Journal of Youth Studies

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/cjys20

University students' experiences and perceptions of interventions for self-harm

Bethany Cliffe & Paul Stallard

To cite this article: Bethany Cliffe & Paul Stallard (2022): University students' experiences and perceptions of interventions for self-harm, Journal of Youth Studies, DOI: 10.1080/13676261.2022.2033187

To link to this article: https://doi.org/10.1080/13676261.2022.2033187

Published online: 31 Jan 2022.

JOURNAL OF YOUTH STUDIES
https://doi.org/10.1080/13676261.2022.2033187

Routledge
Taylor & Francis Group

University students' experiences and perceptions of interventions for self-harm

Bethany Cliffe and Paul Stallard

Department for Health, University of Bath, Bath, UK

ABSTRACT

This study sought to understand students' experiences and perceptions of interventions for self-harm, including what aims of the interventions they felt would be the most beneficial. 25 students with experience of self-harm thoughts/behaviours participated. The data were thematically analysed and three key themes were identified: 'understanding self-harm', 'barriers to seeking support', and 'preferences in support'. Given the variation in preferences for support and the barriers faced when seeking it, the importance of providing options was highlighted. Students suggested that focusing on reducing the frequency of self-harm may not be a helpful goal or accurately indicate recovery. They instead emphasised the importance of addressing other factors such as wider mental health and coping ability.

ARTICLE HISTORY
Received 25 June 2021
Accepted 19 January 2022

KEYWORDS
Self-harm; mental health; university student; interventions

Introduction

University can be a very difficult transition as many students struggle with adapting to new environments, independence, responsibilities, academic stressors, a lack of established support networks, and the associated challenges that these bring (Taliaferro and Muehlenkamp 2015). These pressures leave university students particularly vulnerable to mental health difficulties, with 84% of university students experiencing mental distress compared to 29% of the general population (Stallman 2010). Self-harm in particular is a significant concern among university students, as they are twice as likely to self-harm than non-students of the same age (Swannell et al. 2014). It is estimated that around 20% of students self-harm (Sivertsen et al. 2019) but, due to stigma and a reluctance to disclose self-harm (McManus and Gunnell 2019), it is likely that prevalence rates are higher than reported.

Despite this, help-seeking for self-harm among university students is very low. It is estimated that only one in five of those who self-harm seek professional psychological support (Fitzgerald and Curtis 2017). The stigma and reluctance to disclose self-harm can deter individuals from seeking professional support. Furthermore, if psychological help is sought there is little to suggest that effective interventions are available. Cognitive behavioural therapy (CBT) and dialectical behaviour therapy (DBT) are the recommended

CONTACT Bethany Cliffe Bc731@bath.ac.uk Department for Health, Claverton Down, University of Bath, Bath BA2 7AY, UK

treatments for self-harm (NICE 2013), although there is little high quality evidence to suggest their effectiveness (Hawton et al. 2016). Similarly, there is little evidence to indicate that pharmacological treatments can improve self-harm (Hawton et al. 2015). Moreover, there is an absence of research investigating psychological interventions for self-harm which specifically target university students (Barnett et al. 2021).

Literature suggests that rates of help-seeking in the general population increase to around 66% when friends and family are included as sources of support (Rowe et al. 2014). It is worth noting that university students are in a unique situation whereby they have often relocated to a new area with no social connections or support systems in place. Accessing support from friends and particularly family may therefore be harder for university students. There is limited research on whether students typically seek support for self-harm from their loved ones, however, there is some data to suggest that friends and family can play a role in self-harm cessation for students (Gelinas and Wright 2013).

Digital interventions offer an option for self-harm support which might be particularly appealing for students. It is estimated that around 99% of students own a smartphone, so smartphone applications (apps) offer a very accessible option (Seilhamer et al. 2018). Social media has also been explored as a viable source of support for individuals who self-harm. Developing connections and forming communities online with others who share similar experiences has been found to have therapeutic benefits (Lavis and Winter 2020). Specific benefits include feeling less isolated, the option of anonymity, easier disclosure online, and sharing self-harm cessation strategies (Coulson, Bullock, and Rodham 2017). Overall, research has shown that digital interventions for self-harm have been effective in clinical and community samples (Cliffe et al. 2021) however, research is yet to investigate the effectiveness of digital interventions for self-harm with university students specifically.

Self-harm is a significant concern at universities, yet support for students who self-harm is drastically understudied. To understand the roles and effectiveness of different self-harm interventions for university students, an essential first step is to investigate what forms of interventions/support students would like. In accordance with the 'nothing about us without us' principle, it is important to seek input from the population in question to understand their needs (McDonagh and Bateman 2012). This also applies to the design of the interventions themselves, with co-design/co-production being crucial for ensuring that they are acceptability to end users (Steen, Manschot, and Koning 2011). Similarly, a reduction in self-harm frequency is typically used as an indicator of the success of self-harm interventions within research. However, feedback from people who self-harm implies that reducing self-harm may not be the most appropriate aim as this does not account for other factors, such as the severity of each self-harm episode increasing or any other self-destructive behaviours that may have replaced the self-harm (Owens et al. 2020). It is therefore important to establish what aims of interventions students think are most worthwhile, and would therefore most accurately indicate the success of an intervention for students struggling with self-harm.

The aims of this research were therefore to:

(1) Explore students' opinions on the acceptability of different interventions for self-harm.
(2) Understand what aims of interventions students find the most beneficial.

Methods

This study received approval from the Research Ethics Approval Committee for Health [EP 19/20 015]. All participants provided informed written consent prior to the interview taking place, and also provided verbal consent during the interview.

Participants

Participants were students from one UK university with past or current experience of self-harm thoughts or behaviours. Participants were recruited via social media posts and posters around campus. Students interested in participating were directed to an online information sheet with space to enter their university email address to register interest. They were then contacted by the researcher and sent an online consent form and questionnaires, and an interview was arranged.

Interviews

Audio-only interviews were conducted virtually using Microsoft Teams software due to the COVID-19 pandemic. Interviews took place during lockdown in October and November of 2020 and lasted between 17 and 68 minutes, with an average of 29 minutes. All interviews were conducted by a single researcher. Students attending a virtual interview were asked to join without video in the interest of confidentiality, and interviews were recorded using the inbuilt functionality of Microsoft Teams. The interviews were semi-structured with questions focusing on students' experiences of and preferences for different self-harm interventions, including digital interventions. Some questions assessed how students would want interventions to help and how they would determine if they were effective. The interview schedule was designed to begin with a broad focus so as not to guide participants. They were therefore first encouraged to discuss their opinions on any sources of support that they had received or would consider receiving. They were later asked their opinions on using technology-based sources of support. Initial questions were open-ended, and follow-up questions were used to probe further and/or to clarify responses. Responses were often repeated back to participants to check meaning and to check that their opinions had been accurately captured.

Measures

In order to ascertain an understanding of the sample, demographic and mental health measures were administered.

Anxiety

Symptoms of anxiety were measured using the General Anxiety Disorder-7 (GAD-7) (Spitzer et al. 2006) which is a 7-item measure assessing how often participants have been experiencing symptoms of anxiety over the past two weeks. Ratings are on a 4-point Likert scale ranging from not at all (0) to nearly every day (3), with a possible total score of 21. A score of 10 is recommended as a cut-off value for identifying those experiencing moderate symptoms of anxiety.

Depression

Symptoms of depression were assessed using the Patient Health Questionnaire-9 (PHQ-9) (Kroenke, Spitzer, and Williams 2001), which is a 9-item measure assessing how often participants have been experiencing certain symptoms of depression over the past two weeks. Ratings are on a 4-point Likert scale ranging from not at all (0) to nearly every day (3), with a possible total score of 27. A score of 10 is recommended as a cut-off value for identifying those experiencing moderate symptoms of depression.

Eating disorders

Symptoms of an eating disorder were measured using the SCOFF (Morgan, Reid, and Lacey 1999), which is a 5-item questionnaire assessing the presence of symptoms of bulimia and anorexia. Participants are asked to answer 'yes' or 'no' to each item, with two or more 'yes' indicating symptoms of a possible eating disorder.

Borderline personality disorder (BPD)

The McLean Screening Instrument for borderline personality disorder (MSI-BPD) (Zanarini et al. 2003) is a 10-item questionnaire assessing symptoms of BPD. Participants are asked to answer 'yes' or 'no', with seven or more 'yes' answers indicating possible BPD.

Self-harm

Self-harm was assessed using the Alexian Brothers Urge to Self-Injure Scale (ABUSI) (Washburn et al. 2010) and Inventory of Statements about Self-harm (ISAS) (Klonsky and Glenn 2009). The ABUSI is a 5-item scale used to measure the frequency and severity of self-harm urges over the last week. Each question is rated on a 6-point Likert scale with a possible total score of 30 with higher scores indicating greater urges to self-harm. The ISAS contains two sections, one assessing characteristics of self-harm behaviours, and one assessing the functions of self-harm. The characteristics of self-harm assessed include lifetime frequency of self-harm, main form of self-harm, experience of pain during self-harm time elapsed between the urge and the behaviour, and desire to stop self-harm. The functions list assesses the following: affect regulation, interpersonal boundaries, self-punishment, self-care, anti-suicide, anti-dissociation, sensation-seeking, peer-bonding, interpersonal influence, toughness, marking distress, revenge and autonomy. Each individual function is rated on a 3-point scale ranging from not relevant (0) to very relevant (2). Each function subscale has a possible total score of 6 with a higher score indicating a greater relevance of that subscale.

Data analysis

Interviews were transcribed verbatim by the researcher who conducted the interviews, and an inductive, reflexive thematic analysis was undertaken in accordance with Braun and Clarke's six phases of thematic analysis: (1) familiarise self with the data; (2) generate initial codes; (3) search for themes; (4) review themes; (5) define themes; (6) write-up findings. The researcher first immersed themselves in the data by manually transcribing the data, checking transcriptions against audio files for accuracy, and reading and re-reading transcripts. Initial thoughts about the data were also noted at this point. The transcripts were then re-read and codes were generated from the data. All codes were

collated and organised into potential themes. This was an iterative process where codes were re-organised until the researcher felt that the themes were an accurate representation of the data, and a thematic map was created. Themes were reviewed in the next stage, where the transcripts were read again to ensure that the meanings within the data were captured. Themes were then named and summarised. Detailed notes and records were kept during all stages of the process. All stages of the thematic analysis were undertaken independently by a single researcher.

Results

Demographics

A total of 25 students attended virtual interviews. Participants were mostly undergraduate students (21/25, 84%) in their second (9/21, 43%) or first year (8/21, 38%). They were aged between 18 and 31 (M = 20.6, SD = 3.2) and were predominantly female (20/25, 80%), with one participant identifying as non-binary. Participants mostly described their ethnicity as white (20/25, 80%), with four identifying as Asian/Asian British (16%) and one as having mixed ethnicity (4%). Just over half of participants were heterosexual (14/25, 56%), nine were bisexual (36%), one identified as gay/lesbian (4%) and one as queer (4%).

Mental health symptomatology

84% of participants (21/25) met the threshold on at least one measure, suggesting a possible mental health issue. Just under half (12/25, 48%) of participants met the suggested clinical cut-off for moderate symptoms of anxiety, scoring 10 or higher on the GAD-7 (Spitzer et al. 2006). Similarly, 16 (64%) participants met the suggested clinical cut-off for moderate symptoms of depression, scoring 10 + on the PHQ-9 (Kroenke, Spitzer, and Williams 2001). Around a third of participants (8/25, 32%) met the suggested clinical cut-off for a suspected eating disorder, scoring 2 + on the SCOFF (Morgan, Reid, and Lacey 1999). 52% (13/25) of participants met the suggested clinical cut-off for borderline personality disorder, scoring 7 + on the MSI-BPD (Zanarini et al. 2003).

Self-Harm

20 participants (80%) indicated that they had self-harmed in the past and five (20%) were currently self-harming. Participants' mean score on the ABUSI was 14.4 (SD = 5.7), out of a possible total score of 30 with higher scores indicating higher urges to self-harm; this score is much higher than has been found in community samples (M = 2.3, SD = 3.9) (Peckham and Johnson 2018) and slightly lower than that found in clinical samples (M = 18.02, SD = 8.45) (Washburn et al. 2010). It suggests that even those participants who no longer self-harmed still experienced considerable urges to self-harm. Of the participants who indicated that they had a main form of self-harm, cutting was listed by the majority (17/21, 81%), and the age that participants first harmed themselves ranged from 8 to 23 (M = 15, SD = 3). Participants mostly identified that they do feel pain during self-harm (15/25, 60%), the majority (23/25, 92%) self-harm when they are alone, and 72% (18/25) usually self-harm within one hour of first feeling the urge to

harm themselves. Scores on the ISAS functions subscales indicated that participants primarily used self-harm to regulate affect (M = 5, SD = 1.2) and to self-punish (M = 4.6, SD = 1.9), with possible scores ranging from 0 to 6.

Themes

Three key themes were identified (1) understanding self-harm (2) barriers to seeking support for self-harm, and (3) preferences in support for self-harm. The themes and their sub-themes are outlined below with evidential quotes. Please see Figure 1 for a thematic map.

Theme 1: understanding self-harm

In order to suggest how self-harm should be treated, most participants first discussed how they understood self-harm.

Sub-theme 1: self-harm is a way of coping. Just over half of participants (14/25, 56%) framed self-harm as a tool that they actively used to cope with issues they were experiencing:

> I know it might be different for other people, but for me it's always been to cope with overwhelming feelings, or feeling really, really crappy or like, certain life stresses, or whatever's going on, just sort of coping [06]

Participants emphasised that self-harm was not the dominant issue, but rather a response to a different issue they were experiencing (11/25, 44%) 'I don't think that self-harm is the problem, I understand it's a problem but it's not the problem, there's always a reason that it happens' [02]. It was described as the effect rather than the cause, and the other difficulties of which self-harm was identified as a response to included loneliness, low mood, anxiety, panic, borderline personality disorder, a lack of self-worth, feeling overwhelmed and feeling empty. Participants also described using self-harm to manage suicidal thoughts and saw self-harming 'as an alternative to doing something worse' [13]. It therefore seemed as though self-harm was not an isolated issue, instead serving as a mechanism through which to manage challenging feelings or situations.

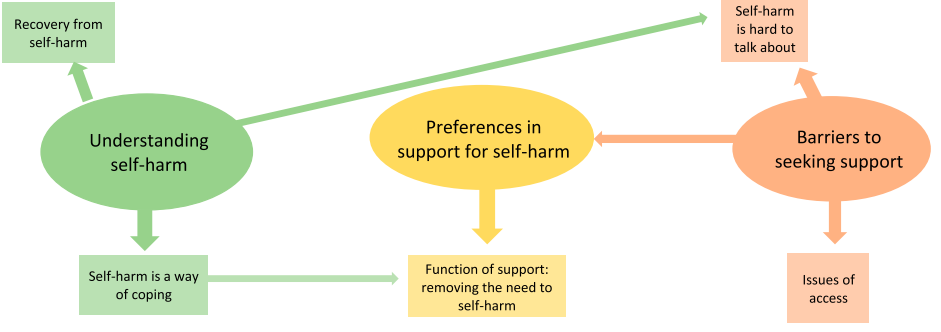

Figure 1. Thematic Map.

Finally, one participant described self-harm as offering them a way of coping when they were otherwise unable to communicate their distress, 'I resorted to self-harm more when I didn't feel able to ask for help … for me definitely self-harm has been my way of asking for help when I can't physically ask for it' [28]. For this individual, self-harm enabled them to cope by serving a communicative function that enabled them to indicate that they needed support without having to verbally ask for it.

Sub-theme 2: understanding recovery from self-harm. Around a third of participants (8/25, 32%) emphasised that recovery from self-harm can be difficult as it is not a linear process, rather it is gradual and changeable. Recovery not being an instant process was highlighted as a challenge as it can be disappointing for those who are starting on the path to recovery and are experiencing setbacks. One participant also commented that the notion of self-harm is not something that necessarily disappears over time:

> for a lot of people anyway it's kind of like a lifelong thing, like I haven't self-harmed in almost like. 10 years now I think, but it's something I think about … several times a week, and if I'm having a bad time it'll be several times a day, so it's still something that just sits on my shoulder [18].

While participants highlighted the role of self-harm in helping them to cope with other difficulties they face, they also discussed becoming too reliant on using self-harm in this way, with around a third (8/25, 32%) describing it as a form of addiction:

> I've always kind of thought of it in terms of an addiction … I think it becomes a bit of a crutch, you sort of rely on that like adrenaline rush and things to kind of, get you through a bad moment, and then the moments that you need that little boost to get through become more and more frequent [18]

In this way, what began as a way of coping with distress escalated into a habitual or compulsive cycle that is hard to escape. This addictive element was also reflected in the language used around self-harm mirroring that typical of addition, such as being 'clean' from self-harm or having 'relapsed'.

Theme 2: barriers to seeking support

When asked about seeking support, the majority of participants expressed that it is something that they did/do not feel able to do for a variety of reasons.

Sub-theme 1: issues of access. Practical issues regarding difficulties accessing support were reported by over half of participants (15/25, 60%). They highlighted uncertainties regarding where or how to get support, and that this was particularly difficult at university as everything is new, unknown and unfamiliar.

> I think it's different if you're, you know, just starting university and you don't particularly know the services and, everything's new like it's a new city and maybe you don't know as much about the mental health service and, you know, where to access the support [06]

This was also true of online and digital support, with some participants (6/15, 40%) commenting that they were unsure what was available or how to access it. Long waiting lists and the NHS being 'really massively underfunded' [28] were also mentioned (6/15, 40%), which tied in with one participant feeling guilty about seeking support as

they felt that they were potentially 'taking up time that could be used on people who might need it more' [18]. Similarly, strains on services had also led to two participants having been turned away due to their self-harm not being perceived as severe enough to qualify for support. One participant commented how they had considered escalating their self-harm in order to be able to receive support:

> the reasons I've thought about self-harming severely has actually been because I thought that would help me get help, because on the NHS it felt like if I tried to kill myself even though I didn't want to kill myself, or I self-harmed really badly then they might pay attention and say 'oh she's actually got something wrong with her', because that's the kind of attitude they have it's like 'oh if you do then we'll give you attention', whereas if you don't do anything and you're not dead yet, then they don't really, they're like 'oh it's not that urgent, it's not that important'. [28]

This showed that even participants who did want to seek support still were unable to.

Sub-theme 2: self-harm is hard to talk about. Around half (12/25, 48%) of participants described self-harm as a very private and secretive act that they were reluctant to share with others, 'you are doing a private thing, it's a horrible thing, but it is a private thing' [14]. Reasons cited for the privacy and secrecy surrounding self-harm centred around the negative stigma attached to it, the self-judgement, shame and embarrassment that participants felt, and how self-harm is perceived as more 'severe' than other mental health issues; participants highlighted being able to disclose other mental health difficulties, including suicidal thoughts, yet were unable to discuss self-harm.

> I was ok talking about suicidal thoughts and things but not to admit that I was self-harming, I actually felt quite guilty, so I think it's quite a hard thing to directly reach out about. [19]

Consequently, the privacy and secrecy surrounding self-harm was commonly listed as a notable barrier that prevented them from seeking help (16/25, 64%):

> Firstly, I couldn't explain what was going on and I was judging myself, and then that meant that I wasn't able to tell someone, I wasn't able to ask who I tell, that sort of thing. It was all like a game of secrecy, I don't want people to know that this is how I feel [02]

Another reason that some participants (11/25, 44%) discussed finding self-harm difficult to disclose was due to the fear of receiving a negative response. One participant discussed how 'there's still very much like a shock factor to people who are self-harming … and that didn't really help me' [10]. Similarly, one participant commented how they thought that self-harm was perceived by others as 'the ugly bit of mental health' and how it makes people 'uncomfortable' [28]. Concerns around being dismissed were also voiced:

> family members that don't understand it, they are more dismissive of it, and in that sense if you're more dismissive and you're just like, 'Stop, why are you doing that? That's stupid', that makes it worse [32]

However, participants were not only concerned about receiving a negative response, but also eliciting one; around a third of participants (8/25, 32%) highlighted the impact that disclosing self-harm can have on loved ones. In particular, participants expressed feeling a lot of guilt around the impact of their self-harming, feeling like a burden, and

fearing disappointing loved ones. This seemed to be specific to self-harm as some participants noted feeling able to be open about other mental health issues:

> I find that (self-harm) the hardest thing to talk about. I mean they (family and friends) know about mental health issues that I have, but never to that extent … I feel a lot of guilt to admit that I'm physically hurting myself, I can't do that to people I care about. [19]

> I'm open with my friends that I have anxiety and I take medication for it and stuff like that, but I would never burden them with something so severe [17]

Theme 3: preferences for support

Participants were mixed in whether they had considered or would consider seeking support, with around a quarter expressing that they would not (6/25, 24%). Some (3/25, 12%) tentatively said that they may be able to or have been able to seek support with encouragement from friends or family:

> if I felt like I wasn't in any immediate danger then I probably wouldn't seek help, but if I felt that I was in a position where it was quite serious, I probably would hopefully tell somebody and perhaps get them to help me seek help, I don't think I'd be able to do it on my own [04]

Because of this, participants preferences over what support that wanted to receive was often hypothetical. Nonetheless, there were varied preferences expressed with regards to the form of support they preferred, how they wanted it to help and what they wanted the outcomes of support to be.

Benefits to online support were identified by most participants (21/25, 84%). Among these, the anonymity was highlighted (8/21, 38%) as something that allowed participants to be more open and free to express themselves, in particular 'there are things you can say online that you won't say in person' [26], while face-to-face support can make people feel 'more self-conscious and less willing to like, share I suppose' [24]. Further, one participant discussed how digital support can be more protective, as it is less 'exposed' and 'it gives you like, a shield almost' [03]. Some (9/21, 43%) mentioned how online support is more accessible and can be accessed immediately anytime and anywhere. As discussed earlier, the difficulties around disclosing self-harm were highlighted as a key barrier to seeking support. Following this, some participants identified that a benefit to technology-based support was that it did not involve sharing their self-harm with a stranger, alongside several other benefits:

> for some people at least, I guess the kind of idea that you don't have to open up to some random person would be somewhat helpful, you know if you're in a crisis situation, the fact that it's (smartphone apps) sort of, it feels much more anonymous if people are sort of, embarrassed or reserved about it. I guess it can be done anytime anywhere, you don't have to wait in a queue for someone, it's just always there. And I guess it's always on you as well, cos you always have your phone on you [16]

Conversely, some (10/25, 40%) felt that digital tools such as apps can be 'impersonal' [16] as they lack the human connection that can be found through professional support. Following this, mental health services provided by the university was the most commonly cited source of support that students had used or would consider using (15/25, 60%), and some participants (10/25, 40%) expressed a definite preference for receiving professional, face-to-face support:

> I'd prefer to see a real-life kind of person, it's just kind of, it's like, speaking to a person is very different than speaking to a person through technology, it's like different interactions and it just feels like more of a connection when it's real life versus using technology [10]

One of the reasons mentioned (4/10, 40%) for preferring face-to-face was how this seemed to facilitate conversations with non-verbal cues:

> I think gauging someone's reaction or like just having a real flowing conversation, um, is quite nice, plus it's like a sensitive topic I guess so it's nice to have someone look like they're listening, if you're at the stage where you can talk about it, it's nice to have that. [03]

As highlighted previously, worries about burdening loved ones was identified as a barrier to seeking informal support or disclosing self-harm to friends and family. Because of this, some participants (3/10, 30%) also mentioned how it was easier to seek professional support as it is 'their job' so it feels less burdensome. For example, one participant commented:

> I'd rather talk to someone who's like, a professional where it's like their job to deal with it rather than a friend as it can be a big deal thing for them [15].

Just over a third of participants (9/25, 36%) mentioned friends and family as a source of support they would definitely not use. However, for around a quarter of participants (6/25, 24%), loved ones were an important source of support, but it was noted that there is a limit to how much can be shared with them due to the impact that it can have, as explored above:

> I think it's really important to talk to your friends and family … also talking to your friends and family can be difficult as well cos, for me anyway I feel like there's a sort of limit, like obviously it's important to be open about what you're thinking and feeling and stuff but to sort of delve down into those really dark thoughts and stuff, it can be quite difficult, so I feel like, if I'm speaking to them about it, I'm sort of masking certain sides of it cos I don't want it to be sort of too much [06].

Sub-theme 1: function of support: removing the need to self-harm. In theme one it was identified that participants saw self-harm as a coping mechanism. Following this, many participants (17/25, 68%) endorsed wanting support to help them learn other coping strategies for regulating emotions or managing stressful life events, so they did not have to rely on self-harm:

> I think the most positive outcome would be to be able to learn skills, you know like, you can use instead of self-harm, so other coping mechanisms … ultimately it's just about learning how to regulate those really intense, stressful emotions or life events if they come up, in like, a more healthier way [06]

Similarly, as participants did rely on self-harm to cope, it then follows that several (11/25, 44%) highlighted that support that prioritises stopping the self-harm, as opposed to targeting what causes it, is an unhelpful strategy:

> There's no point in counter-acting just the self-harm, you need to counter act the thing that caused it and often self-harm may be scary, it may be horrible, it may affect the person quite a lot, but what's affecting that person more is that initial thing that's making them self-harm. [02]

Of those participants, some (7/11, 64%) elaborated that focussing on self-harm and neglecting the underlying issue could mean that the self-harming behaviour may indeed stop, but 'another destructive behaviour will just take its place if you don't solve the issue' [16].

Similarly, it was highlighted that the most important function of support is to help the individual 'feel better' by addressing the underlying issues, and that even if the self-harming behaviours remain, this does not necessarily indicate that their wellbeing is not improving:

> just relying on instances of self-harm is not the full picture … if the feelings behind it that trigger self-harm, if that's like, feeling worthless, if that person is still not valuing their body or their self, then the core kind of, underlying the behaviour hasn't changed at all, so then it's quite likely that that person has just switched that behaviour into something else [18]

It was clear that participants did not value support that ignored the reasons why they were self-harming and instead prioritised stopping the behaviour. As self-harm for some was identified as a way of coping with difficult feelings, including suicidal thoughts, it follows that removing this behaviour with no other coping mechanisms in place not only overlooks the individual's needs, but could also cause harm.

Discussion

This study sought to understand university students' opinions on support for self-harm, including digital interventions.

Self-harm was understood as a tool for coping with difficult thoughts and feelings. This resonates with research that has identified a link between self-harm and low ability to cope with emotions among university students (Midkiff et al. 2018). Following this, participants discussed wanting interventions to help them learn other coping mechanisms so they did not have to resort to self-harm. Indeed, Gelinas and Wright (2013) found that students were able to stop self-harming when they had successfully developed other coping mechanisms that they could use instead. Participants did not believe that interventions should focus on simply stopping self-harm behaviour as this would leave them unable to cope, which could mean that other self-destructive behaviours may take its place. Gelinas and Wright (2013) also supported this finding, with university students having cited turning to other negative coping behaviours such as taking drugs as a reason they were able to stop self-harming. This endorses Owens et al's research (2020) that identified how relying on a reduction in self-harm will not necessarily give a complete understanding of the individual's recovery. This is something to be mindful of when interpreting a reduction in self-harm episodes as an indicator of improvement. From this, it can be concluded that more varied and nuanced ways of measuring recovery from self-harm are warranted, for example coping self-efficacy or general mental wellbeing.

Self-harm was discussed as being a private and secretive act, which is a concept that has been widely endorsed by research (Chandler 2018; Lloyd, Blazely, and Phillips 2018). This feeds in to self-harm being a difficult subject to discuss, and therefore why individuals who self-harm may find it difficult to seek support (McManus and Gunnell 2019). This was

also highlighted in the present study, with the challenges of disclosing self-harm being a significant barrier for individuals in seeking support. Fearing a negative response upon disclosure also reinforced participants' need to keep self-harm private. These concerns have been identified by others, with young people in one study highlighting how stigmatising and unsupportive responses from emergency department staff had deterred future help-seeking (Byrne et al. 2021).

Participants had clear preferences about what support they would like to receive and, for some, the secrecy, shame and privacy around self-harm seemed to dictate these decisions. Some participants noted a preference for in-person professional support noting the importance of the trust and connection that can develop, and the non-verbal cues that some believed to be important tenets of an intervention. Contrastingly, the majority of participants identified benefits to online support, including anonymity and convenience. They noted that they felt less inhibited and exposed using a digital intervention, whereas in-person support made them feel more self-conscious. Importantly, some expressed that their difficulty seeking professional support was specific to self-harm as they were able to seek support for other mental health difficulties, including suicidal thoughts. This is consistent with what other researchers have evidenced, where 52% of university students who were self-harming were attending therapy, but only 8.9% of those reported discussing self-harm with their mental health professional (Whitlock, Eckenrode, and Silverman 2006). Similarly, among the current sample, some participants noted how they would comfortably discuss other mental health difficulties with friends and family but would not go as far as to discuss something so 'severe' as self-harm. However, this is in contrast to a body literature suggesting that friends and family are typically a preferred source of support for self-harm (Fortune, Sinclair, and Hawton 2008; Nada-Raja, Morrison, and Skegg 2003; Nixon, Cloutier, and Jansson 2008; Rossow and Wichstrøm 2010; Rowe et al. 2014; Ystgaard et al. 2009). As most of this research comes from adolescents, it may be that older individuals, such as university students, are more detached from their families and previous social networks.

Limitations

As this study was advertised as seeking to understand students' opinions on different interventions and sources of support for self-harm, the sample may have been biased in several ways. Firstly, it may be that participants were those who felt more able to be open and discuss their self-harm. Indeed, most participants identified themselves as not currently experiencing self-harm thoughts or behaviours, indicating that perhaps it was largely participants who had some distance from their struggle with self-harm and were therefore more able to discuss it. Secondly, it may have been biased in that it attracted those who had notable experience of seeking or receiving support for self-harm that they wanted to share. Because of this, these findings may not be representative of other students experiencing self-harm who did not participate. Similarly, participants were only recruited from one university site, so the findings may not be representative of students' experiences at other universities. Finally, while non-heterosexual students were widely represented in this study, participants were mostly Caucasian females with high levels of mental ill health symptomatology, meaning findings cannot be generalised outside of this population.

Conclusion

This study identified the heterogeneity around students' preferences for support for self-harm. Despite this, there was general agreement on several things, such as the secrecy, shame and stigma surrounding self-harm and the associated difficulties faced in disclosing and discussing self-harm. This was one of several barriers identified that students faced when seeking or considering seeking support. Participants highlighted the importance of providing a variety options so that more students who struggle with self-harm have a resource that they would feel comfortable accessing. This would hopefully help to increase the extremely low rates of help-seeking among this population, meaning that the 80% of students who currently do not ask for help for self-harm will eventually be able to.

Finally, students also agreed that relying on a reduction in self-harm to indicate success of an intervention may not be a reliable method, given the propensity for the behaviour to be replaced by something equally self-destructive or harmful. Because of this, they urged consideration of other factors, such as general wellbeing and the presence of alternative coping mechanisms.

Acknowledgements

The authors would like to thank all participants for their contributions.

Disclosure statement

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

ORCID

Bethany Cliffe http://orcid.org/0000-0002-0520-3726
Paul Stallard http://orcid.org/0000-0001-8046-0784

References

Barnett, P., L.-L. Arundell, R. Saunders, H. Matthews, and S. Pilling. 2021. "The Efficacy of Psychological Interventions for the Prevention and Treatment of Mental Health Disorders in University Students: A Systematic Review and Meta-Analysis." *Journal of Affective Disorders* 280: 381–406.

Byrne, S. J., I. Bellairs-Walsh, S. M. Rice, S. Bendall, M. Lamblin, E. Boubis, B. McGregor, M. O'Keefe, and J. Robinson. 2021. "A Qualitative Account of Young People's Experiences Seeking Care from Emergency Departments for Self-Harm." *International Journal of Environmental Research and Public Health* 18 (6): 2892.

Chandler, A. 2018. "Seeking Secrecy: A Qualitative Study of Younger Adolescents' Accounts of Self-Harm." *YOUNG* 26 (4): 313–331.

Cliffe, B., J. Tingley, I. Greenhalgh, and P. Stallard. 2021. "mHealth Interventions for Self-Harm: Scoping Review." *Journal of Medical Internet Research* 23 (4): e25140.

Coulson, N. S., E. Bullock, and K. Rodham. 2017. "Exploring the Therapeutic Affordances of Self-Harm Online Support Communities: An Online Survey of Members." *JMIR Mental Health* 4 (4): e44.

Fitzgerald, J., and C. Curtis. 2017. "Non-suicidal Self-Injury in a New Zealand Student Population: Demographic and Self-Harm Characteristics." *New Zealand Journal of Psychology* 46 (3): 156–163.

Fortune, S., J. Sinclair, and K. Hawton. 2008. "Help-seeking Before and After Episodes of Self-Harm: A Descriptive Study in School Pupils in England." *BMC Public Health* 8 (1): 369.
Gelinas, B. L., and K. D. Wright. 2013. "The Cessation of Deliberate Self-Harm in a University Sample: The Reasons, Barriers, and Strategies Involved." *Archives of Suicide Research* 17 (4): 373–386.
Hawton, K., K. G. Witt, T. L. T. Salisbury, E. Arensman, D. Gunnell, P. Hazell, E. Townsend, and K. van Heeringen. 2016. "Psychosocial Interventions Following Self-Harm in Adults: A Systematic Review and Meta-Analysis." *The Lancet Psychiatry* 3 (8): 740–750.
Hawton, K., K. G. Witt, T. L. Taylor Salisbury, E. Arensman, D. Gunnell, P. Hazell, E. Townsend, and K. van Heeringen. 2015. "Pharmacological Interventions for Self-Harm in Adults." *Cochrane Database of Systematic Reviews*.
Klonsky, E. D., and C. R. Glenn. 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.
Kroenke, K., R. L. Spitzer, and J. B. W. Williams. 2001. "The PHQ-9." *Journal of General Internal Medicine* 16 (9): 606–613.
Lavis, A., and R. Winter. 2020. "#Online Harms or Benefits? An Ethnographic Analysis of the Positives and Negatives of Peer-Support Around Self-Harm on Social Media." *Journal of Child Psychology and Psychiatry* 61 (8): 842–854.
Lloyd, B., A. Blazely, and L. Phillips. 2018. "Stigma Towards Individuals who Self Harm: Impact of Gender and Disclosure." *Journal of Public Mental Health* 17 (4): 184–194.
McDonagh, J. E., and B. Bateman. 2012. "'Nothing About us Without us': Considerations for Research Involving Young People." *Archives of Disease in Childhood - Education and Practice* 97 (2): 55–60.
McManus, S., and D. Gunnell. 2019. "Trends in Mental Health, non-Suicidal Self-Harm and Suicide Attempts in 16–24-Year old Students and non-Students in England, 2000–2014." *Social Psychiatry and Psychiatric Epidemiology* 55: 125–128.
Midkiff, M. F., C. R. Lindsey, E. A. Meadows, and L. Cerniglia. 2018. "The Role of Coping Self-Efficacy in Emotion Regulation and Frequency of NSSI in Young Adult College Students." *Cogent Psychology* 5 (1): 1520437.
Morgan, J. F., F. Reid, and J. H. Lacey. 1999. "The SCOFF Questionnaire: Assessment of a new Screening Tool for Eating Disorders." *BMJ* 319 (7223): 1467–1468.
Nada-Raja, S., D. Morrison, and K. Skegg. 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.
NICE. 2013. *Self-Harm* (Quality Standard). https://www.nice.org.uk/guidance/qs34/resources/selfharm-2098606243525.
Nixon, M. K., P. Cloutier, and S. M. Jansson. 2008. "Nonsuicidal Self-Harm in Youth: A Population-Based Survey." *CMAJ : Canadian Medical Association Journal* 178 (3): 306–312.
Owens, C., F. Fox, S. Redwood, R. Davies, L. Foote, N. Salisbury, S. Williams, L. Biddle, and K. Thomas. 2020. "Measuring Outcomes in Trials of Interventions for People who Self-Harm: Qualitative Study of Service Users' Views." *BJPsych Open* 6 (2).
Peckham, A. D., and S. L. Johnson. 2018. "Cognitive Control Training for Emotion-Related Impulsivity." *Behaviour Research and Therapy* 105: 17–26.
Rossow, I., and L. Wichstrøm. 2010. "Receipt of Help After Deliberate Self-Harm among Adolescents: Changes Over an Eight-Year Period." *Psychiatric Services (Washington, D.C.)* 61 (8): 783–787.
Rowe, S. L., R. S. French, C. Henderson, D. Ougrin, M. Slade, and P. Moran. 2014. "Help-seeking Behaviour and Adolescent Self-Harm: A Systematic Review." *Australian & New Zealand Journal of Psychiatry* 48 (12): 1083–1095.
Seilhamer, R., B. Chen, S. Bauer, A. Salter, and L. Bennett. 2018. *Changing Mobile Learning Practices: A Multiyear Study 2012*–2016. https://er.educause.edu/articles/2018/4/changing-mobile-learning-practices-a-multiyear-study-2012-2016.
Sivertsen, B., M. Hysing, M. Knapstad, A. G. Harvey, A. Reneflot, K. J. Lønning, and R. C. O'Connor. 2019. "Suicide Attempts and non-Suicidal Self-Harm among University Students: Prevalence Study." *BJPsych Open* 5 (2).
Spitzer, R. L., K. Kroenke, J. B. W. Williams, and B. Löwe. 2006. "A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7." *Archives of Internal Medicine* 166 (10): 1092.

Stallman, H. M. 2010. "Psychological Distress in University Students: A Comparison with General Population Data." *Australian Psychologist* 45 (4): 249–257.

Steen, M., M. Manschot, and N. D. Koning. 2011. "Benefits of co-Design in Service Design Projects." *International Journal of Design* 5 (2): 53–60.

Swannell, S. V., G. E. Martin, A. Page, P. Hasking, and N. J. S. John. 2014. "Prevalence of Nonsuicidal Self-Injury in Nonclinical Samples: Systematic Review, Meta-Analysis and Meta-Regression." *Suicide and Life-Threatening Behavior* 44 (3): 273–303.

Taliaferro, L. A., and J. J. Muehlenkamp. 2015. "Risk Factors Associated With Self-Injurious Behavior Among a National Sample of Undergraduate College Students." *Journal of American College Health* 63 (1): 40–48.

Washburn, J. J., K. R. Juzwin, D. M. Styer, and D. Aldridge. 2010. "Measuring the Urge to Self-Injure: Preliminary Data from a Clinical Sample." *Psychiatry Research* 178 (3): 540–544.

Whitlock, J., J. Eckenrode, and D. Silverman. 2006. "Self-injurious Behaviors in a College Population." *Pediatrics* 117 (6): 1939–1948.

Ystgaard, M., E. Arensman, K. Hawton, N. Madge, K. van Heeringen, A. Hewitt, E. J. de Wilde, D. De Leo, and S. Fekete. 2009. "Deliberate Self-Harm in Adolescents: Comparison Between Those who Receive Help Following Self-Harm and Those who do not." *Journal of Adolescence* 32 (4): 875–891.

Zanarini, M. C., A. A. Vujanovic, E. A. Parachini, J. L. Boulanger, F. R. Frankenburg, and J. Hennen. 2003. "A Screening Measure for BPD: The McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD)." *Journal of Personality Disorders* 17 (6): 568–573.