lot yeah, we do argue a lot.”* (Hannah)

Participants spoke about how their family and friends’ responses changed as the nature of their self-harm became more severe:

*“Specifically, the cutting because it’s such an obvious deliberate attempt to harm myself. I don’t think many people were that bothered until it got to the point where I was in hospital they didn’t really seem to see it as, they didn’t really know how to handle it or talk to me about it and I think obviously the shock just kind of grew and grew, it was incrementally more and more concern the closer I got to killing myself really.”* (Ben)

Participants also reflected on how their own perceptions of their family’s response had changed over time with hindsight:

*“They’re[parents] about [age] now, so I think, I don’t think it were personal, as such, looking back on it. I think it was just their way of what they’d been brought up like, and obviously I were their child and I were everything, so I understand why... that initial anger, could’ve been coming out as like a bit of shock and concern. Rather than just being angry.”* (Matthew)

### ***Co-creating a Language***

After participants had disclosed their self-harm to their chosen disclosure recipients they then had to navigate further conversations, which felt unfamiliar, as previously this information was private. Ongoing conversations were sometimes needed because for many participants their self-harm was not static or stable over time. Participants spoke about how they conducted these conversations, sometimes co-

creating a language with their disclosure recipient that felt comfortable when talking about their self-harm experiences. Therefore allowing participants to retain control over the ongoing disclosure process. One example of language participants developed to manage these new ways of relating was to create a number system with their disclosure recipients in order to continue conversations about their self-harm:

*“Now she [friend] will phone me on a daily basis to find out where I am, she will just say give me a score of where you are between a one and a ten and she’ll know... she will still phone me on a daily basis just to see where I’m at.” (Peter)*

*“With my husband, it got to the point, ‘Look I find it really difficult to tell you, the urges are through the roof or I’ve started feeling suicidal now,’. I said, ‘Can we do a one to ten system, ten I’m excellent... Anything above five I’m perfectly safe, you know whatever’s going on I can deal with it. We start going below five and the urges are quite strong, below four, things are getting dangerous... my chances are I’m going to self-harm. He’ll send me a text in the morning from work... So, I text him back... I’m okay, you know we’re safe... now I might say about a four: self-harm urges are really strong, which I didn’t used to before so I tell him more now, that’s worked really well for us; I mean we’ve been doing that for a year now.” (Wendy)*

For Peter and Wendy the number system enabled them to share more information with their disclosure recipients than they otherwise would have felt able to. Wendy reflected on how previously she felt unable to have these conversations with her husband so in the past would allow her self-harm to be visible, but would not have conversations about it:

*“If I was really struggling at some point you’d notice that there was a fresh cut and that made it easier to get it out in the open. My husband used to get really hurt; really upset with it, because it’s like, I don’t know what to do... just hope you stop... cause he felt inadequate and it wasn’t enough to help me to stop it. It was easy for him to have a look... so I didn’t have to say I self-harmed this week. That’s how it started with the t-shirts; it was just easier for me than trying to tell them” (Wendy).*

Some participants continued to communicate about their self-harm in a more distant way and found that most helpful:

*“Sometimes I just say, ‘Not today.’ Or I’ll send a text. Sometimes I just don’t want face-to-face; like it’s just too much sometimes.” (Hannah)*

*“I could tell without me saying it they all knew what I meant and they were all fine they all gave me hugs and they told me that I needed to talk to them and not just disappear when things got hard and were just really supportive without being pushy or in your*

*face, and then they kind of subtly just sent me messages on a very regular basis to make sure that I was doing ok for a while after that so I felt really nicely supported by them.”* (Becky)

In the account above, Becky had not directly had to disclose her self-harm to a group of friends but had said enough that they all knew about it and then they maintained conversation through sending messages on a group messaging service. This experience felt helpful for Becky.

Although some participants wanted to continue having conversations about their self-harm, other participants did not:

*“He was just like if you ever wanna talk about it, talk about it. If you don’t, you don’t, and I was like basically... I don’t, I don’t particularly like talking about it with friends, but I find it a lot easier if they know so that’s why I told him. Then it was really funny, we only exchanged a couple of messages about it and he sent me this massive message back and was really sound about it. And then like within like five minutes we just went back into like sorting out [sport] stuff for the weekend...I don’t think we’ve talked about it since actually but he’ll ring me and stuff like that and check in with me and just talk about anything really.”* (Adam)

For Adam it was enough that his friend knew, but he did not think having further conversations about his self-harm would have been helpful.

This theme shows that disclosure was not a static process and it evolved over time. Both disclosers’ and disclosure recipients’ understanding and insight changed over time. This could be helpful because if a disclosure recipient’s initial response was unhelpful there was an opportunity to rectify this, which could have a lasting positive impact on the person who disclosed. However, it also meant that there was more uncertainty as initial responses could change so the long-term outcome of disclosing self-harm could be difficult to predict. After disclosure there was more aspects to consider such as, finding a way to continue talking about self-harm with disclosure recipients that was acceptable to both people in the relationship or deciding that further conversation would not be helpful.

### **Advice from the Participants**

The findings indicated that others’ responses to self-harm disclosure are important. When self-harm disclosures go well they can bring lots of benefits, including people who self-harm feeling less isolated and alone. However, negative or unhelpful responses could have harmful and ongoing consequences for people who self-harm and

other people did not always seem to know how to respond positively. As a person considering disclosing self-harm it can feel there is a lot to think about and a lot of potential risk. At the end of the interviews I asked participants if they had suggestions for people who self-harm and do not know how to tell others. The information gathered is displayed in Table 2. Participants were also asked if they had suggestions about how health professionals could best support self-harm disclosures. The responses of which can be found in Table 3. A further Table 4 details the helpful ways of responding that participants spoke about in this study and which emerged during coding of the transcripts. I have included this section with the hope that it could be helpful for both people who self-harm and people who receive a self-harm disclosure.

*Table 2.* Advice from participants to other people who self-harm and worry about disclosure.

Advice from participants	Supporting extract
Write things down	<p><i>“I think a good way to do things is to write it down and then you can get it all out without falling all over your words and then telling someone that you have got something that you would like them to read, give it to them and then walk away, so it gives them the space to react initially, without maybe trying to hide part of the reaction from you... then sort of agreeing to talk about it afterwards when they both feel ready” (Becky)</i></p> <p><i>“If you are somebody who finds it easy to express in writing do so” (Jane)</i></p>
Take pressure off yourself	<p><i>“Don’t necessarily expect yourself to be able to articulate it perfectly... people might be expecting you to have a clear and coherent reason... but sometimes the answer at the time just is... it doesn’t have to make sense” (Jane)</i></p>
Attend self-harm support groups	<p><i>“At groups you don’t have to be pressured to talk, sometimes it is just helpful to listen to other people and it gave me ideas for trying other stuff. I</i></p>



---

	<p><i>thought I'd read a lot on the internet, but then hearing people actually do it rather than sometimes kind of like text-book stuff. I learnt a lot of stuff before I decided to share anything, so that were quite good" (Hannah)</i></p> <p><i>"Just to say stuff out loud for the first time was really useful and that gave me the confidence to tell my friends. So, if someone asked for advice I would say go to Battle Scars first cause it's almost like practicing speaking about it and once you've said it out loud a few times it's not as jarring" (Adam)</i></p>
<p>Seek out anonymous support if you are worried about disclosing to people that you know</p>	<p><i>"I think the most basic advice would be [contact] the Samaritan's, like an anonymous resource where there's no judgement" (Ben)</i></p>
<p>Give the person you are disclosing to time to digest the information before expecting a response</p>	<p><i>"I think where I went wrong a lot of the time with my imaginings of how this perfect conversation was going to go was that I was just going to drop it on someone. I wasn't going to give them chance - if I'm being charitable to [friend] it's that I did, 'there it is' if he'd had two minutes to come up with a response then maybe he would've responded better" (Jane)</i></p>
<p>Provide information about self-harm to the person you are disclosing to</p>	<p><i>"If you don't trust that the other person knows enough about self-harm and what it is about then find some information about that and send them that" (Jane)</i></p>
<p>Consider carefully the person you are disclosing to</p>	<p><i>"It'll all depend on who they're thinking of telling. How that person or them people have reacted to different things in the past, if they're normally supportive or not... if you are going to see that person long-term or is it just a short-term thing,</i></p>

---

---

	<p><i>how well you know the person; how long you've known them for" (Matthew)</i></p> <p><i>"Pick carefully who you're gonna talk to... you know based on reactions that you've seen from that person; are they calm, are they sort of person that panics... so it has to be somebody who you're pretty certain will stay by your side" (Wendy)</i></p>
Do not feel you have to tell everything all at once, tell people in your own time	<p><i>"Don't give them the full story in one sitting... just tell them some of it, cause also if they act badly you tell them some of it and then you pull back, you've kinda tested the water out and that's not the right person" (Wendy)</i></p>
Consider telling different people different aspects of your experiences	<p><i>"You don't have to tell the whole story to one person. You might end up splitting it down to two or three people cause some people will understand part of it and they won't the rest...cause you know it's a big story, it's complicated" (Wendy)</i></p>
Have a think about what you want from the person you are choosing to disclose to	<p><i>"Have a little think what you want from that person...do you want to just off load... if you do it more slowly you can gauge what you're getting out of that person. So you might want to change your techniques; or you might decide that's as far as I'm gonna go actually I don't want what they're trying to give me or force me to do, I don't want that. Just do it a bit more gradually for yourself and because it's a learning curve process for both of you" (Wendy)</i></p>

---

Table 3. Advice from participants for health professionals

How professionals can support positive self-harm disclosures	Supporting extract
Health professionals can help the person who self-harms work out what they want to say	<p><i>“It could be helpful for the therapist and the individual to sit down together and try and work out exactly what it is that you want to say” (Becky)</i></p> <p><i>“Helping them make some sense out of it, and helping them be able to explain it to somebody, or find the words to be able to say something or helping them with different methods of saying it cause verbal isn’t the only thing that’s there... there are a lot of ways to help somebody get to that. They could have a conversation ‘Who are you planning on talking to?’ ‘How do you think they might react?’ and bring some different examples, ‘Have you told them anything else quite important? How did they react to that?’” (Wendy)</i></p>
Being honest when you do not know about something	<p><i>“I think sometimes if they don’t know they just give textbook advice, it’d probably be easier to say actually I don’t know, I don’t have any experience of it” (Hannah)</i></p>
Role-playing conversations with the person who self-harms	<p><i>“I think roleplaying conversations is always a good idea. I think an encouragement to be open about it is good because I think we just need to be open about stuff. But I don’t think we should go against the wishes of the patient” (Ben)</i></p>
Treat every person who self-harms as an individual	<p><i>“I think it’s case by case. It’s going to be different for each person. I don’t think there’s any way of really categorising self-harm as all people with mental</i></p>

---

	<i>health problems. There's just no way of doing it" (Ben)</i>
Have a conversation with the person who self-harms about who else knows	<i>"They haven't even asked me if I've told anyone so even just to like have more conversation with a patient and then they're more likely to have conversations with other people if you don't brush over it" (Adam)</i>
Be non-judgemental and do not talk about 'shoulds' and 'coulds'	<i>"They should remain non-judgemental. If you are going to talk to a health professional about this sort of thing then you don't want to be judged and you don't want to, you know, the should and coulds, you should do this and you could do that. If a professional can show that care and understanding it would make a person feel more comfortable rather than kind of almost like a quiz" (Martin)</i>
Consider whether the person will actually benefit from telling people in their social network about self-harm, do not assume that they will	<i>"It'll be very much on an individual basis, part of your professional judgement is, 'Is this person I'm working with going to benefit from accessing support in their family; or will they suffer as a result of it?' Is it actually going to do something for them or would they be better off looking for support from people they don't know through some kind of peer support group" (Anne)</i>
Have up-to-date information	<i>"Having some up-to-date information; certainly one of the things I found quite frustrating is that my GP, who is now retired, lovely bloke, he used to get very frustrated because he didn't necessarily have access to up-to-date information" (Anne)</i>

---

Table 4: Helpful ways of responding to self-harm disclosures that emerged during coding

Helpful ways of responding	Supporting extract
Letting self-harm exist	<i>“With my mates I can just let that be and it can just sit and exist” (Adam)</i>
Subtle checking-in	<i>“They subtly just sent me messages on a very regular basis to make sure that I was doing ok for a while after that so I kind of felt really nicely supported by them, that was a positive experience” (Becky)</i>
Letting the person who self-harms tell you at their own pace in their own terms	<i>“That first day we talked about it she asked enough but she didn’t like delve too deep, if that makes sense” (Hannah)</i>
Not just focusing on the self-harm	<i>“I think not to normalise self-harm but to not just focus on that and like he’ll check in and see how I am, that is more meaningful than chatting about ‘Have you cut yourself’” (Adam)</i>
Physical affection	<i>“He gave me a hug... [it felt] amazing, it felt like he was just accepting me” (Becky)</i>
Being honest – not pretending to understand	<i>“He was like obviously... he hasn’t had those experiences, so it was like you’re gonna understand this a lot better than me stuff like that, which is a pretty good thing to say” (Adam)</i>
Ask the person who self-harms what they would find helpful	<i>“She was basically like, ‘what do you want? Like what do you need from me?’ and I think that’s a really good question because, she wasn’t trying to fix me or do anything” (Adam)</i>
Reassure the person who self-harms that you will be there for them	<i>“She said something along the lines that she was always there for me and if I need to talk then just text her or ring her” (Matthew)</i>

Remain calm	<i>“She’s very calm about it so she was easy to talk to” (Anne)</i>
Being available, but not trying to fix	<i>“They kind of acknowledged it. They didn’t want to try like fix me. It was like, ‘I’m about if you ever want to talk.’” (Adam)</i>
Be non-judgemental	<i>“Relief that she reacted so well, and glad that she didn’t judge, she didn’t act overly concerned.. obviously I knew she was concerned but it made me feel like I could approach her again” (Matthew)</i>
Provide practical support if wanted	<i>“She were like, ‘Right, I’m ringing doctors for ya; get you an appointment. I’m gonna come with ya.’ It worked out better actually cause I couldn’t find my words and she ended up saying some stuff from like her point of view as well” (Hannah)</i>
Making sure that control remains with the person who is disclosing self-harm	<i>“She worked out that I needed to have that control over it... so, she’d decided, okay I’m not going to say anything unless you instigate a conversation” (Wendy)</i>
Finding a way to have ongoing conversation that the person who self-harms finds helpful	<i>“She will phone me to find out where I am she will just say give me a score of where you are between a one and a ten” (Peter)</i>
Do not treat self-harm like an overwhelming thing	<i>“Within like five minutes we just went back into like sorting out [sport] stuff... and that for me was like a really good way of going about it; I know it was like a big thing to hear but not to treat it like this overwhelming thing” (Adam)</i>

## CHAPTER FOUR: DISCUSSION

In this chapter I summarise the research findings and discuss them in relation to the existing literature. I then outline the strengths and limitations of the project and consider the clinical implications. Finally, I provide suggestions for future research, followed by personal reflections and a conclusion.

### Revisiting Research Aims

The aim of this study was to explore the expectations and experiences of adults who self-harm when they disclose to non-professionals. I gathered data through semi-structured interviews and used thematic analysis to analyse the data to address the following research questions:

- 1) What influences the decision to make a disclosure about self-harm to a non-professional?
- 2) What are the expectations of those who consider disclosing self-harm to a non-professional?
- 3) What are the experiences of adults who disclose self-harm to a non-professional – both at the time and following disclosure?
- 4) For those who disclose self-harm to a non-professional, what are the impacts on the individual who discloses?
- 5) What are the barriers to disclosing self-harm to a non-professional?

### Summary of Findings

Results from the analysis generated four overarching themes; ‘The insular nature of self-harm’, ‘Imagined versus reality’, ‘Self-preservation’ and ‘New ways of relating’. Common themes in the disclosure process of self-harm were found despite the difference in participants’ gender, age and methods of self-harm. The overarching themes interacted and there was a dynamic relationship between themes and sub-themes.

Participants described the insular nature of self-harm, which made it particularly difficult to disclose. Participants felt disconnected from others and often concealed their self-harm, maintaining its insular nature. Therefore prior to disclosure participants were on their own with their self-harm. Tensions existed about disclosing or not and self-harm disclosure was complex and nuanced. In some circumstances self-harm disclosure

was not a process that participants instigated themselves. Findings indicated that when participants did disclose their self-harm there were risks associated, including stigma, worsening relationships and losing control. Due to these risks participants carefully considered the decision to disclose and spent time imagining their disclosures. Participants considered their own expectations, rehearsed disclosures, and considered the impact that disclosing would have on their relationships. They felt ambivalent throughout the disclosure process as the outcome of disclosing was uncertain.

When participants disclosed their self-harm, they described a range of responses and outcomes. Negative responses included hurtful, over-intrusive, dismissive and ego-centric responses. Helpful responses were those that felt accepting and left participants feeling relieved. The responses participants received influenced their expectations and imagining of future disclosure experiences. Negative responses could lead to participants feeling more disconnected post disclosure and reinforce the insular nature of self-harm, whereas positive responses could lead to participants finding new ways of relating.

As the disclosure process was uncertain, participants' efforts were focused on self-preservation and they employed strategies of control and distancing to try to minimise negative impacts. It is likely that the ambivalence participants felt related to their need for control over the disclosure process and the distancing strategy related to the insular nature of self-harm and their need to still keep some aspects of their self-harm private. When the previously private information about participants' self-harm was shared, a new balance emerged and participants found new ways of relating to their disclosure recipients that enabled them to have ongoing communication about their self-harm.

## **Discussion of Findings**

I will discuss each overarching theme in turn, in relation to the research questions and the wider theoretical and clinical literature.

### ***The insular nature of self-harm***

Participants described how self-harm was often an insular and hidden behaviour, which created an inherent tension when considering disclosure, which is an interactional social process. Previous studies using adolescent samples have shown that there is a reluctance to disclose self-harm and it is seen as an inherently private behaviour (e.g.,



Klineberg et al., 2013). However, the insular nature of self-harm may be more pronounced among adult samples. Participants felt self-harm among adults is particularly hidden in society and rarely represented in mainstream media. This may be because current discussions around self-harm in both media and research focus on young people and self-harm is often viewed as a teenage phenomenon. Research supports this, suggesting that self-harm is a common feature of the teenage social landscape (Purington & Whitlock, 2010). The perceived lack of adult self-harm representation in the media may mean that adults who self-harm feel more disconnected and unable to disclose, as they have less opportunity to see others who are like them. Some participants had kept their self-harm concealed for many years, sometimes over decades. As some participants had disclosed later in life, it suggests a greater degree of resistance, which may be linked to the ambivalence that emerged in the 'Imagined versus reality' theme.

Participants were harbouring and carrying their feelings about self-harm over a prolonged time, across multiple contexts, which may intensify their feelings of disconnection and isolation. Crucially, adults who self-harm may not only feel disconnected from their friends and family, but could also feel disconnected from others who self-harm as the common portrayal of people who self-harm tends to be young white females (Alderton, 2018). Some participants commented that self-harm was framed as a 'teenage girl thing', therefore adults who self-harm, particularly adult males who self-harm, may feel more disconnected and marginalised. A study exploring the perspectives of men who self-harm found that the conceptualisation of self-harm as essentially female behaviour could lead to men who self-harm feeling ashamed and emasculated (Taylor, 2003). Disconnected is similar to the concept of 'thwarted belongingness', which is a precursor to suicidality according to the Interpersonal Theory of Suicide (Joiner, 2005). The theory proposes that humans have a fundamental need 'to belong' (Baumesiter & Leary, 1995), and when this need is unmet, people experience 'thwarted belongingness' and are at increased risk of suicide. It is possible that adults who self-harm may experience 'thwarted belongingness' to a higher degree, due to feeling disconnected over a longer time period, across several contexts.

Participants concealed their self-harm through hiding or lying about the cause of their injuries. Many participants described facing a dilemma in how to respond when they were unexpectedly asked about their self-harm. Approaches to managing questioning about self-harm was previously explored in Hodgson's (2004) study on self-harm stigma management strategies. Hodgson found that to prevent unwanted self-

harm disclosures, many of the adult participants told a cover story when unexpectedly confronted about the cause of their injuries. The cover stories usually detailed activities or situations that could possibly result in an injury, however some cover stories were less plausible. Despite these inconsistencies, participants described their surprise that their cover stories were frequently believed. Participants in this study, shared similar experiences where implausible stories about their self-harm were believed by others. It could be that there is collusion, whereby it is easier for other people to accept what they are told rather than challenge these stories, particularly if they may find self-harm difficult to hear about and respond to. Participants had ambivalent feelings about others not questioning their stories, describing how they felt ashamed about lying to their family and friends, but sometimes felt pride that they were able to conceal their self-harm.

Hodgson (2004) also described 'passing' as an alternative method of avoiding unwanted disclosures. This involved not participating in activities which may reveal self-harm injuries, choosing to self-harm in discreet places, wearing clothing that covers injuries and making cuts seem like accidents. These approaches were also endorsed by participants in the current study. Although participants went to great lengths to conceal their self-harm, feeling guilty about lying to people close to them was what sometimes prompted participants to disclose. Chandler (2010) explored the decision to hide or disclose self-harm scars, remarking that for many participants, the decision to disclose their self-harm scars was more correctly described as the decision to stop hiding their scars. Participants in this study described similar experiences where they reached a point that they stopped hiding their scars, although this was only in certain contexts, such as when their self-harm became more severe or their mental health deteriorated, when they felt they could not continue lying to people about their self-harm, or when they no longer wanted to be alone with their self-harm. Participants therefore had conflicting desires to both conceal their self-harm, keeping it private, but also to disclose their self-harm to connect with others.

Recent research has attempted to highlight these conflicting tensions and present more of a nuanced account of the need to both conceal and disclose self-harm (Steggals et al., 2020). A crucial feature of the ambiguity around self-harm is how the communicative aspects persistently trouble what is otherwise deemed an intensely private behaviour (Chandler, 2016; Chandler et al., 2011; McShane, 2012 & Steggals, 2015). The dominant models of self-harm typically conceptualise it as a personal behaviour; something 'inner', individual and private and therefore not something

‘outer’, social and interpersonal (Chandler, 2016; Chandler et al., 2011; Steggals 2015). However, common descriptions of self-harm in the literature describe a communicative function such as, self-harm as a type of ‘violent communication’ (Grocutt, 2009), a ‘system of signs marking statements about the self’ (Gardner, 2001, p.4) and a ‘personal language’ (Edmonson et al., 2016), a ‘way of communicating the pain within’ (Harris, 2000, p.167). Although self-harm may remain mostly hidden, some research suggests that self-harm does not remain entirely secret across all situations (Muehlenkamp et al., 2012), rather that people who self-harm engage in a complicated and ambiguous process of revealing and concealing their self-harm.

Chandler (2016) highlighted a process, termed ‘visibility’, where the act of passively showing self-harm enables communication without it being framed as a deliberate communication attempt. Some participants in the current study passively disclosed by failing to hide injuries or scars and allowing them to be seen in certain contexts. Therefore, self-harm is multifaceted and often ambiguously crosses the borders of the inner/outer divide and the private/public boundary (Steggals et al., 2020). For example, Brossard (2014) proposed an interactionist account of self-harm and spoke about how participants who were about to self-harm imagined social scenes in which their intentions were disclosed in the hope of eliciting understanding and involvement from others. Participants reported examples of going into a shop to buy razorblades to self-harm, hoping that the cashier would notice and realise what they were doing. Therefore, although self-harm was private, participants still imagined a social element and had a need for connection. Other examples included using implausible explanations for visible injuries or hiding scars in prominent ways such as under heavy clothing during hot weather. Thus, although participants in this study talked about the insular nature of self-harm, they still chose to disclose in some contexts, showing that self-harm is intimately connected with issues of both self and social communication (Steggals et al., 2020). The paradoxes outlined help explain why self-harm disclosure is not straightforward and why participants had ambivalent feelings throughout the disclosure process.

### ***Imagined versus reality***

This theme demonstrated the complexity of disclosure decisions and the mental effort participants used trying to pre-empt disclosures by imagining the process and outcome. Previous studies on self-harm disclosure have not highlighted this aspect of the disclosure process (e.g., Rosenrot & Lewis, 2018). Findings indicated participants’

expectations were informed in various ways, including how participants viewed self-harm themselves. Participants shared their sense that self-harm was not ‘normal’, which is an example of internalised stigma when an individual believes the negative stereotypes of an identity pertain to the self (Quinn & Earnshaw, 2013). Furthermore, participants’ expectations were set by the stigmatising attitudes they felt others held, such as self-harm being attention-seeking. A stigmatised identity is devalued by society and has negative beliefs associated with it (Goffman, 1963). However, individuals can differ in how they think and feel about their own identity. Quinn & Earnshaw (2013) developed a model of the elements of concealable stigmatised identities including valenced content and magnitude. Valenced content refers to the beliefs and experiences related to the stigmatised identity, which can either make an individual feel better or worse about themselves. For example, most participants in this study felt ashamed or embarrassed about their self-harm and expected negative reactions from others, however some participants had more positive expectations and experiences related to their self-harm.

Valenced content includes internalised stigma, anticipated stigma, enacted stigma, disclosure reactions, and specific positive information. Participants appeared to have internalised stigma and endorsed some of the negative beliefs about self-harm. Some of the male participants spoke about stigmatising beliefs about self-harm being juvenile and how when they disclosed their self-harm they felt childish, suggesting that they had internalised stigma. Participants also had a feeling of being “freaky” and “abnormal” due to their self-harm, which shows that their behaviour and self-identity were intertwined. If an individual feels that negative beliefs apply to the self they will believe they are bad compared to others (Quinn & Earnshaw, 2013). This relates to the insular nature of self-harm and highlights why participants worried about disclosing their self-harm because this did not just involve disclosing their behaviour, but crucially disclosing something about who they felt they were as a person. Therefore, internalised stigma could act as a barrier to self-harm disclosure. Hence, the way society views self-harm is important and the perception that self-harm is somehow deviant is not helpful. However, literature on adolescent self-harm suggests that ‘normalising’ may contribute to the rise of adolescent rates of self-harm (James, 2013). Therefore a tension exists between de-stigmatising self-harm, but not normalising it.

Another aspect of valenced content that occurred in the participants’ imagined disclosures was anticipated stigma. This refers to the negative attention people with

stigmatised identities believe they would receive if others knew about their identity. This was perceived to have influenced participants' expectations and acted as a barrier to disclosure. For example, participants spoke about not wanting to be "judged" and "looked down on", showing that they anticipated stigma. Enacted stigma is what can happen in reality after somebody has disclosed their stigmatised identity. Participants talked about stigma they faced when they disclosed, such as others implying that they were "dangerous" or "crazy" because of their self-harm. These negative responses impacted subsequent disclosures and meant that participants sometimes did not disclose again for a long time after receiving a stigmatising response.

Research suggests that the three types of valenced content (internalised, anticipated, and enacted stigma) are associated with increased suicidal ideation and mental health problems for individuals with minority sexual orientations (Hatzenbuehler, 2009). Therefore, it may be assumed that this would also be true for people who self-harm, particularly because self-harm is already a risk factor for suicide (Carroll et al., 2014). Many participants spent a long time imagining their disclosures and had negative expectations of others responses, meaning even if they had not disclosed their self-harm, internalised stigma and anticipated stigma could potentially increase participants' risk of suicidal ideation.

Recent literature has highlighted how shame evolves within social interactions (Gunnarson, 2020). It is suggested that shame and self-harm may magnify each other, hence turning into a self-perpetuating cycle of shame and self-harm. Shame is not thought to be triggered in isolation within the individual self but derives from how an individual believes they are perceived by others (Leeming & Boyle, 2013). Thus, even if an individual imagines that the other thinks badly about them, shame reactions are triggered. There are several situations that can be suggestive of shame related to self-harm, including, disappointing others, being or feeling rejected by others either in reality or imagined, feeling isolated and alone, feeling worthless and feeling a failure (Gunnarson, 2020). The feeling of shame is closely related to how individuals who self-harm, in their internal dialogues with imagined others, anticipate how others will think and respond to them. This is important as participants in this study often imagined their disclosure experiences and anticipated that others would perceive them negatively, which may have triggered feelings of shame. Some participants explicitly said they felt shame because of their self-harm, however many participants spoke about feeling isolated, feeling a failure and worried about being rejected suggesting that they may also

have been experiencing shame. Thus, shame was something that may have acted both as a barrier to disclosure or been experienced by the participants during their disclosure experiences. A recent systematic review and meta-analysis found that shame was positively correlated with frequency of self-harm engagement (Sheehy et al., 2019). This suggests that those individuals who imagine negative reactions from others may feel increased shame and in turn self-harm more, whilst remaining alone and unsupported.

Internalised, anticipated and enacted stigma are all negatively valenced content but there are ways in which the content of a stigmatised identity can become more positive (Quinn & Earnshaw, 2013). When people with a stigmatised identity choose to tell others, they may receive positive responses. This relates to the reality aspect of the 'Imagined versus reality' theme and refers to responses participants actually received. Some participants in this study had positive responses when they disclosed, which similar to previous studies (e.g., Rosenrot & Lewis, 2018) were characterised around acceptance. These responses from significant others can have a profound effect on how the identity and self are understood and it is likely that acceptance from others also increases self-acceptance.

Quinn and Earnshaw (2013) also described how individuals seek out specific positive information related to their stigmatised behaviour or identity. Individuals with stigmatised identities are likely to search for ways to make positive meaning out of the adverse experience (Park, 2010). Identity stage theories, based on people with minority sexual identities (e.g., Cass, 1984), include an identity stage in which people surround themselves with positive information related to the identity. This was the case in the current study as participants, feeling that self-harm was abnormal, sought out other people in self-harm support groups, who they deemed were like them. Participants spoke about this helping them to feel less "isolated" and less "freaky" and spoke about it being helpful to see people who self-harm from different "walks of life". Previous research has found that attending self-harm support groups can enable people who self-harm to find others in the same boat, receive support from people who understand, gain trusting relationships, feel less stigmatised and feel less isolated (Boyce, 2016). Participants in the current study echoed this by speaking about how attending a self-harm support group made the "world feel a little less insular".

Previous research has shown that meeting others who share a similar experience in a self-help group can facilitate a sense of normality and significantly reduce feelings

of difference (Adamsen, 2002; Helgeson & Gottlieb, 2000; Yalom, 2005). Boyce (2016) found that attending a self-harm support group, enabled most members to better manage, and in some cases even reduce their self-harm. This supports the idea suggested by Corcoran et al. (2007) who argue that sharing similar experiences with others in a group assists in decreasing the secrecy and isolation associated with self-harm, and in the process can reduce the need to self-harm. Findings also demonstrated how sharing personal experiences within a group could reduce individual members' feelings of shame associated with their self-harm (Boyce, 2016). This process led to some members challenging stigmatising assumptions and disclosing their self-harm to others outside the group. Similar findings were confirmed in the current study and being around others who self-harmed challenged some participants' own internalised stigma about self-harm to the extent that they were able to disclose in other relationships. This suggests internalised stigma is potentially an important factor in disclosure decisions. However, for other participants they only felt safe disclosing in self-harm groups and still concealed their self-harm from their friends and family. For these participants, the peer support provided in the self-harm group was the only form of support they received for their self-harm.

Magnitude describes the size of the stigmatised identity within the self-concept (Quinn & Earnshaw, 2013). For some individuals, the stigmatised identity is peripheral, forming only a small part of the self, whereas for others the stigmatised identity is the dominant part of the self, overshadowing all other identities. People who self-harm will vary in the extent to which they feel their self-harm is crucial to their identity. Self-harm in some ways differs from other stigmatised identities in that its centrality can perhaps change more over time. For example, individuals' minority sexual orientation may be unlikely to change over time, however people who self-harm can stop self-harming so this identity may become less important to them. One participant demonstrated this point "*I thought of myself as a self-harmer. I don't really anymore*" showing that the centrality of their identity had decreased. Self-verification theory proposes that individuals have a need for evaluations that verify their chronic, firmly held identities, even if these are undesirable (Swann et al., 1992). Hence, individuals disclose stigmatising information about themselves because they have a need for congruency and are motivated to have others see them as they see themselves. Self-perception is important and individuals who do not see their stigmatising identity as central to their self-concept likely have little motivation to disclose this identity (Ragins, 2008). This suggests that people who have stopped self-harming may have little desire to disclose,

however visible scarring may mean that individuals need to continue having unwanted conversations about self-harm long after they stop self-harming. The scars can be a permanent reminder to self and others about the stigmatised identity, even if it no longer feels relevant.

When considering disclosure, people considered people in their social network to disclose to. When a relationship was perceived to be close and supportive participants were more likely to disclose their self-harm. Several participants reflected on the significance of knowing their recipients for many years, trusting them and the relationship fulfilling multiple roles, all of which seemed to aid self-harm disclosure. Frey et al. (2018) explored the decision making process for disclosing suicidal ideation and behaviour and found the presence of a confidant was a significant factor that influenced the decision to disclose. The confidant was usually somebody who had responded supportively to participants' suicide disclosure in the past. Similarly, in this study participants often disclosed to people who had responded supportively to other similarly related issues in the past, such as mental health issues more generally, but not specifically self-harm. Previous research has highlighted the reciprocity of disclosure and how disclosure decisions may be influenced by the recipients own willingness to disclose (Dindia, 2000). This was also apparent in this study and many participants disclosed to other people who had also disclosed their own mental health difficulties, even if this was not self-harm. However, one participant specifically talked about not finding it helpful when immediately after disclosing the recipient shared some of their own struggles. Perhaps the reciprocity is most helpful when it works outside of the act of disclosure. Therefore people may choose to disclose to other people who have been open with them previously, but it may not be helpful to have their own disclosure 'hijacked', in the sense that the focus of the conversation turns to the recipient.

Another aspect of the decision to disclose was based on the participants' belief as to whether disclosing their self-harm was likely to have a positive or negative impact on their existing relationships. Some participants spoke about how their relationships became closer and more authentic after they disclosed their self-harm. Similar findings have been highlighted in previous studies, with participants reporting that suicide-related disclosure strengthened their relationships, through increased intimacy and trust (Sheehan et al., 2019). Similar to previous research, participants in this study worried about the impact of the disclosure on the disclosure recipient and this was enough to prevent a disclosure (Rosenrot & Lewis, 2018). This was particularly true in relationships that involved a close emotional attachment and generally participants



found it difficult to disclose to their own parents or their adult children. Some participants spoke about feeling like a burden. Therefore, participants' existing relationships and worrying about the impact the disclosure could have on those close to them influenced their decision to disclose self-harm. Joiners (2005) interpersonal theory of suicide states that as well as 'thwarted belongingness', 'perceived burdensomeness', which is 'perception that one is a burden on loved ones' (Van Orden et al., 2006, p. 457) is also a predictor of suicide. Furthermore, the theory states that individuals need to have acquired the capability for suicide and this is acquired through repeated exposure to physically painful experiences, which could include self-harm. Therefore individuals who self-harm, feel disconnected and feel like a burden could be at particularly high risk of suicide.

### *Self-preservation*

Participants experienced a conflict between being "known" and being private. Research suggests that relationships involve contradictory and opposing influences, such as expressiveness-protectiveness (Baxter & Montgomery, 1996; Tardy & Dindia, 2006). Individuals repeatedly face the contradictory desires to be open and expressive yet protective of self and/or other. Self-disclosure is necessary to achieve closeness and trust in relationships, but disclosure can make individuals more vulnerable, particularly when the information to be disclosed may be stigmatised. Therefore, individuals must undertake protective measures. Communication boundary management theory (Petronio, 1991, 2002) argues that individuals manage their communication boundaries in balancing the need for disclosure with the need for privacy. To manage disclosing private information, individuals impose a figurative boundary as a means of protection and to reduce the possibility of rejection. Therefore, privacy regulation is a strategy to manage the dialectical tension of the need to disclose and conceal. In the current study, the participants managed this conflict through control and distancing, which were self-preservation strategies. Participants tried to protect themselves in various ways, such as implementing strategies to avoid unwanted disclosure interactions or implementing strategies during disclosure to limit the potential for damage to self.

Participants perceived level of control varied and was dependent on different factors, for example one important aspect was the visibility of participants' self-harm. Some participants had no visible evidence from self-harm so were able to conceal it, however other participants described experiences where their disclosure interactions had been initiated by others who noticed evidence of their self-harm. Many participants in

this study spoke about being “forced” into disclosures. When this happened, participants felt that their personal information had been “stolen”. In addition to this type of disclosure being a potentially distressing experience, disclosing self-harm is not guaranteed to be a helpful experience and an individual’s goals for disclosing can affect the outcome of disclosure (Chaudoir & Fisher, 2010). Chaudoir and Fisher (2010) suggest that individuals with avoidance focused goals may have more difficult disclosure experiences and may be more sensitive to rejection. If individuals’ disclosure goals affect the disclosure experience and outcome, it is important to consider the outcomes of disclosures, which do not consider the disclosers’ goals because they are initiated by others. Participants spoke about the negative impact forced disclosures had on them and research suggests that difficult disclosure experiences may predict worse outcomes than not disclosing at all (Chaudoir & Fisher, 2010; Ullman, 2010).

Participants also spoke about different aspects of control throughout the disclosure process, such as control during the disclosure interaction and afterwards. As highlighted in the ‘Insular nature of self-harm’ theme, even if participants had disclosed their self-harm to certain people, most participants concealed their self-harm in some contexts. Research has shown that the distress associated with concealing a stigmatised identity or behaviour is magnified by the fact that disclosure is not an all-or-nothing phenomenon but occurs, on a continuum with varying degrees of disclosure (Ragins, 2008). Previous research on disclosing other stigmatised identities has revealed that individuals with concealed stigmas have not disclosed their stigmatised identity to the same degree across all life settings (Clair et al., 2005; Ragins, 2004; Sanchez & Schlossberg, 2001). This was true of the participants in this study as most participants had not disclosed their self-harm in certain contexts, particularly such as at work or with children, even if they had disclosed in other contexts. Research has shown that this can lead to disclosure disconnects, which involves varying degrees of disclosure in different life domains (Ragins, 2008).

Disclosure disconnects may lead to psychological distress and conflict as individuals attempt to manage an identity that is concealed to different degrees across life settings. A challenge faced by individuals who have not fully disclosed their stigmatised behaviour is the lack of control over the disclosure process. For example, individuals who conceal their behaviour in one domain are at risk of having their identity involuntarily disclosed after it is discovered in another domain (Ragins, 2008). Many of the participants in this study described experiences where they had been

“outed” and people who knew about their self-harm had told other people without their consent. In these cases, participants experienced a loss of control over the disclosure process and were negatively impacted. Participants also worried about this happening in the future, for example some participants spoke of worrying about their parents finding out from someone else. These situations created an ongoing state of uncertainty for many participants. The control sub-theme demonstrated how participants have a need for control throughout the whole disclosure process to protect themselves from potential harm. Feeling out of control at any stage during the disclosure process had a negative impact on the participants and left them feeling vulnerable, sometimes dissuading further disclosures.

Participants frequently distanced themselves during their self-harm disclosure by talking about self-harm in the past tense, only sharing certain aspects of self-harm, limiting their own emotional expression and through using indirect modes of disclosure. Research suggests that distancing oneself from an issue may be a strategy for dealing with shame (Silver, 2007). Therefore, participants may have distanced themselves during disclosures to try to protect themselves from negative responses and thus reduce their feelings of shame. Many participants found it easier to disclose their self-harm when talking about it in the past tense. Previous research has highlighted that it is common to wait some time before disclosing difficult experiences, for example childhood abuse disclosures are often delayed (Quadara, 2008). Similarly, other research found that veterans shared their struggles on social media after time had passed and the researchers termed these “delayed disclosures.” (Semaan et al., 2017). It is important to consider the implications of participants finding it easier to disclose past self-harm rather than current because presumably there may be less opportunity for individuals to access help and support with their self-harm when it is a current problem.

Some participants also found it easier to disclose in a detached manner rather than sharing the emotional aspects of their experiences. It is thought that participants did this to protect themselves from becoming overwhelmed and feeling overexposed. However, previous research suggests that emotional disclosures are more likely to create intimacy than factual disclosures because they are perceived to convey more private and central aspects of the discloser (Reis & Shaver, 1988). Research has demonstrated that self-disclosure of emotion is a strong predictor of intimacy between interaction partners, but self-disclosure of facts is not (Laurenceau et al., 1998). While this evidence only explored relationship intimacy as an outcome of disclosure, it does suggest that emotion-based disclosures may be more effective in communicating private

information and may possibly be viewed in a more positive way by recipients compared to fact-based disclosures. This could suggest that although disclosers may limit their own emotional expression to protect themselves and enhance the possibility of a positive experience, this could have the reverse effect.

Participants sometimes distanced themselves by disclosing through indirect means such as social media, instant messaging services and text messages. When disclosing on a social media platform, participants were engaging in a one-to-many approach, perhaps as a way of avoiding many difficult one-to-one disclosures. Participants spoke about disclosing through text messages because they were not ready for a conversation about their self-harm and did not want to see the recipient's immediate response to the disclosure. Chaudoir and Fisher (2010) suggest that individuals with avoidance-focused goals for disclosure may use more indirect methods that they believe will minimise the distress caused by rejection. While this could reduce the possibility of potential harm, using indirect methods does not provide the opportunity for 'give-and-take' that occurs in a verbal conversation and there may be less opportunity for interaction partners to ask questions of each other, clarify information and emotionally connect with one another (Chaudoir & Fisher, 2010).

### *New ways of relating*

This theme highlighted how participants negotiated new ways of relating with their friends and family after they had disclosed their self-harm. Participants' accounts showed that their experiences were not fixed and sometimes disclosure recipient responses changed over time. In some cases, disclosure recipient responses became more helpful over time as they developed new understandings and sometimes apologised for previous reactions. Participants experienced this as helpful and there was the opportunity for repair within the relationship and a lasting positive impact. However, in other cases disclosure recipients' responses became more negative over time and one participant spoke about having ongoing arguments about self-harm. Changes in responses over time can make it difficult for the discloser to predict the outcome of their disclosure, which may increase ambivalence about the disclosure process.

After disclosing their self-harm some participants had ongoing conversations about their self-harm with their disclosure recipients and had to negotiate ways of doing this. Some participants created a number system, which enabled them to share more information about their self-harm with their disclosure recipient. Recent research using

illustrative case studies highlighted a similar process (Steggals et al., 2020). Participants described how a new form of communication developed over time, which provided a wordless way of communicating that bypassed the issues of trying to talk about self-harm using ordinary language. Steggals and colleagues (2020) found that participants spoke about using a system which was “almost like a morse code” (p. 167). Previous research has found that a barrier to suicide attempt disclosure is not being able to find the words (Maple et al., 2019). This was also a barrier to self-harm disclosure, but this was overcome in some cases by finding a different communicative system to allow for conversations about self-harm to continue.

Some participants preferred to continue talking about self-harm from a distance and found it helpful receiving texts from their disclosure recipients rather than having face-to-face conversations. Theories of personal relationships suggest that continuing relationships might display cycles of openness and closedness (Altman et al., 1981). It may be that participants’ contrasting needs for privacy and connection ‘ebbs and flows’ over time so their disclosure experiences differ depending on what need takes priority in any given situation.

## **Strengths and Limitations**

### ***Strengths***

As far as I am aware this is the first UK based study to explore the self-harm disclosure experiences of adults to non-professionals. This study included a more diverse sample than previous studies on self-harm disclosure experiences (e.g., Rosenrot & Lewis, 2018), with an equal number of men and women and a wider age range of participants. This study also explored the whole self-harm disclosure process rather than specific aspects, highlighting the disclosure process from pre to post disclosure. Exploring individuals’ personal accounts provided insight into this little understood experience and helped to develop an understanding of the varying disclosure experiences individuals can have. Therefore, this study has made a new contribution to the literature and highlighted what is and is not helpful when disclosing self-harm.

People with personal experience of self-harm were consulted in the development of this research. Individuals from different NHS and third-sector services helped with the development of the interview topic guide to ensure that I was asking relevant questions in a sensitive and thoughtful manner. They also provided feedback on recruitment documents and these were amended in line with constructive comments.

This improved the accessibility of information given to participants and ensured the implications of taking part in the study were made clear, allowing participants to make an informed decision about their choice to participate in the research.

As outlined in the methods section, I implemented several checks to ensure the quality of the research. I kept a reflective journal throughout the process to monitor personal influences on data collection, analysis and interpretation. I also provided a section on researcher reflexivity to be transparent about how I influenced the research. I had regular research supervision from researchers who are experienced in both self-harm and thematic analysis. I provided the reader with pen-portraits to provide contextual information about the participants that may be relevant to understanding the findings. Finally, I grounded examples in the raw data to give the reader the opportunity to reach different interpretations of the findings as I recognise that my understanding of the data is only one way of interpreting it.

### *Limitations*

Most of the participants were recruited from Battle Scars, which is a third sector self-harm support group. Despite approaching different NHS services only two participants were recruited from the NHS. This will have influenced the findings, for example, by definition people who already attend a self-harm support group must have some experience of disclosing and must have felt comfortable enough to disclose in this context. Therefore, there may have been less positive experiences reflected of self-harm support groups if I had not recruited from people who presumably found them useful because they were attending. Furthermore, certain barriers to disclosure may not have been identified as people who do not disclose their self-harm at all would not attend a self-harm support group and would potentially not participate in a study such as this. It is likely that people who self-harm and have not disclosed to anyone are under-represented in this study and some of the findings may not be generalisable to all people who self-harm. Furthermore, although the sample recruited were diverse in gender and age, there was less diversity on other important variables such as race, ethnicity and culture. Thus there may be differences in the disclosure experiences of BAME individuals who self-harm. Further research would be needed to explore whether the disclosure experiences highlighted in this study resonates with others' experiences.

It should be acknowledged that participants in this study were often reflecting on disclosure experiences that had occurred sometime previously. This was helpful in some respects as participants could reflect on when their own interpretations had changed

over time and make sense of earlier disclosure experiences in new ways. However, the information provided during the interviews was the participants' version of reality at that time, described in a way to make sense of their experiences (Polkinghorne, 2005). I believe we only have partial awareness, and not complete access, to our own experiences. Therefore, the accounts might not have fully captured the participants' disclosure experiences, particularly as they were shared sometime after the disclosure experience may have occurred (Polkinghorne, 2005).

### **Clinical Implications**

This study aimed to explore and understand the process of disclosing self-harm to non-professionals from the perspective of adults who self-harm. Participants shared their experiences of disclosure and through an analysis of their accounts themes were developed. This research has wider clinical implications related to self-harm disclosure.

As outlined in the introduction, there are several different definitions of self-harm used in the literature and the one I used was "Any act of self-poisoning or self-injury carried out by an individual irrespective of motivation" (NICE, 2011). This definition does not exclude people based on self-harm method or intent. As I used a broad definition, I recruited a sample of participants who had different methods of self-harm. Participants described self-harm methods such as, cutting, scratching, burning, punching and dislocating. Some participants also spoke about previous suicide attempts, although this was rarer. The participants tended to talk about their experiences of disclosing that they are someone who has harmed or is harming themselves, rather than necessarily telling someone about a specific act of self-harm at a specific time.

The problem of using an alternative definition, such as the DSM-5 (APA, 2013) distinction between suicidal behaviour and NSSI, is that this definition conflates intent with method, so for example, it assumes that someone who self-harms via poisoning has an intent to die. However, many studies that have explored 'overdose' or 'self-poisoning', which might be considered behaviours with suicidal intent, often found participants reported intentions other than to die (Brooke & Horn, 2010; Rodham et al., 2004). If I had only recruited people who identified with the label of NSSI I may have had a different group of participants and excluded people who feel that they do sometimes have suicidal intent. The DSM-5 distinction also conflates the definition of self-harm with the person who has harmed themselves, for example, research may seek to discover when someone who has self-harmed becomes suicidal and transitions from

NSSI to a suicide attempt, rather than recognising that a wish to die and a wish to live can coexist within the same individual at the same time.

As well as the participants recruited potentially being different the disclosure responses received from others may also have been different if I had used the NSSI definition. There may be more stereotyping of NSSI and perhaps less tolerance of non-suicidal motives, whereas self-poisoning may be more likely to be responded to as a symptom of mental illness and taken more seriously. It is likely that different people may 'identify' with different definitions, even though a classification of what they do may be the same. I used a broader definition in the hope that a wider group of people may be able to identify with it and hence I may recruit a diverse sample to the study. The experiences described by participants in this study likely resonate with other people who self-harm, regardless of the definition used, in that people tend to worry about how others will react to their self-harm and how they react is likely to impact on future disclosures.

One important clinical implication is reducing the stigma that surrounds self-harm, particularly among an adult population, so that social environments can be created that are accepting of and prepared for adult self-harm disclosures. Participants spoke about the rarity with which adult self-harm is represented in the media and the lack of conversation and knowledge about self-harm generally. Self-harm is often represented as something that people grow out of and is associated with child-like behaviours, such as 'attention seeking'. Participants felt that adult self-harm is largely ignored, and this may perpetuate the assumption that the lifecycle of self-harm is something that naturally ends in adulthood, which further marginalises adults who self-harm. There is a perceived need for more education about what self-harm is and acknowledgement that self-harm occurs amongst adults. This could be achieved by increasing awareness through public health campaigns or adult self-harm storylines could be portrayed in popular television programmes so that this issue reaches a wide audience. There is a self-harm awareness day advertised through Young Minds and the Mix, which is a UK charity that provides free support for young people under 25, but this is geared towards people under the age of 25 who self-harm (Young Minds, 2020). Specific self-harm campaigns targeting adults, including those from an older age range, would be helpful.

Non-professionals need to be informed about helpful ways to respond to self-harm disclosures so that they are prepared for someone disclosing self-harm. It is



important that individuals who are more likely to be the recipient of disclosures (e.g., friends, family members; Armiento et al., 2014; Evans et al., 2005) are prepared for these conversations. Helpful ways of responding to self-harm disclosures have been highlighted by participants in this study, such as being accepting and non-judgemental, letting people disclose their self-harm in their own way on their own terms, subtly checking-in and asking the person who discloses what they would find most helpful. It is essential that control remains with the person who is disclosing as much as possible. Guidance around responding to self-harm disclosures could be published and displayed in public areas such as, mental health waiting rooms and doctors' surgeries so that the general public has access to this information.

The findings from this study highlighted different motivations for self-harm disclosure. Participants who disclosed their self-harm did not necessarily want to stop self-harm and some participants continued self-harming, even after a positive disclosure experience. Some participants disclosed their self-harm to feel 'known' and to be more authentic in their relationships. Once their self-harm was known about by those close to them they no longer needed to conceal it and some participants described an increase in their self-harm. Therefore disclosing self-harm and help-seeking are different concepts and it should not be assumed that by encouraging and supporting people to disclose their self-harm this will always lead to a reduction in self-harm or people stopping self-harm. In some cases, after disclosure the nature of an individual's self-harm may change or increase as it is accepted and they no longer need to hide it. Furthermore, an increase in self-harm may not represent a deterioration in an individual's mental state.

Health professionals that work with people who self-harm should be having conversations with individuals about who they have disclosed to. It will be important for health professionals to highlight how people often spend a long time thinking about self-harm disclosure and feel a lot of ambivalence about it so people who have these experiences are not alone or unusual. Health professionals could acknowledge with people who self-harm that it can feel like there are big decisions to make, which can feel risky. Health professionals could then help prepare people who self-harm as much as possible for the disclosure process. This could involve helping them think through who they may disclose to and things to consider prior to disclosing, what responses might be given and how to cope with difficult situations, such as a loss of control. For example, preparing individuals who self-harm for the possibility of being questioned about the nature of their injuries or scars and helping them to decide how they would like to

manage such questioning. It may be useful for adults to consider the interpersonal boundaries they would like to set and practice various ways of responding to questions and comments about their self-harm in the context of a safe, therapeutic relationship. Many participants suggested that role playing these conversations would be helpful, whilst acknowledging that all eventualities cannot be predicted or prepared for and there will always be some level of risk when disclosing self-harm.

Health professionals could suggest to people who self-harm that they may find self-harm support groups helpful. This may be particularly beneficial for individuals who feel unable to disclose their self-harm to their own social network as this may be the only form of consistent informal support they can receive. Self-harm support groups seemed to reduce internalised stigma for participants in this study, which is crucial to minimise feelings of shame and isolation, which may be predictive of increased suicide risk. Furthermore, attending self-harm support groups was what sometimes enabled participants to disclose to people in their own social network, potentially increasing their feelings of belongingness.

### **Future Directions for Research**

Future research should continue to explore self-harm disclosures among adults and could focus on participants from particular ethnic, cultural, religious, or socioeconomic backgrounds in order to reveal differences in disclosure processes. A purposive sampling method could be used to achieve this rather than a convenience sampling method. Future research could explore self-harm disclosures in a larger sample of adults, which may make it possible to elucidate gender differences in self-harm disclosures. Furthermore, future research could focus on specific types of disclosure experiences, such as disclosures to strangers in online forums or the difference in outcomes between disclosures which are initiated by self or others. Finally, future research could also explore self-harm disclosure experiences from the perspective of the discloser recipient as well as the person who discloses. This may help to highlight the dyadic nature of this interactive process and whether disclosers and disclosure recipients share similar or divergent views about the self-harm disclosure process.

### **Personal Reflections**

When beginning this project, I was surprised by the paucity of research regarding adult self-harm disclosure experiences, despite there being lots of research on

adolescent self-harm disclosures. I sensed that self-harm among adults was hidden and particularly stigmatised and was concerned I would have difficulty recruiting people to the study. However, shortly after advertising the study I had an immediate positive response from adults, who self-harm, who were willing to give up their time to share their experiences with me. I appreciated the openness and honesty of participants when sharing their personal experiences and this highlighted that if given the opportunity adults who self-harm are willing to talk, if other people are willing to listen.

It was disheartening to hear that participants felt isolated and some had kept their self-harm concealed for several decades and were still concealing it within certain contexts and important relationships. However, it was uplifting to hear participants talk so positively about Battle Scars and what a powerful positive impact being around others who share a similar experience can have.

It has been a privilege to conduct this research and communicate the participants' responses to a wider audience. I hope I have done participants' accounts justice and that the findings in this study will be useful to people who self-harm, the families and friends of people who self-harm and health professionals supporting people who self-harm.

## **Conclusion**

Disclosure of self-harm can be a helpful experience with the potential for a positive impact, but it needs to be considered carefully. Increasing awareness and reducing stigma of self-harm will hopefully contribute to fostering an environment in which conversations about self-harm are responded to with increased acceptance and understanding so that adults who self-harm can feel listened to and less isolated.

## REFERENCES

- Abrams, L. S., & Gordon, A. L. (2003). Self-harm narratives of urban and suburban young women. *Affilia, 18*(4), 429-444.
- Adamsen, L. (2002). From victim to agent': the clinical and social significance of self-help group participation for people with life-threatening diseases. *Scandinavian Journal of Caring Sciences, 16*(3), 224-231.
- Adler, P.A., & Adler, P. (2007). The demedicalization of self-injury: From psychopathology to sociological deviance. *Journal of Contemporary Ethnography, 36*(5), 537-570.
- Alderton, Z. (2018). *The Aesthetics of Self-Harm: The Visual Rhetoric of Online Self-Harm Communities*. Routledge.
- Alexander, N., & Clare, L. (2004). You still feel different: the experience and meaning of women's self-injury in the context of a lesbian or bisexual identity. *Journal of Community & Applied Social Psychology, 14*(2), 70-84.
- Altman, I., & Taylor, D. A. (1973). *Social penetration: The development of interpersonal relationships*. Holt, Rinehart & Winston.
- Altman, I., Vinsel, A. & Brown, B. H. (1981). Dialectic conceptions in social psychology: an application to social penetration and privacy regulation. In L. Berkowitz (Ed.). *Advances in experimental social psychology*. Academic Press.
- American Psychiatric Association, APA. (2013). *Diagnostic and statistical manual of mental disorders* (5<sup>th</sup> ed.). DSM-5.
- Ammerman, B. A., & McCloskey, M. S. (2020). The development of a measure to assess social reactions to self-injury disclosure. *Assessment, 1*-13.
- Anderson, C. (2010) Presenting and evaluating qualitative research. *American Journal of Pharmaceutical Education, 74*(8), 141.
- Ando, H., Cousins, R., & Young, C. (2014). Achieving saturation in thematic analysis: development and refinement of a codebook. *Comprehensive Psychology, 3*, 1–7.
- Andover, M. S., Morris, B. W., Wren, A., & Bruzzese, M. E. (2012). The co-occurrence of non-suicidal self-injury and attempted suicide among adolescents: distinguishing risk factors and psychosocial correlates. *Child and Adolescent Psychiatry and Mental Health, 6*(1), 11.
- Apter, A., Horesh, N., Gothelf, D., Graffi, H., & Lepkifker, E. (2001). Relationship

- between self-disclosure and serious suicidal behavior. *Comprehensive Psychiatry*, 42(1), 70–75.
- Armiento, J. S., Hamza, C. A., & Willoughby, T. (2014). An examination of disclosure of non-suicidal self-injury among university students. *Journal of Community & Applied Social Psychology*, 24(6), 518–533.
- Armstrong, D., Gosling, A., Weinman, J., & Marteau, T. (1997). The place of inter-rater reliability in qualitative research: An empirical study. *Sociology*, 31(3), 597-606.
- Baumeister, R. F., & Leary, M. R. (1995). The need to belong: desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin*, 117(3), 497.
- Baxter, L. A., & Montgomery, B. M. (1996). *Relating: Dialogues and dialectics*. Guilford Press.
- Beals, K. (2003). *Stigma Management and Well-Being: The Role of Social Support, Cognitive Processing, and Suppression*. Doctoral Dissertation. CA: University of California.
- Beals, K. P., Peplau, L. A., & Gable, S. L. (2009). Stigma management and well-being: The role of perceived social support, emotional processing, and suppression. *Personality and Social Psychology Bulletin*, 35(7), 867-879.
- Bergen, H., Hawton, K., Waters, K., Cooper, J., & Kapur, N. (2010). Psychosocial assessment and repetition of self-harm: the significance of single and multiple repeat episode analyses. *Journal of Affective Disorders*, 127(1-3), 257-265.
- Bergen, H., Hawton, K., Waters, K., Ness, J., Cooper, J., Steeg, S., & Kapur, N. (2012). Premature death after self-harm: a multicentre cohort study. *The Lancet*, 380(9853), 1568-1574.
- Biddle, L., Cooper, J., Owen-Smith, A., Klineberg, E., Bennewith, O., Hawton, K., Kapur, N., Donovan, J., & Gunnell, D. (2013). Qualitative interviewing with vulnerable populations: individuals' experiences of participating in suicide and self-harm based research. *Journal of Affective Disorders*, 145(3), 356-362.
- Birks, M., & Mills, J. (2011). *Grounded theory: A practical guide*. Sage.
- Blades, C. A., Stritzke, W. G., Page, A. C., & Brown, J. D. (2018). The benefits and risks of asking research participants about suicide: A meta-analysis of the impact of exposure to suicide-related content. *Clinical Psychology Review*, 1-45.

- Bos, A. E., Kanner, D., Muris, P., Janssen, B., & Mayer, B. (2009). Mental illness stigma and disclosure: Consequences of coming out of the closet. *Issues in Mental Health Nursing, 30*(8), 509-513.
- Borges, G., Nock, M. K., Abad, J. M. H., Hwang, I., Sampson, N. A., Alonso, J., ... & Bruffaerts, R. (2010). Twelve-month prevalence of and risk factors for suicide attempts in the WHO World Mental Health Surveys. *The Journal of Clinical Psychiatry, 71*(12), 1617.
- Boyce, M. J. (2016). " *It's a safe space*": The role of self-harm self-help/mutual aid groups. Doctoral dissertation. Anglia Ruskin University.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.
- Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.
- Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*(4), 589-597.
- Braun, V., & Clarke, V. (2019). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health, 1*-16.
- Bresin, K., & Schoenleber, M. (2015). Gender differences in the prevalence of nonsuicidal self-injury: A meta-analysis. *Clinical Psychology Review, 38*, 55-64.
- Brickman, B. J. (2004). 'Delicate' cutters: Gendered self-mutilation and attractive flesh in medical discourse. *Body & Society, 10*(4), 87-111.
- Brooke, S., & Horn, N. (2010). The meaning of self-injury and overdosing amongst women fulfilling the diagnostic criteria for 'borderline personality disorder'. *Psychology and Psychotherapy-Theory Research and Practice, 83*, 113-128.
- Brossard, B. (2014). Fighting with oneself to maintain the interaction order: a sociological approach to self-injury daily process. *Symbolic Interaction, 37*(4), 558-575.
- Brunner, R., Kaess, M., Parzer, P., Fischer, G., Carli, V., Hoven, C.W., Wasserman, C., Sarchiapone, M., Resch, F., Apter, A., Balazs, J., Barzilay, S., Bobes, J., Corcoran, P., Cosmanm, D., Haring, C., Iosuec, M., Kahn, J.P., Keeley, H., Meszaros, G., Nemes, B., Podlogar, T., Postuvan, V., Saiz, P.A., Sisask, M., Tubiana, A., Varnik, A., & Wasserman, D. (2014) Life-time prevalence and

- psychosocial correlates of adolescent direct self-injurious behaviour: A comparative study of 11 European countries. *Journal of Child Psychology and Psychiatry*, 55(4), 337-348.
- Buckley, M. (1986). The concept of confiding ties: Implications for social work research and practice. *Journal of Social Work Practice*, 2(3), 60-76.
- Burke, R. J., Weir, T., & Harrison, D. (1976). Disclosure of problems and tensions experienced by marital partners. *Psychological Reports*, 38(2), 531-542.
- Burton Denmark, A., Hess, E., & Becker, M. S. (2012). College students' reasons for concealing suicidal ideation. *Journal of College Student Psychotherapy*, 26(2), 83-98.
- Carr, M. J., Ashcroft, D. M., Kontopantelis, E., Awenat, Y., Cooper, J., Chew-Graham, C., ... & Webb, R. T. (2016). The epidemiology of self-harm in a UK-wide primary care patient cohort, 2001–2013. *BMC Psychiatry*, 16(1), 53.
- Carroll, R., Metcalfe, C., & Gunnell, D. (2014). Hospital presenting self-harm and risk of fatal and non-fatal repetition: systematic review and meta-analysis. *PLoS One*, 9(2), 1-9.
- Carver, C. S. (2006). Approach, avoidance, and the self-regulation of affect and action. *Motivation and Emotion*, 30(2), 105-110.
- Cass, V. C. (1984). Homosexual identity formation: Testing a theoretical model. *Journal of Sex Research*, 20(2), 143-167.
- Cepeda-Benito, A., & Short, P. (1998). Self-concealment, avoidance of psychological services, and perceived likelihood of seeking professional help. *Journal of Counselling Psychology*, 45(1), 58.
- Chan, J., Draper, B., & Banerjee, S. (2007). Deliberate self-harm in older adults: a review of the literature from 1995 to 2004. *International Journal of Geriatric Psychiatry: A Journal of the Psychiatry of Late Life and Allied Sciences*, 22(8), 720-732.
- Chandler, A. (2010). *Pain incarnate: A narrative exploration of self-injury and embodiment*. Doctoral dissertation. University of Edinburgh.
- Chandler, A. (2016). *Self-injury, medicine and society: Authentic bodies*. Springer.
- Chandler, A., Myers, F., & Platt, S. (2011). The construction of self-injury in the clinical literature: a sociological exploration. *Suicide and Life-Threatening Behavior*, 41(1), 98-109.
- Charmaz, K. (2000). Grounded theory methodology: Objectivist and constructivist

- qualitative methods. In N. Denzin and Y. Lincoln (Eds.), *SAGE handbook of qualitative psychology*. Sage.
- Charmaz, K. (2002). Qualitative interviewing and grounded theory analysis. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research: context & method*. Sage.
- Charmaz, K., & Belgrave, L. L. (2007). *Grounded theory. The Blackwell encyclopedia of sociology*. Blackwell Pub.
- Chaudoir, S. R. (2009). *HIV/AIDS disclosure decision making and outcomes: A longitudinal, event-based analysis*. Unpublished doctoral dissertation. University of Connecticut.
- Chaudoir, S. R., & Fisher, J. D. (2010). The disclosure processes model: understanding disclosure decision making and post disclosure outcomes among people living with a concealable stigmatized identity. *Psychological Bulletin*, *136*(2), 236.
- Chaudoir, S. R., & Quinn, D. M. (2010). Revealing concealable stigmatized identities: The impact of disclosure motivations and positive first-disclosure experiences on fear of disclosure and well-being. *Journal of Social Issues*, *66*(3), 570-584.
- Clair, J. A., Beatty, J. E., & Maclean, T. L. (2005). Out of sight but not out of mind: Managing invisible social identities in the workplace. *Academy of Management Review*, *30*(1), 78-95.
- Cleaver, K. (2014). Attitudes of emergency care staff towards young people who self-harm: A scoping review. *International Emergency Nursing*, *22*(1), 52-61.
- Clement, S., Schauman, O., Graham, T., Maggioni, F., EvansLacko, S., Bezborodovs, N.,... Thornicroft, G. (2015). What is the impact of mental-health related stigma on helpseeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, *45*, 11-27.
- Cooper, J., Steeg, S., Bennewith, O., Lowe, M., Gunnell, D., House, A., . . . Kapur, N. (2013). Are hospital services for self-harm getting better? An observational study examining management, service provision and temporal trends in England. *BMJ Open*, *3*.
- Corcoran, J., Mewse, A., & Babiker, G. (2007). The role of women's self-injury support-groups: a grounded theory. *Journal of Community & Applied Social Psychology*, *17*(1), 35-52.
- Derlega, V. J., Anderson, S., Winstead, B. A., & Greene, K. (2011). Positive disclosure



- among college students: What do they talk about, to whom, and why?. *The Journal of Positive Psychology*, 6(2), 119-130.
- Derlega, V. J., Winstead, B. A., & Folk-Barron, L. (2000). Reasons for and against disclosing HIV-seropositive test results to an intimate partner: A functional perspective. In S. Petronio (Ed.), *Balancing the secrets of private disclosure*. Erlbaum.
- Derlega, V. J., Winstead, B. A., Wong, P. T., & Greenspan, M. (1987). Self-disclosure and relationship development: an attributional analysis. In M. E. Roloff & G. R. Miller (Eds.), *Interpersonal processes: New directions in communication research*. Sage.
- Dickson, S., Steeg, S., Gordon, M., Donaldson, I., Matthews, V., & Kapur, N. (2011). *The Manchester self-harm project: Self-harm in Manchester January 2008-December 2009*. Manchester: The University of Manchester.
- Dindia, K. (2000). Sex differences in self-disclosure, reciprocity of self-disclosure, and self-disclosure and liking: Three meta-analyses reviewed. *Balancing the Secrets of Private Disclosures*, 21-36.
- Duffy, D. F. (2006). Self-injury. *Psychiatry*, 5(8), 263-265.
- Edmondson, A. J., Brennan, C. A., & House, A. O. (2016). Non-suicidal reasons for self-harm: A systematic review of self-reported accounts. *Journal of Affective Disorders*, 191, 109-117.
- Elliot, R., Fischer, C.T., and Rennie, D.L. (1999). Evolving guidelines for the publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38(3), 215-229.
- Emmel, N. (2013). *Sampling and choosing cases in qualitative research: A realist approach*. Sage.
- Evans, E., Hawton, K., & Rodham, K. (2005). In what ways are adolescents who engage in self-harm or experience thoughts of self-harm different in terms of help-seeking, communication and coping strategies?. *Journal of Adolescence*, 28(4), 573-587.
- Fortune, S., Sinclair, J., & Hawton, K. (2008). Help-seeking before and after episodes of self-harm: a descriptive study in school pupils in England. *BMC Public Health*, 8(1), 369.
- Frattaroli, J. (2006). Experimental disclosure and its moderators: A meta-analysis. *Psychological Bulletin*, 132(6), 823-865.

- Frey, L. M., & Fulginiti, A. (2017). Talking about suicide may not be enough: Family reaction as a mediator between disclosure and interpersonal needs. *Journal of Mental Health, 26*(4), 366-372.
- Frey, L. M., Fulginiti, A., Lezine, D., & Cerel, J. (2018). The decision-making process for disclosing suicidal ideation and behavior to family and friends. *Family Relations, 67*(3), 414-427.
- Frey, L. M., Hans, J. D., & Cerel, J. (2017). An interpretive phenomenological inquiry of family and friend reactions to suicide disclosure. *Journal of Marital and Family Therapy, 43*(1), 159-172.
- Gable, S. L., & Berkman, E. T. (2008). Which face in the crowd? Social goals and attention to facial stimuli. *Manuscript submitted for publication.*
- Gardner, F. (2001) *Self-Harm: A Psychotherapeutic Approach*. Routledge.
- Gayfer, B. L., Mahdy, J. C., & Lewis, S. P. (2018). Peer reactions to non-suicidal self-injury disclosures: a thematic analysis. *Counselling Psychology Quarterly, 33*(1), 79-99.
- Geulayov, G., Kapur, N., Turnbull, P., Clements, C., Waters, K., Ness, J., ... & Hawton, K. (2016). Epidemiology and trends in non-fatal self-harm in three centres in England, 2000–2012: findings from the Multicentre Study of Self-harm in England. *BMJ Open, 6*(4).
- Glaser, B. G. (1965). The constant comparative method of qualitative analysis. *Social Problems, 12*(4), 436-445.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies in qualitative research*. Wiedenfeld and Nicholson.
- Goffman, E. (1963). *Stigma: notes on the management of a spoiled identity*. Prentice Hall.
- Gonzalez, J. M., Alegria, M., & Prihoda, T. J. (2005). How do attitudes toward mental health treatment vary by age, gender, and ethnicity/race in young adults? *Journal of Community Psychology, 33*, 611-629.
- Gratz, K. L., & Chapman, A. L. (2007). The role of emotional responding and childhood maltreatment in the development and maintenance of deliberate self-harm among male undergraduates. *Psychology of Men & Masculinity, 8*(1), 1.
- Gratz, K. L., Conrad, S., & Roemer, L. (2002). Risk factors for deliberate self-harm among college students. *American Journal of Orthopsychiatry, 72*(1), 128–140.
- Greene, K., & Faulkner, S. L. (2002). Expected versus actual responses to disclosure in

relationships of HIV-positive African American adolescent females. *Communication Studies*, 53(4), 297-317.

- Greene, K., Derlega, V. J., & Mathews, A. (2006). Self-disclosure in personal relationships. *The Cambridge Handbook of Personal Relationships*, 409-427.
- Greene, K., Derlega, V. J., Yep, G. A., & Petronio, S. (2003). *Privacy and disclosure of HIV in interpersonal relationships: A sourcebook for researchers and practitioners*. Erlbaum.
- Grocutt, E. (2009). Self-harm cessation in secure setting. *Managing self-harm: Psychological Perspectives*, 180-203.
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, 18(1), 59-82.
- Gunnarsson, N. V. (2020). The Self-perpetuating Cycle of Shame and Self-injury. *Humanity & Society*, 1-21.
- Hamza, C., Willoughby, T., & Good, M. (2012). A preliminary examination of the specificity of the functions of nonsuicidal self-injury among a sample of university students. *Psychiatry Research*, 205(1-2), 172-175.
- Harris, J. (2000). Self-harm: Cutting the bad out of me. *Qualitative Health Research*, 10(2), 164-173.
- Hasking, P., Rees, C. S., Martin, G., & Quigley, J. (2015). What happens when you tell someone you self-injure? The effects of disclosing NSSI to adults and peers. *BMC Public Health*, 15(1), 1039.
- Hatzenbuehler, M. L. (2009). How does sexual minority stigma “get under the skin”? A psychological mediation framework. *Psychological Bulletin*, 135(5), 707.
- Hawton, K., & Rodham, K. (2006). *By their own hand. Deliberate self-harm and suicidal ideas in adolescents*. Kingsley Publishers.
- Hawton, K., Bergen, H., Casey, D., Simkin, S., Palmer, B., Cooper, J., ... & Noble, R. (2007). Self-harm in England: a tale of three cities. *Social Psychiatry and Psychiatric Epidemiology*, 42(7), 513-521.
- Hawton, K., Harriss, L., Hall, S., Simkin, S., Bale, E., & Bond, A. (2003). Deliberate self-harm in Oxford, 1990-2000: a time of change in patient characteristics. *Psychological Medicine*, 33(6), 987-995.
- Hawton, K., Harriss, L., Simkin, S., Bale, E., & Bond, A. (2004). Self-cutting: patient characteristics compared with self-poisoners. *Suicide and Life-Threatening Behavior*, 34(3), 199-208.

- Hawton, K., Rodham, K., Evans, E., & Weatherall, R. (2002). Deliberate self-harm in adolescents: Self report survey in schools in England. *British Medical Journal*, 325, 1207-1211.
- Hawton, K., Saunders, K. E., & O'Connor, R. C. (2012). Self-harm and suicide in adolescents. *The Lancet*, 379(9834), 2373-2382.
- Heath, N. L., Ross, S., Toste, J. R., Charlebois, A., & Nedecheva, T. (2009). Retrospective analysis of social factors and nonsuicidal self-injury among young adults. *Canadian Journal of Behavioural Science*, 41(3), 180.
- Heath, N., Toste, J., Nedecheva, T., & Charlebois, A. (2008). An examination of nonsuicidal self-injury among college students. *Journal of Mental Health Counselling*, 30(2), 137-156.
- Helgeson, V. S., & Gottlieb, B. H. (2000). Support groups. *Social support measurement and intervention: A Guide for Health and Social Scientists*, 221-245.
- Henwood, K. L., & Pidgeon, N. F. (1992). Qualitative research and psychological theorizing. *British Journal of Psychology*, 83(1), 97-111.
- Hodgson, S. (2004). Cutting through the silence: A sociological construction of self-injury. *Sociological Inquiry*, 74(2), 162-179.
- Hom, M. A., Stanley, I. H., Podlogar, M. C., & Joiner Jr, T. E. (2017). "Are you having thoughts of suicide?" Examining experiences with disclosing and denying suicidal ideation. *Journal of Clinical Psychology*, 73(10), 1382-1392.
- Horesh, N., & Apter, A. (2006). Self-disclosure, depression, anxiety, and suicidal behavior in adolescent psychiatric inpatients. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 27(2), 66-71.
- Isman, E., Mahmoud Warsame, A., Johansson, A., Fried, S., & Berggren, V. (2013). Midwives' experiences in providing care and counselling to women with female genital mutilation (FGM) related problems. *Obstetrics and Gynecology International*. Article ID: 785148.
- ITV. (2020). *The return of Britain Get Talking sees 3 million people take action*. <https://www.itv.com/presscentre/press-releases/return-britain-get-talking-sees-3-million-people-take-action>
- John, E. (2017). Suicides in the UK: 2016 registrations. *Office for National Statistics*, 4-10.
- Joiner, T. E., Jr. (2005). *Why people die by suicide*. Harvard University Press.

- Jourard, S. M. (1971). *The transparent self* (2<sup>nd</sup> ed.). Van Nostrand.
- Kaiser, C. R., Vick, S. B., & Major, B. (2006). Prejudice expectations moderate preconscious attention to cues that are threatening to social identity. *Psychological Science*, *17*(4), 332-338.
- Kapur, N., Cooper, J., O'Connor, R.C., & Hawton, K. (2013). Non suicidal self-injury v. attempted suicide: New diagnosis or false dichotomy?. *British Journal of Psychiatry*, *202*, 326–328.
- Kelly, A. E. (2002). *The psychology of secrets*. Kluwer Academic/Plenum
- Kivunja, C., & Kuyini, A. B. (2017). Understanding and Applying Research Paradigms in Educational Contexts. *International Journal of Higher Education*, *6*(5), 26.
- Klineberg, E., Kelly, M. J., Stansfeld, S. A., & Bhui, K. S. (2013). How do adolescents talk about self-harm: a qualitative study of disclosure in an ethnically diverse urban population in England. *BMC Public Health*, *13*(1), 572.
- Klonsky, E. D. (2011). Non-suicidal self-injury in United States adults: prevalence, sociodemographics, topography and functions. *Psychological Medicine*, *41*(9), 1981-1986.
- Klonsky, E., & Glenn, C. R. (2009). Assessing the functions of non-suicidal self-injury: Psychometric properties of the Inventory of Statements About Self-injury (ISAS). *Journal of Psychopathology and Behavioral Assessment*, *31*(3), 215–219.
- Klonsky, E. D., & Muehlenkamp, J. J. (2007). Self-injury: A research review for the practitioner. *Journal of Clinical Psychology*, *63*(11), 1045-1056.
- Langridge, D. (2004). *Introduction to research methods and data analysis in psychology*. Pearson.
- Laurenceau, J. P., Barrett, L. F., & Pietromonaco, P. R. (1998). Intimacy as an interpersonal process: The importance of self-disclosure, partner disclosure, and perceived partner responsiveness in interpersonal exchanges. *Journal of personality and social psychology*, *74*(5), 1238.
- Laurenceau, J. P., Barrett, L. F., & Rovine, M. J. (2005). The interpersonal process model of intimacy in marriage: A daily-diary and multilevel modelling approach. *Journal of Family Psychology*, *19*(2), 314.
- Leeming, D., & Boyle, M. (2013). Managing shame: An interpersonal perspective. *British Journal of Social Psychology*, *52*(1), 140-160.

- Levinger, G. K., & Snoek, J. D. (1972). *Attraction in relationship: A new look at interpersonal attraction*. General Learning Press.
- Lewis, S. P., & Baker, T. G. (2011). The possible risks of self-injury websites: A content analysis. *Archives of Suicide Research, 15*(4), 390–396.
- Lewis, S. P., Heath, N. L., Sornberger, M. J., & Arbuthnott, A. E. (2012). Helpful or harmful? An examination of viewers' responses to non-suicidal self-injury videos on YouTube. *Journal of Adolescent Health, 51*(4), 380–385.
- Lilley, R., Owens, D., Horrocks, J., House, A., Noble, R., Bergen, H., ... & Cooper, J. (2008). Hospital care and repetition following self-harm: multicentre comparison of self-poisoning and self-injury. *The British Journal of Psychiatry, 192*(6), 440-445.
- Long, M., Manktelow, R., & Tracey, A. (2013). We are all in this together: working towards a holistic understanding of self-harm. *Journal of Psychiatric and Mental Health Nursing, 20*(2), 105-113.
- Long, M., Manktelow, R., & Tracey, A. (2015). The healing journey: Help seeking for self-injury among a community population. *Qualitative Health Research, 25*(7), 932-944.
- Lynch, L., Long, M., & Moorhead, A. (2018). Young men, help-seeking, and mental health services: exploring barriers and solutions. *American Journal of Men's Health, 12*(1), 138-149.
- Lyubormirsky, S., Sousa, L., & Dickerhood, R. (2006). The costs and benefits of writing, talking, and thinking about life's triumphs and defeats. *Journal of Personality and Social Psychology, 90*, 692-708.
- Maple, M., Frey, L. M., McKay, K., Coker, S., & Grey, S. (2019). "Nobody Hears a Silent Cry for Help": Suicide Attempt Survivors' Experiences of Disclosing During and After a Crisis. *Archives of Suicide Research, 1*-19.
- Madge, N., Hewitt, A., Hawton, K., Wilde, E. J. D., Corcoran, P., Fekete, S., ... & Ystgaard, M. (2008). Deliberate self-harm within an international community sample of young people: comparative findings from the Child & Adolescent Self-harm in Europe (CASE) Study. *Journal of Child Psychology and Psychiatry, 49*(6), 667-677.
- Maisel, N. C., & Gable, S. L. (2009). The paradox of received social support: The importance of responsiveness. *Psychological Science, 20*(8), 928-932.

- Manusov, V., & Harvey, J. H. (2001). *Attribution, communication behavior, and close relationships*. Cambridge University Press.
- Marshall, M. N. (1996). Sampling for qualitative research. *Family Practice, 13*(6), 522-526.
- Martin, G., Swannell, S. V., Hazell, P. L., Harrison, J. E., & Taylor, A. W. (2010). Self-injury in Australia: A community survey. *Medical Journal of Australia, 193*(9), 506–510.
- McAndrew, S., & Warne, T. (2014). Hearing the voices of young people who self-harm: Implications for service providers. *International Journal of Mental Health Nursing, 23*(6), 570-579.
- McManus, S., Gunnell, D., Cooper, C., Bebbington, P. E., Howard, L. M., Brugha, T., ... & Appleby, L. (2019). Prevalence of non-suicidal self-harm and service contact in England, 2000–14: repeated cross-sectional surveys of the general population. *The Lancet Psychiatry, 6*(7), 573-581.
- McShane, T. 2012. *Blades, blood and bandages: The experiences of people who self-injure*. Palgrave MacMillan.
- Mental Health Foundation. (2006). *Truth Hurts: Report of the National Inquiry into Self-harm among Young People*. Mental Health Foundation.
- Messer, J. M., & Fremouw, W. J. (2008). A critical review of explanatory models for self-mutilating behaviors in adolescents. *Clinical Psychology Review, 28*(1), 162-178.
- Michelmore, L., & Hindley, P. (2012). Help-seeking for suicidal thoughts and self-harm in young people: A systematic review. *Suicide and Life-Threatening Behavior, 42*(5), 507-524.
- Moran, P., Coffey, C., Romaniuk, H., Olsson, C., Borschmann, R., Carlin, J. B., & Patton, G. C. (2012). The natural history of self-harm from adolescence to young adulthood: a population-based cohort study. *The Lancet, 379*(9812), 236-243.
- Muehlenkamp, J. J., Claes, L., Havertape, L., & Plener, P. L. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health, 6*(1), 10.
- Nada-Raja, S., Morrison, D., & Skegg, K. (2003). A population-based study of help-seeking for self-harm in young adults. *Australian and New Zealand Journal of Psychiatry, 37*(5), 600-605.

- Nam, S. K., Chu, H. J., Lee, M. K., Lee, J. H., Kim, N., & Lee, S. M. (2010). A meta-analysis of gender differences in attitudes toward seeking professional psychological help. *Journal of American College Health, 59*, 110-116.
- Newcomer, K. E., Hatry, H. P., & Wholey, J. S. (2015). Conducting semi-structured interviews. *Handbook of Practical Program Evaluation, 492*.
- NICE (2011) *Self-harm in over 8s: long term management*. National Institute for Health and Care Excellence. <http://www.nice.org.uk/CG133>.
- Nixon, M. K., Cloutier, P., & Jansson, S. (2008). Nonsuicidal self-harm in youth: A population-based survey. *Canadian Medical Association Journal, 178*(3), 306–312.
- Nock, M. K., Borges, G., Bromet, E. J., Alonso, J., Angermeyer, M., Beautrais, A., ... & De Graaf, R. (2008). Cross-national prevalence and risk factors for suicidal ideation, plans and attempts. *The British Journal of Psychiatry, 192*(2), 98-105.
- Nock, M.K. (2010) Self-injury. *Annual Review of Clinical Psychology, 6*(1), 15.1-15.25.
- O'Connor, R. C., Rasmussen, S., Miles, J., & Hawton, K. (2009). Self-harm in adolescents: self-report survey in schools in Scotland. *The British Journal of Psychiatry, 194*(1), 68-72.
- Ogden, J., & Bennett, A. (2015). Self-harm as a means to manage the public and private selves: A qualitative study of help seeking by adults. *Health Psychology Open, 2*(2), 2055102915605987.
- Omarzu, J. (2000). A disclosure decision model: Determining how and when individuals will self-disclose. *Personality and Social Psychology Review, 4*(2), 174-185.
- Ougrin, D., & Zundel, T. (2009). Defining self-harm. In D. Ougrin, T. Zundel, & A. Vg, *Self-Harm in Young People: A Therapeutic Assessment Manual*. Taylor and Francis.
- Ougrin, D., Tranah, T., Stahl, D., Moran, P., & Asarnow, J. R. (2015). Therapeutic interventions for suicide attempts and self-harm in adolescents: systematic review and meta-analysis. *Journal of the American Academy of Child & Adolescent Psychiatry, 54*(2), 97-107.
- Owens, D., Kelley, R., Munyombwe, T., Bergen, H., Hawton, K., Cooper, J., ... & Kapur, N. (2015). Switching methods of self-harm at repeat episodes: findings from a multicentre cohort study. *Journal of Affective Disorders, 180*, 44-51.
- Pachankis, J. E. (2007). The psychological implications of concealing a stigma: a



- cognitive-affective-behavioral model. *Psychological Bulletin*, 133(2), 328.
- Park, C. L. (2010). Making sense of the meaning literature: an integrative review of meaning making and its effects on adjustment to stressful life events. *Psychological Bulletin*, 136(2), 257.
- Pennebaker, J. W. (1995). *Emotion, disclosure, & health*. American Psychological Association.
- Pescosolido, B. A., Martin, J. K., Lang, A., & Olafsdottir, S. (2008). Rethinking theoretical approaches to stigma: A framework integrating normative influences on stigma (FINIS). *Social Science & Medicine*, 67(3), 431-440.
- Petronio, S. (1991). Communication boundary management: a theoretical model of managing disclosure of private information between marital couples. *Communication Theory*, 1, 311–335.
- Petronio, S. (2002). *Boundaries of privacy: Dialectics of disclosure*. Suny Press.
- Pettigrew, T. F., & Tropp, L. R. (2006). A meta-analytic test of intergroup contact theory. *Journal of Personality and Social Psychology*, 90(5), 751.
- Polkinghorne, D.E. (2005) Language and meaning: Data collection in qualitative research. *Journal of Counselling Psychology*, 52(2), 137-145.
- Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. Sage.
- Purington, A., & Whitlock, J. (2010). Non-suicidal self-injury in the media. *The Prevention Researcher*, 17(1), 11-14.
- Quadara, A. (2008). *Responding to young people disclosing sexual assault: A resource for schools*. Australian Institute of Family Studies.
- Quinn, D. M., & Earnshaw, V. A. (2013). Concealable stigmatized identities and psychological well-being. *Social and Personality Psychology Compass*, 7(1), 40-51.
- Ragins, B. R. (2004). Sexual orientation in the workplace: The unique work and career experiences of gay, lesbian and bisexual workers. *Research in Personnel and Human Resource Management*, 23, 37–122.
- Ragins, B. R. (2008). Disclosure disconnects: Antecedents and consequences of disclosing invisible stigmas across life domains. *Academy of Management Review*, 33(1), 194-215.

- Reis, H. T., & Shaver, P. (1988). *Intimacy as an interpersonal process*. In S. Duck (Ed.), *Handbook of personal relationships*. Wiley.
- Rethink Mental Illness (2020). *Time to Change: Two thirds of people feel they have no one to talk to about personal problems such as mental health*. Rething.org. <https://www.time-to-change.org.uk/news/two-thirds-people-feel-they-have-no-one-talk-about-personal-problems-such-mental-health>
- Rickwood, D. J., Deane, F. P., & Wilson, C. J. (2007). When and how do young people seek professional help for mental health problems?. *Medical Journal of Australia*, 187(S7), S35-S39.
- Rodham, K., Hawton, K., & Evans, E. (2004). Reasons for deliberate self-harm: comparison of self-poisoners and self-cutters in a community sample of adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43(1), 80-87.
- Roloff, M. E., & Ifert, D. E. (2000). Conflict management through avoidance: Withholding complaints, suppressing arguments, and declaring topics taboo. *Balancing the Secrets of Private Disclosures*, 151-163.
- Rosenrot, S. A., & Lewis, S. P. (2018). Barriers and responses to the disclosure of non-suicidal self-injury: a thematic analysis. *Counselling Psychology Quarterly*, 1-21.
- Rothì, D. M., & Leavey, G. (2006). Mental health help-seeking and young people: A review. *Pastoral Care in Education*, 24(3), 4-13.
- Rowe, S. L., French, R. S., Henderson, C., Ougrin, D., Slade, M., & Moran, P. (2014). Help-seeking behaviour and adolescent self-harm: a systematic review. *Australian & New Zealand Journal of Psychiatry*, 48(12), 1083-1095.
- Royal College of Psychiatrists. (2010). *Self-Harm, Suicide and Risk: Helping People who Self-Harm* (College Report CR158). <http://www.rcpsych.ac.uk/>
- Sanchez, M., Schlossberg, L. (2001). *Passing: Identity and Interpretation in Sexuality, Race, and Religion*. New York University Press.
- Sandelowski, M. (1995a). Sample size in qualitative research. *Research in Nursing & Health*, 18(2), 179-183.
- Sandelowski, M. (1995b). Qualitative analysis: What it is and how to begin. *Research in Nursing & Health*, 18(4), 371-375.

- Semaan, B., Britton, L. M., & Dosono, B. (2017). Military masculinity and the travails of transitioning: Disclosure in social media. In *Proceedings of the 2017 ACM Conference on computer supported cooperative work and social computing* (pp. 387403).
- Sheehan, L., Oexle, N., Armas, S. A., Wan, H. T., Bushman, M., Glover, L., & Lewy, S. (2019). Benefits and risks of suicide disclosure. *Social Science & Medicine*, 223, 16-23.
- Sheehy, K., Noureen, A., Khaliq, A., Dhingra, K., Husain, N., Pontin, E. E., ... & Taylor, P. J. (2019). An examination of the relationship between shame, guilt and self-harm: A systematic review and meta-analysis. *Clinical Psychology Review*, 101779.
- Silfver, M. (2007). Coping with guilt and shame: A narrative approach. *Journal of Moral Education*, 36(2), 169-183.
- Sinclair, J. M., Gray, A., Rivero-Arias, O., Saunders, K. E., & Hawton, K. (2011). Healthcare and social services resource use and costs of self-harm patients. *Social Psychiatry and Psychiatric Epidemiology*, 46(4), 263-271.
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health*, 11(2), 261-271.
- Smith, J.A. (2015) *Qualitative Psychology: A practical guide to research methods*. Sage publications.
- Smyth, J. M., Pennebaker, J. W., & Arigo, D. (2001). What are the health effects of disclosure. *Handbook of Health Psychology*, 339-348.
- Smith, R., Rossetto, K., & Peterson, B. L. (2008). A meta-analysis of disclosure of one's HIV-positive status, stigma and social support. *AIDS Care*, 20(10), 1266-1275.
- Sornberger, M., Heath, N., Toste, J., & McLouth, R. (2012). Nonsuicidal self-injury and gender: Patterns of prevalence, methods and locations among adolescents. *Suicide and Life Threatening Behaviour*, 42(3), 266-278.
- Sprecher, S., & Hendrick, S. S. (2004). Self-disclosure in intimate relationships: Associations with individual and relationship characteristics over time. *Journal of Social and Clinical Psychology*, 23(6), 857-877.
- Steggals, P. (2015) *Making Sense of Self-Harm: The Cultural Meaning and Social Context of Nonsuicidal Self-Injury*. Palgrave Macmillan.

- Steggals, P., Lawler, S., & Graham, R. (2020). The social life of self-injury: exploring the communicative dimension of a very personal practice. *Sociology of Health & Illness*, 42(1), 157-170.
- Strachman, A., & Gable, S. L. (2006). What you want (and do not want) affects what you see (and do not see): Avoidance social goals and social events. *Personality and Social Psychology Bulletin*, 32(11), 1446-1458.
- Swann, W. B., Stein-Seroussi, A., & Giesler, R. B. (1992). Why people self-verify. *Journal of Personality and Social Psychology*, 62(3), 392.
- Talley, A. E., & Bettencourt, B. A. (2011). The moderator roles of coping style and identity disclosure in the relationship between perceived sexual stigma and psychological distress. *Journal of Applied Social Psychology*, 41(12), 2883–2903.
- Tardy, C., & Dindia, K. (2006). Self-disclosure: Strategic revelation of personal information in personal and professional relationships. In O. Hargie (Ed.), *A Handbook of Communication Skills* (3rd Ed.) Routledge.
- Taylor, B. (2003). Exploring the perspectives of men who self-harm. *Learning in Health and Social Care*, 2(2), 83-91.
- Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic analysis. *The Sage Handbook of Qualitative Research in Psychology*, 17-37.
- Treharne, G. J., & Riggs, D. W. (2014). Ensuring quality in qualitative research. *Qualitative Research in Clinical and Health Psychology*, 57-73.
- Ullman, S. E. (2010). *Talking about sexual assault: Society's response to survivors*. American Psychological Association.
- Van Orden, K. A., Lynam, M. E., Hollar, D., & Joiner, T. E. (2006). Perceived burdensomeness as an indicator of suicidal symptoms. *Cognitive Therapy and Research*, 30(4), 457-467.
- Walsh, B. (2007). Clinical assessment of self-injury: A practical guide. *Journal of Clinical Psychology*, 63(11), 1057-1068.
- Wetherell, M. (1998). Positioning and interpretative repertoires: conversation analysis and post-structuralism in dialogue. *Discourse & Society*, 9(3), 387–412.
- Whitlock, J., Eckenrode, J., & Silverman, D. (2006). Self-injurious behaviors in a college population. *Pediatrics*, 117, 1939–1948.

- Whitlock, J., Prussien, K., & Pietrusza, C. (2015). Predictors of self-injury cessation and subsequent psychological growth: results of a probability sample survey of students in eight universities and colleges. *Child and Adolescent Psychiatry and Mental Health*, 9(1), 19.
- Williams, E. P., Grunberg, P. H., Rosenrot, S. A., Mahdy, J. C., & Lewis, S. P. (2013). *Barriers and gateways: Preliminary insight into the experience of NSSI disclosure*. Poster session presented at the annual meeting of the International Society for the Study of Self-Injury (ISSS), Vancouver, BC.
- Willig, C. (2013). *Introducing qualitative research in psychology*. McGraw-hill education (UK).
- World Health Organisation. (2009). *Strengthening the health sector response to adolescent health and development*.  
[https://www.who.int/maternal\\_child\\_adolescent/documents/cah\\_adh\\_flyer\\_2010\\_12\\_en.pdf?ua=1](https://www.who.int/maternal_child_adolescent/documents/cah_adh_flyer_2010_12_en.pdf?ua=1)
- Wu, C. Y., Whitley, R., Stewart, R., & Liu, S. I. (2012). Pathways to care and help-seeking experience prior to self-harm: a qualitative study in Taiwan. *Journal of Nursing Research*, 20(1), 32-42.
- Yalom, I.D. (2005). *The theory and practice of group psychotherapy*. Basic Books.
- Young Minds. (2020). *Self-harm Awareness Day*. <https://youngminds.org.uk/get-involved/campaign-with-us/success-stories/self-harm-awareness-day/>

## APPENDICES

### Appendix A Ethical Approval



## *Health Research Authority* Yorkshire & The Humber - Leeds East Research Ethics Committee

NHSBT Newcastle Blood Donor Centre  
Holland Drive  
Newcastle upon Tyne  
NE2 4NQ

Telephone: 0207 1048 088

**Please note:**  
**This is an  
acknowledgement  
letter from the  
REC only and  
does not allow  
you to start your  
study at NHS  
sites in England  
until  
you receive HRA  
Approval**

29 May 2019

Miss Emily Higgins  
Clinical Psychology Training Programme  
Leeds Institute of Health Sciences, University of Leeds, Level 10 Worsley  
Building Clarendon Way, Leeds  
LS2 9NL

Dear Miss Higgins

**Study title:** Experiences of Disclosing Self-Harm to Non-Professionals

**REC reference:** 19/YH/0137

**Protocol number:** 1

**IRAS project ID:** 256924

Thank you for your submission of 24 May 2019. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 23 May 2019

### Documents received

The documents received were as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Other [Ethical Review - additional conditions]	V1.0	24 May 2019
Participant consent form [Consent Form]	V2.0	24 May 2019
Participant information sheet (PIS) [Participant Information Sheet V2.0]	V2.0	24 May 2019

A Research Ethics Committee established by the Health Research Authority

### Approved documents

The final list of approved documentation for the study is therefore as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Copies of advertisement materials for research participants [Recruitment Advert]	V1.0	04 March 2019
Evidence of Sponsor insurance or indemnity (non-NHS Sponsors only) [Sponsor Insurance]	V1.0	01 April 2019

Interview schedules or topic guides for participants [Interview Topic Guide]	V1.0	25 February 2019
IRAS Application Form [IRAS_Form_03042019]		03 April 2019
Other [Research Panel Constitution and feedback]	V1.0	27 September 2018
Other [Risk Protocol]	V1.0	01 February 2019
Other [Transcription Statement]	V1.0	18 March 2019
Other [Consent to contact form]	V1.0	10 February 2019
Other [Information Letter]	V1.0	18 March 2019
Other [Ethical Review - additional conditions]	V1.0	24 May 2019
Participant consent form [Consent Form]	V2.0	24 May 2019
Participant information sheet (PIS) [Participant Information Sheet V2.0]	V2.0	24 May 2019
Research protocol or project proposal [Research Protocol]	V1.0	11 February 2019
Summary CV for Chief Investigator (CI) [EH CV]	V1.0	25 February 2019
Summary CV for student [EH CV]	V1.0	25 February 2019
Summary CV for supervisor (student research) [RK CV]	V1.0	18 March 2019
Summary CV for supervisor (student research) [Allan House Short CV January 2017]		16 April 2019
Summary CV for supervisor (student research) [Brennan CV Research March 2019]		16 April 2019

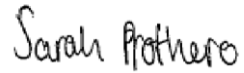
You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.



**19/YH/0137**

**Please quote this number on all  
correspondence**

Yours sincerely



**Sarah Prothero**  
**Approvals Officer**

E-mail: [nrescommittee.yorkandhumber-leedseast@nhs.net](mailto:nrescommittee.yorkandhumber-leedseast@nhs.net)

*Copy to: Miss Emily Higgins, The Leeds Teaching Hospitals NHS Trust*

## **Appendix B**

### **Participant Information Sheet**

#### **Research Project Title: Experiences of disclosing self-harm to non-professionals.**

I am inviting you to take part in a research project with the above title. Before you decide whether to take part it is important for you to understand why the project 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. The lead researcher is myself, Emily Higgins, and I am completing the research as part of the qualification of the Doctorate in Clinical Psychology. Please ask me if there is anything that is not clear or if you would like more information. My contact details are at the bottom of this document.

*All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Yorkshire & The Humber - Leeds East Research Ethics Committee.*

#### **What is the purpose of the project?**

I am interested in exploring the experiences of people who self-harm when they tell non-professionals, such as family, friends and partners. Little is known about why people who self-harm decide to tell other people, how they find talking to others about their self-harm, or how they feel afterwards. I want to improve understanding of these experiences and find out what is and isn't helpful when talking to other people about self-harm.

#### **Why have I been invited to take part?**

This research project is about people who have self-harmed. I am interested in talking to both:

- People who have had the experience of telling someone else about their self-harm.
- People who may not have told others about their self-harm.

So that I can understand what helps or makes it difficult for people to share their experiences of self-harm with others.

#### **Do I have to take part?**

No, it is entirely up to you to decide whether to take part or not. If you decide to take part, I will give you this information sheet to keep and ask you to complete a consent form. You can withdraw from the study without providing a reason, up until four weeks after your interview. During the interview you can choose not to answer any questions that you feel uncomfortable answering.

**What will happen if I decide to take part?**

If you decide to take part, I will ask you to read and sign a consent form. I will then invite you to attend an interview at a time and place which is convenient for you, which will last between 30 and 90 minutes. I will ask you questions about your experiences of talking to other people about your self-harm. It may also be possible that you have not told others about your self-harm and I may ask you more about this. I will try to make the interview as relaxed and comfortable for you as possible. At the end of the interview a five to ten minute de-brief will be offered to check that you feel okay before leaving. With your permission, the interview will be audio-recorded. The audio recordings will be transferred to a secure University computer server that will be password protected and only accessible to myself. The audio recordings will be transferred on the day of the recording, and then deleted from the Dictaphone. If you do not consent to your interview being audio-recorded you can still take part in the study and written notes will be taken instead. You will be given the option to arrange one further follow-up interview if you missed out something important that you wanted to say in the initial interview.

**What are the possible advantages of taking part?**

There may not be any immediate benefits to participating in the project, but you may find it helpful to talk about your experiences with someone who will listen and be interested. The research findings will provide new insights into the experience of talking to others about self-harm and will highlight what is and isn't helpful when talking to other people about self-harm. The findings will result in improved understanding of the potential benefits of disclosing self-harm and overcoming barriers to disclosure. Furthermore, it may assist professionals to support people they work with to disclose self-harm to significant others or provide support for non-professionals who may be unsure how to respond to somebody else's self-harm disclosure.

**What are the possible disadvantages of taking part?**

Although it is not the intention of the research to cause distress, it is possible that discussing your experiences may bring up difficult issues for you. If you become upset,

I will pause or stop the interview and offer you immediate support. I will give you details for local services that can be contacted if you need further support. Being interviewed will also take up time. Your travel expenses to the interview location will be reimbursed.

**Will my taking part in this project be kept confidential?**

All the information that you share will remain confidential. All data will be anonymised, and any identifying information will be taken out so you will not be able to be identified in any reports or publications. The only circumstance in which confidentiality would be broken is if I believed that you or somebody else is at serious risk, for example, there is an immediate risk to your life. In exceptional cases where confidentiality does have to be broken, and information needs to be shared, every effort would be made to inform you of this first.

**Where will my data be stored?**

If you are recruited through the NHS or through another non-NHS organisation then your consent to contact form with your personal details will be passed by that organisation to myself at the University of Leeds. All paper-based data, including consent to contact and consent forms, containing names and addresses, will be separated from other paper-based data (e.g., anonymised interview transcripts). The two separated types of paper data will be stored in separate locked filing cabinets at the University, in an office which is kept locked. All data will be destroyed after three years.

**What will happen to the results of the research project?**

The research will be written up as part of the Doctorate in Clinical Psychology Training Programme and will be held by the University of Leeds Library. When the research has been written up as a thesis it will be available to read at the following link:

<http://etheses.whiterose.ac.uk/cgi/search/advanced>. The research may also be published in a journal article and may be presented at a conference to peers in the future. If you decide to participate you can request a summary of the research on the consent form.

**Who is sponsoring and funding the research?**

The University of Leeds is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Leeds will keep identifiable

information about you for three years after the study has finished. Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information at <https://dataprotection.leeds.ac.uk/wp-content/uploads/sites/48/2019/02/Research-Privacy-Notice.pdf>.

### **Contact for further information**

If you would like further information about this project, please contact:

Lead Researcher: Emily Higgins, Psychologist in Clinical Training, [umejh@leeds.ac.uk](mailto:umejh@leeds.ac.uk)

Supervisors: Professor Allan House, [a.o.house@leeds.ac.uk](mailto:a.o.house@leeds.ac.uk)

Dr Cathy Brennan, [c.a.brennan@leeds.ac.uk](mailto:c.a.brennan@leeds.ac.uk)

Dr Rachael Kelley, [r.s.kelley@leeds.ac.uk](mailto:r.s.kelley@leeds.ac.uk)

### **What if there is a problem?**

If you have any concerns about any aspect of the study, please speak to me and I will be happy to address your questions. If you would like to make a complaint about the research, details about the process can be obtained from:

Clare Skinner (Head of Research Integrity and Governance)

Faculty of Medicine & Health Research Office, Level 9

Worsley Building

University of Leeds

Leeds

LS2 9NL

Email: [governance-ethics@leeds.ac.uk](mailto:governance-ethics@leeds.ac.uk)

**Thank you for taking the time to read this information sheet.**

## Appendix C

### Consent Form

Participant Identification Number:

**Title of Project: Experiences of disclosing self-harm to non-professionals.**

**Name of Researcher:** Emily Higgins

Once you have read the participant information sheet (version 2, 24/05/19) and are happy to participate in the research, please read the items listed below. Please initial each item you agree with and sign and date at the bottom before handing back to the researcher

If you agree, please initial box

1. I confirm that I have read and understood the information sheet explaining the research project.
2. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
3. I understand that my participation is voluntary and that I am free to withdraw up to four weeks after the interview without giving any reason and this will not affect my care.
4. I understand that should I not wish to answer any specific question(s) I am free to decline.
5. I understand that my responses will be kept confidential, unless I disclose something that means I or others may be at serious risk.
6. I understand that some direct quotes may be used in the final report, however these will be anonymised and identifiable information will be removed.
7. I agree to take part in the above study.
8. I agree for the interview to be audio recorded.
9. I would like to receive a summary of the research.

Name of Participant:

Date:

Signature:

Name of Researcher:

Date:

Signature:

## Appendix D

### Risk Management Protocol

All participants will be given the contact details for agencies whom they can contact should they feel at risk or require further support. These include:

- A reminder that they can contact their GP
- **Samaritans**- available 24 hours a day for anyone struggling to cope. They provide a safe place to talk where calls are completely confidential. Phone: 116 123. Email: jo@samaritans.org
- **HopelineUK**- a confidential support and advice service for young people under the age of 35 who may be having thoughts of suicide. Freephone 0800 068 41 41. Text: 07786209697. Email: [pat@papyrus-uk.org](mailto:pat@papyrus-uk.org)  
Website: <https://www.papyrus-uk.org/help-advice/about-hopelineuk>.
- **Mind Infoline**- The Mind team can provide information on a range of topics such as different mental health problems, where to get help (including support in your own area), medication and alternative treatments and advocacy. Call 0300 123 3393 Text 86463. info@mind.org.uk  
<https://www.mind.org.uk/information-support/helplines/>
- **Leeds City Council Crisis Card** – providing the details of various 24-hour services that can be contacted in a crisis.

### Participants recruited via NHS Trusts

Participants recruited via local NHS trusts are able to access the referral pathways to other professionals, if required (for example, to the Crisis team).

Confidentiality and disclosure are discussed at the outset of the interviews by going over the participant information sheet and consent form. This ensures the participant is aware of what the researcher's responsibility is with regards to disclosure of serious risk to self.

### Action Plan around distress and disclosure:

- a) If the participant becomes visibly distressed during the interview, the researcher will enquire about the participant's wellbeing. The researcher will ask the participant whether they would like to take a break or stop the interview. The researcher shall remind the participant they can stop at any point during the interview, without suffering any negative consequences. Regardless of the participant's decision to continue or not the researcher shall go over the sources of support.
- b) If disclosure of self-harm ideas/ urges is expressed by the participant, the researcher will ascertain the severity and if these urges are imminent.
  - a. If these urges are not imminent/ immediate the researcher will discuss with the participant, the options for sources of support (contact agencies as above and the MindWell resource for LYPFT users). If the participant reports that there is no immediate risk and they can keep themselves safe, the researcher shall still ensure the participant knows what they can do should this change (i.e. contact their GP, Crisis/ SPA, or their clinician).
  - b. If the participant expresses self-harm ideas and the level of distress is higher and/or urges are more imminent the researcher will encourage the participant to seek help and attempt to draw up a plan with them. The researcher will ask the participant if they want the researcher to contact the 24/7 single point of access (SPA) Crisis team (0300 300 1485).
- c) If the participant discloses serious self-harm or suicidal ideation or the researcher is wondering to contact somebody without the participant's consent (e.g. capacity in question) the researcher will have telephone number(s) available to call for advice, namely the SPA (Crisis) number (0300 300 1485).
  - a. If the participant leaves before establishing a 'plan' for managing their risk and the researcher believes the risk to be high, the researcher will call the SPA team for advice.
  - b. If the researcher wants to debrief the researcher can also contact their supervisors (for non-urgent cases).



## Appendix E

### Interview Topic Guide

#### Intro:

“Self-harm is a very private and sensitive issue for many people and it is common for people to find it difficult to talk to others about their experiences of self-harm. Even if you have been able to talk to someone about your self-harm before, I appreciate that it may be difficult to talk about it with me today. I am grateful for your willingness to participate and recognise that it may not be an easy thing for you to do”.

“I am going to be asking you some questions to get a sense of what your experiences of telling others about your self-harm have been like. Please let me know if you need to take a break at any point or if you would like to finish the interview. You can do this without providing a reason”.

Provide definition of self-harm – “Any act of self-poisoning or self-injury carried out by an individual irrespective of motivation” (NICE, 2011).

“To begin, have you told anyone else about your self-harm who is not a health professional, for example a member of your family or friend”

#### For participants who have disclosed to a non-professional:

... Can you recall the first experience you had of telling someone (who was a non-professional) about your self-harm?

... Can you tell me about the time just before you told somebody for the first time?

#### Prompts

... Time between onset of self-harm and telling someone

... Aspects of making the decision

- Was it, *planned or spontaneous?*
- *Who did you tell and why?*
- *How did you tell them?*
- *What actually happened?*
- *What did you tell them?*

... Before you disclosed your self-harm how did you feel?

#### Prompts

- *What were your expectations/hopes/worries?*
- *What was your reason for telling someone?*
- *What did you imagine It would be like?*

... How did you feel at the time?

... What immediate response did you get?

... After you disclosed your self-harm what happened?

*Prompts*

- *How did you feel afterwards?*
- *Did it affect your self-harm in any way?*
- *Have you spoken about it to that person again?*
- *Has their response changed in any way?*
- *Have you told anyone else since?*
- *How do you make sense of the experience now?*

... Can you recall any other experiences you've had telling someone (who was a non-professional) about your self-harm?

*Prompts*

- *Number of experiences, how many people have you told?*
- *Have you disclosed to several people?*
- *Have people's responses changed over time?*
- *Have you had different experiences each time?*
- *Any particular experiences that stand out to you? (e.g. because they were positive, negative, other reason)*
- *Comparison of different experiences*

**For participants who have not disclosed to non-professionals:**

... Barriers to self-harm disclosure – What has prevented you from telling other people about your self-harm?

... Expectations of self-harm disclosure – What do you think it would be like to tell someone about your self-harm?

*Prompts*

- *fears, worries, risks of self-harm disclosure*
- *Any perceived benefits of self-harm disclosure*

... What would make self-harm disclosure feel easier?

**For all participants:**

- Suggestions for people who self-harm and do not know how to tell others
- Suggestions for health-professionals (*what could health professionals do to best support self-harm disclosures*).
- Anything to add?

Appendix F

Example of phase 1 of analysis: Anonymised transcript

363 P: and id gone traveling erm, and really liked him, he liked me but I mean obviously we were up in the  
 364 tropics almost so it was red hot and there was no chance of wearing long sleeves and stuff like that so  
 365 like my scars were out erm but wed gone on a date night one night and drinking as usual and that was  
 366 kind of how I worked up the courage to tell him erm, in fact he brought it up because he started asking  
 367 what happened to my arms er, and then that kind of made it easy, erm just said that id struggled when  
 368 I were younger, still struggling, and that I use self-harm to deal with stuff, and just kind of kept it simple.

369 **I: So it made it easy because it sounds like you'd already made the decision to tell him, so you**  
 370 **were wanting to tell him but he actually asked you and that made it feel easier**

371 P: yeah

372 **I: that you didn't have to start**

373 P: yeah, yeah definitely

374 **I: and when he asked you how did you feel immediately?**

375 P: erm, nervous, erm worried that it would scare him off, yeah

376 **I: and then you told him that you'd struggled, and this was your way of dealing with things**  
 377 **and what was his first response, can you remember?**

378 P: he gave me a hug.

379 **I: without saying anything?**

380 P: yeah, erm [pause] erm, yeah he wanted to know if I still felt that way erm and I said I did sometimes  
 381 but I was kind of trying to use stuff without, like just before I met him erm, I'd gone up to see some  
 382 people that id met well I was over there still that was an hour away from the place I was living and then  
 383 I got a phone call, a voicemail left on my phone telling me, it was [friend's] mum saying there version of  
 384 the council found out that I was living with them so they wanted more money so they said that I couldn't  
 385 live with them anymore and that they had packed my bags and put them under my house so I could  
 386 collect them , I'd only been in [country] about two months at this point erm, and I didn't self-harm I  
 387 went on a massive bender and got reported missing by my parents to the [country] police, but I didn't  
 388 self-harm, erm and that felt like a massive achievement that made me have more confidence because I  
 389 could kind of describe it as a thing of the past

390 **I: right**

391 P: erm rather than being something current ..

392 **I: so was that the first time when something really difficult had happened since you'd started**  
 393 **self-harming that you had not used self-harm and you'd gone on a bender instead**

394 P: [laughing] yeah, and broken both my big toes,

395 **I: oh no**

396 P: not deliberately though

397 **I: oh no, did you have a fall**

398 P: I walked into a curb (P and I laughing together).

399 **I: and can I just take you back because you mentioned this guy that you were seeing erm, and**  
 400 **he gave you a hug, how did that feel, how did his response feel?**

401 P: amazing, it felt like he was just accepting me, I think for a long time part of me had felt that erm,  
 402 self-harm was all that I was, there wasn't really anything else to me , so him accepting the self-harm felt  
 403 that he was accepting me

*scars were visible*  
*Not easy to hide (scars)*  
*he had courage to disclose -> used drink to build up courage*  
*He initiated disclosure*  
*kept disclosure simple*  
*leading:*  
*'dangerous secret'*  
*fear of negative response*  
*worried about scaring someone*  
*physical closeness / affection (acceptance)*  
*Asking question about way she felt*  
*Not self-harming felt like a massive achievement -> grew in confidence*  
*Easier to disclose past self-harm than current*  
*talking about self-harm as a thing of the past -> distancing*  
*warm interaction between us.*  
*felt accepted very different reaction and emotional response.*  
*Response felt amazing*  
*self-harm felt like whole identity*

10