THE LIVED EXPERIENCES OF FEMALES IN MID-ADOLESCENCE WHO USE SOCIAL MEDIA IN RELATION TO SELF-HARM

Lucy Brett-Taylor

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ABSRACT

Social media use and self-harm prevalence are both highest among young people. Many explanatory models of self-harm have been proposed which are helpful in understanding the functions self-harm serve. Social media is a relatively new phenomenon requiring further research to increase understanding of the psychological processes associated with its use. The connection between self-harm and social media has received increased media attention in recent years and is of clinical and social importance. The current study intended to increase

the understanding of the connection between the two phenomena. Seven females in mid-adolescence accessing a DBT service were interviewed about their use of social media in relation to self-harm. Their interviews were analysed using Interpretative Phenomenological Analysis (IPA). Data analysis led to the identification of four super-ordinate themes, extension of everyday social media use, unexpected pitfalls; expected benefits and misunderstandings: “unless you’re part of it, you wouldn’t understand it”. The findings suggest that social media is used in a number of ways in relation to self-harm and its use is frequently an extension of the way young people use social media more generally. This is influenced by many factors. Its use can lead to pitfalls and benefits and navigating between the two is difficult and can be misunderstood by others. The consideration of the findings in relation to the wider research context has increased knowledge about the use of social media in relation to self-harm within this population. Clinical implications and recommendations for future research are suggested.

1. INTRODUCTION

How young people use social media in relation to self-harm and to what effect is an important psychological, social and clinical issue. The use of social media amongst young people in the general population and those who access mental health services is widespread. Social media is a relatively new phenomenon in need of further research to increase understanding about how it is interacted with psychologically and to what effect. Young people use social media for a wide variety of functions. These range from everyday connection with friends and seeking support, which can have positive and supportive effects to others

functions such as posting and viewing graphic images of self-harm, which can have negative and harmful effects. Social media use has received a great deal of media coverage. ‘Cyber self-harm’ has been identified as a new phenomenon exacerbated by social media. Media attention has often focused on the tragic stories of young people who have ended their lives and who used social media. Understandable concern exists amongst clinicians who work with young people, parents and wider society, including young people themselves, about the risks associated with the role social media plays in young people’s lives. However, there also exist many positive aspects to utilising social media. This research aims to explore the views of young people who use social media to expand understanding and knowledge about how and why they use it in relation to self-harm and to what effect. The introduction will present the current context; explore and introduce explanatory models and theories of self-harm and an associated diagnostic label; consider perceptions of young people and the role of development and neurobiology; connect these areas with and present explanations for the use and effects of using technology and social media; and review the relevant research.

1.1 The current context

1.1.1 Media coverage of self-harm and social media

Mass media portrayals of self-harm and social media have raised the profile of the issue in recent years, for example; “a troubled ballerina, addicted to the internet, shared photos of her own bleeding arms on grisly self-harm websites before killing herself” (Radnedge, 2014, p.1). Tallulah Wilson, aged 15, spent time on pages alleged to have promoted suicide posting pictures of her cutting

herself on Tumblr. Her Mother said that Tallulah felt loved by 18,000 people online. She sadly ended her life in 2012 by jumping in front of a train. Sasha Stedman, aged 16, also became preoccupied by self-harm images on social media sites and sadly died of what is described as an accidental heroin overdose in 2014 (Moore-Bridger, 2014). Hannah Smith was 14 years old when she ended her life in 2013 following harassment via the social media site Ask.fm, which on closer investigation came mostly from her own computer. The death of Tallulah Wilson and the association with social media led the government to intervene demanding more vigilant monitoring of social media sites. In 2012, Tumblr adhered to the governments demands (Tumblr, 2015; Hern, 2014).

1.1.2 Current guidance

The prominence and importance of the issue has led to the development of recent clinical guidance on how to respond to self-harm in relation to social media. The guidance states; “it is critical for professionals to include an assessment of a young person’s digital life as part of clinical assessments, especially when there are concerns about self-harm” (‘Managing self-harm in young people’ recommendation 13, Royal College of Psychiatrists, RCP, 2014 p. 23). Lewis, Heath, Michal and Duggan (2012) devised assessment guidance. The importance of understanding young peoples’ experiences of the differing content of, and connections with other users of, social media has been highlighted (RCP, 2014).

1.2 Literature search

The searches utilised the relevant University of East London databases through the Ebsco search engine. The databases used were PsychINFO, Academic

search complete and Communication. The following search terms were used and combined using AND in various groupings: self-harm, self-injury, self-injurious behaviour, cutting, social media, social network, internet, adolescents, young people, children and teens. In addition, relevant articles and books were included from the reference lists of the retrieved articles.

1.3 Self-harm

1.3.1 Definitions, functions and explanatory models of self-harm

Various terms are used interchangeably to describe self-harm including non-suicidal self-injury, self-mutilation and para-suicidal behaviour. Self-harm, the commonly used term in England, has been defined as behaviour an individual engages in which causes harm to their body and is performed without conscious intent to end one's life (Favazza, 1996). Self-harm can take various forms and typically occurs in private (Adler & Adler, 2011; Duggan & Whitlock, 2012). Some of the most common methods among young people include scratching, cutting, punching or banging objects or one self, biting and burning (Duggan & Whitlock, 2012). Self-harm can be non-suicidal, occur with suicidal intent, culminate in suicide or individuals may be ambivalent about whether they live or die (Hawton, Saunders & O'Connor, 2012). Evidence shows an increased risk of suicide in those with a history of self-harm (Hawton & Harris, 2007; Fortune, Stewart, Yadav, & Hawton, 2007). In this study a broad definition of self-harm was adopted in line with the service approach and Favazza's (1996) definition. This was to ensure inclusion with regard to methods of self-harm undertaken and to maintain an exploratory position rather than imposing a restrictive definition.

Psychological and medical research has conceptualised acts of self-harm as unsuccessful suicide attempts, as an attempt to manage negative emotions and cope with stress and a way to elicit care and attention (Whitlock, Powers & Eckenrode, 2006; Jacobson & Gould, 2007). Such explanations apply to some individuals however, functions are idiosyncratic, can change over time and can differ for each individual in different contexts.

A wide variety of functions have been reported by individuals who self-harm and relevant findings will now be outlined. 240 female participants from a community sample reported self-harm served as self-punishment, enabled relaxation and relieved feelings of depression and loneliness (Favazza & Contiero, 1989). Briere and Gill (1998) found functions chosen by 70% or more of the female sample again included self-punishment, stress and management, and in addition distraction and enhanced feelings of self-control (Briere & Gill, 1998). Klonsky & Muehlenkamp (2007) explained self-harm as a form of self-punishment for some in response to feelings of low self-regard.

Self-harm has been conceptualised as a form of self-soothing behaviour; an attempt to regulate unmanageable negative feelings felt prior to self-harming which temporarily become feelings of calm and comfort afterwards (Klonsky & Muehlenkamp, 2007). The physical pain is said to replace the emotional pain at least for a time. Self-harming can release stress, pressure and emotional pain and can be a form of communication to others therefore not only a secret behaviour (Hawton et al., 2006; Cormack, 2014a). It is thought feelings of calm and relief following self-harm could reinforce such behaviour and lead to a cycle of emotional pain, self-harm and relief (Gratz, 2007).

Emotional relief was deemed a principal function of self-harm by 96% of the women diagnosed with 'borderline personality disorder' ('BPD') in one sample (Brown, Comtois, & Linehan, 2002). Similarly, Gratz (2000) found 76% of participants reported the function of self-harm as emotional relief in a qualitative study asking open-ended questions. Rodham, Hawton and Evans (2004) found 73% of adolescents to report relief from a 'terrible' state of mind. In summary, the dominantly reported functions were avoiding or escaping unwanted internal experiences (Chapman, Gratz & Brown, 2006).

In their study on communication and the language used to describe self-harm online, Harvey and Brown (2012) reported that young people described self-harm as an addiction or compulsive behaviour over which they did not have control; an understanding which serves to locate responsibility and blame outside of the individual. Such a discourse is interesting and likely to be a response to prevalent but arguably now changing, opinions in British and North American societies and health services of self-harm as 'deliberate' or 'intentional' (Skegg, 2005). Prefixing the term self-harm with these words implies that one could refrain from doing so if one wished, arguably placing judgement and blame on those who self-harm (Allen, 2007).

Sociological explanations of why people self-harm look to the influence of increased media coverage, including films and magazines, on people starting to self-harm, learning from others via conversations or in institutions such as psychiatric hospitals (Adler & Adler, 2011). In recent history self-harm was considered to be associated with and more prevalent amongst certain alternative subcultures, for example 'Goth' or 'Emo' cultures (Young, Sweeting & West, 2006). Self-harm appeared to occur for sociological reasons and these groups

“were more driven by their connection to a music, style, or ideological movement” rather than the medical and psychological explanations cited above (Adler & Adler, 2011). Self-harm could also be a way for young people to bond with others and form friendships with others who self-harm (Klonsky & Muehlenkamp, 2007).

1.3.2 Explanatory models of self-harm

Many explanatory models of self-harm have been proposed. A range of different models will now be presented.

1.3.2.1 The behavioural four function model

This model posits that behaviours occur because of events which precede or follow them (Nock, 2010). From this view self-harming behaviour is maintained by differing processes of reinforcement. These differ depending on whether the reinforcement is positive or negative and whether the following event is intra- or interpersonal (Nock, 2010). For example, if self-harm is followed by a feeling of reduced anger the behaviour might be maintained by intrapersonal negative reinforcement. An example of interpersonal positive reinforcement might be if after self-harming one receives care and attention which then maintains the behaviour. Studies into self-reported reasons for self-harming reported findings consistent with this model (Brown et al., 2002; Lloyd-Richardson et al., 2007; Nock & Prinstein, 2004). However, this model does not account for why some experience negative thoughts and feelings which lead to self-harm.

1.3.2.2 Emotion regulation

Different theories of self-harm tend to agree that many individuals self-harm to manage, escape or avoid emotions (Brown et al., 2002).

1.3.2.2.1 Experiential avoidance model (EAM)

Chapman et al. (2006) proposed the EAM which posited self-harm to be "primarily maintained by negative reinforcement in the form of escape from, or avoidance of, unwanted emotional experiences" (p. 371). A vicious cycle is said to ensue whereby a process of habituation to the negative effect of self-harming and rule governed behaviour (for example "if I cut I will feel better") worsen the cycle leading self-harm to become an automatic, conditioned response to distress (Chapman et al., 2006).

1.3.2.3 Self-punishment

It is argued that people self-harm because, in addition to regulating feelings, the behaviour serves to punish them for perceived shortcomings or wrongdoing (Favazza, 1996). The self-punishment hypothesis states that emotional arousal is reduced through self-harm via a process of self-verification (Swann, Hixon, Stein-Seroussi, & Gilbert, 1990). Self-verification theory posits individuals behave in ways which match the beliefs they hold about themselves (Aronson & Mette, 1968). When one's beliefs are challenged unwanted feelings of anxiety can occur making one feel out of control. Anxiety is said to arise due to the individual's need to understand the world being prevented. Self-harming is deemed an attempt to reinstate control and predictability and when beliefs, such as punishment is deserved, are confirmed heightened emotions are reduced (Swann et al, 1990).

Commonly reported thoughts and feelings of self-hatred and anger towards the self (Nock et al., 2009) and higher reported amounts of self-criticism were found to precede self-harm (Glassman et al., 2007).

1.3.2.4 Response to and communication of trauma

Traumatic events and abuse in childhood are common amongst people who self-harm (Everett & Gallop, 2000; Vivekananda, 2000). Self-harm has been proposed as a way to manage memories of abuse and posited as the repetition, symbolisation and/or communication of abuse (van der Kolk, 1991). McAllister (2003) explained self-harm as a way of remembering experienced trauma through acting it out, 'telling without retelling' the abuse (Calof, 1995) and potentially doing so with a feeling of control that was not possible at the time of the abuse.

1.3.2.5 Psychodynamic

Self-harm has been explained from a psychodynamic perspective as self-directed anger, the externalisation and destruction of a persecutory object, as an effort to self-heal and as an alternative means of communication ([1]Favazza & Conterio, 1989; Fonagy, Gergely, Jurist & Target 2002). Psychodynamic theories have posited that "self-harm must be understood as having meaning within interpersonal and intrapsychic relationships" (Briggs, Lemma & Crouch, 2008 p. 1). Psychodynamic theorists have written of using one's body to express uncontained affect, say what is unspeakable and express dilemmas which are inexpressible (Davies, 1994; Grand, 2003).

1.3.2.6 Social learning theory and contagion

Much of what we do is learned from observing others and imitating their behaviour (Bandura, 1977). How peers behave can be influential in shaping

[1] Provide further discussion which is beyond the scope of this study

behaviours including self-harm in adolescence (Prinstein & Dodge, 2008). Media coverage and portrayals of self-harm can also influence young people's behaviour (Deliberto & Nock, 2008). Social learning theory can contribute to understandings of social contagion. Social contagion states through processes of reinforcement and modelling individuals observe and learn that self-harm is rewarded in some way and imitate it (Jarvi, Jackson, Swenson & Crawford, 2013). Based on a review of the evidence self-harm was proposed to be a "socially transmitted behaviour" (Jarvi et al., 2013, p.16).

1.3.2.7 Systemic

The systemic model suggests self-harm is a symptom of family or wider systemic discord (Suyemoto & McDonald, 1995). A young person is seen to self-harm in an attempt to distract attention away from the wider issue. The system can unwittingly reinforce and perpetuate the behaviour because of its distracting effect (Suyemoto & McDonald, 1995).

1.3.2.8 Gender and Feminist theory

As self-harm is often viewed in society as a female issue inclusion of feminist understanding of self-harm is warranted. McAllister (2003) stated that women have been socialised into expressing distress emotionally rather than physically, are more likely to harm themselves rather than others and are more likely to experience abuse than men. Feminist theory explains self-harm as an expression of distress and resistance (Gilligan, 1982).

1.3.2.9 Linehan's (1993) biosocial theory of 'BPD'

It appears relevant to outline Linehan's theory as it informs Dialectical Behaviour Therapy (DBT), the treatment the young people in this study engaged in. Linehan (1993) conceptualised 'BPD' as a difficulty in regulating emotions. 'Emotional dysregulation' means individuals experience increased emotional sensitivity, difficulty in regulating strongly felt emotional responses and a slow return to emotional baseline (Crowell, Beauchaine, & Linehan, 2009). Linehan (1993) explained the aetiology of 'BPD' as an interaction between a biological vulnerability to experiencing heightened emotions and an inadequate environment for learning to manage emotions. Experiencing 'emotional dysregulation' according to Linehan (1993) then leads to unhelpful patterns emerging in response to difficult emotional events. The model explains 'BPD' to emerge in response to an invalidating developmental environment where emotional expression is not accepted. Children do not learn how to recognise, understand or manage their emotions as they receive the message that they should deal with their feelings alone and internally. Consequently children can experience and vacillate between intense emotional outbursts and periods of inhibited emotional expression (Crowell et al, 2009). Self-harm is seen as an attempt to minimise or remove unwanted and intolerable distressing emotions (Jarvi et al, 2013).

1.3.3 Who self-harms?

Self-harm remains a cultural taboo. It carries with it shame and stigma making prevalence unclear (Shaw, 2002). This can make researching the area difficult therefore it remains under researched (Mental Health Foundation, MHF, 2006; Harvey & Brown, 2012). However, consensus exists that self-harm is most commonly observed in adolescents and onset is typically between 12 and 14

years old (Whitlock et al., 2006; Nock, Teper & Hollander, 2007). Self-harm in teenagers is said to be a particular problem in the UK compared to the rest of Europe, the specific reasons why are unclear (Harvey & Brown, 2012). One in five UK adolescents is believed to have self-harmed (MHF, 2006) and a survey of 2000 adolescents showed almost one third (29%) to have done so (Mindfull, 2011). Mitchell et al. (2014) highlighted risk factors for self-harm including depression (Fortune & Hawton, 2005), living in poverty and substance abuse (Hawton et al., 2012) and difficult parent-child relationships (Fergusson, Woodward, & Horwood, 2000).

Despite research suggesting young women are 1.5 to 3 times more likely to self-harm than males (Whitlock et al., 2006) other research found self-harm to be common among both girls and boys (Choate, 2013). Data from the NHS Health and Social Care Information Centre (2014) showed that rates of boys aged 10 to 14 accessing accident and emergency departments having self-harmed rose by 30% between 2009/10 and 2014. It is unclear whether this increase is due to a rise in self-harm or improved recording of data. However, Choate (2013) states the early onset and prevalence of self-harming behaviour is of greater concern in relation to girls due to the transition into adolescence which often signifies a vulnerable period where self-harm and other psychological difficulties can arise. It has been said that girls experience increased pressures to perform academically, to look a certain way, to live up to cultural ideals such as to look and behave in sexually attractive ways, whilst going through puberty and experiencing developmental changes (Choate, 2013). Self-harm, both public and private, was deemed a predominantly female behaviour by those interviewed in Scourfield, Roen and McDermott's (2011) study, arguably reflecting dominant societal views

regarding gender and self-harm. If self-harm has been constructed as a female expression of distress it could suggest that girls are more able to seek help than boys who experience increased barriers to doing so (Welch, 2014). Also it is important to be aware the means by which boys self-harm, for example, punching walls and getting into fights, might not be construed as self-harm in the same way that a girl cutting would.

Studies considering rates of self-harm among different ethnicities have led to inconclusive findings (Duggan & Whitlock, 2012). Sexual orientation has been found to be related to self-harm prevalence, which is increased in those who describe themselves as bisexual or questioning their orientation (Whitlock et al., 2006). Increased rates of self-destructive behaviour have been found where bullying and victimisation were experienced by young lesbian, gay and bisexual people (Rivers, 2000).

1.3.4 How self-harm is viewed? Dominant discourses

The behaviour of self-harm receives moral judgement. Anecdotally from my experience of accompanying young people who had self-harmed to accident and emergency departments to access treatment, the response from medical staff was often exasperated, unsympathetic and judgemental. This is also evidenced in the literature (Jeffrey, 1979; Arnold, 1995). This is perhaps in part due to the lack of parity between physical and mental health, the latter being more contested (Scourfield et al., 2011). In addition, mental health difficulties are often fused with moral judgements (Foucault, 1967). Scourfield et al. (2011) discovered a polarity to exist when they conducted focus groups and interviews with 69 young people aged between 16 and 25 years. This polarity was between views of

those who self-harm in private, which was deemed authentic and worthy of sympathy and public displays of self-harm, showing scars for example, which was deemed attention seeking and self-indulgent. Public displays were considered less credible as the person was judged to have intended for it to be seen meaning they were 'seeking attention', a term which carries very negative connotations. Public or visible self-harm was perceived as meaning the individual was less distressed than those who do so in private as the former was considered to be glamorised and copied. Whether this dualism exists online too is of interest as arguably most self-harm will be communicated in some way to another for example via social media, online, through talking or visually (Scourfield et al., 2011).

1.4 'Borderline Personality Disorder'

Chapman et al. (2006) highlighted that between 48 and 79% of individuals with a 'BPD' diagnosis self-harm making it the diagnosis most associated with the behaviour (Brodsky, Cloitre, & Dulit, 1995; Dubo, Zanarini, Lewis & Williams, 1997; Linehan, 1993). The young people interviewed in the current study all received a diagnosis of 'BPD'. The diagnosis followed an assessment by the clinical team to consider whether DBT would be an appropriate treatment intervention, given the main difficulties experienced by a young person, and that these were not better explained or formulated by an alternative explanatory model. The following section will explain and critique the diagnosis.

1.4.1 Contested category

The diagnosis of 'BPD' first appeared in the third Diagnostic and Statistical Manual of Mental Disorders (DSM, American Psychiatric Association, APA, 1980)

and by 1984 was the most commonly diagnosed of the 'personality disorders' (Gunderson & Zanarini, 1987). The diagnosis is the only one to include self-harm as a symptom criterion (APA, 2000). 'BPD' is said to be characterised by emotional instability, disturbed patterns of thinking, impulsive behaviour and unstable relationships (APA, 2013). The term is contested based on the view it medicalises personality offering only a thin description of 'problems' locating these and the responsibility for change within individuals ignoring social, historical and contextual factors which influence aetiology (Shaw & Proctor, 2005; Bourne, 2011). In addition, the diagnosis lacks validity therefore utility (Cloninger and Svravic, 2008).The diagnosis carries with it moral ambiguity regarding volition and intention about whether individuals choose to behave and act as they do, for example self-harm, or whether it is not their fault and not within their control (Bourne, 2011). Such moral judgement contributes to the stigma people who receive the diagnosis experience. In contrast, it is acknowledged that some service users report receiving a diagnosis as a helpful and containing experience (Mind, 2015) and it can be useful in accessing treatment.

1.4.2 'Emerging Borderline Personality Disorder'

Placing the term 'emerging' before 'BPD' is an increasingly popular and debated way of describing young people who appear to be showing signs of 'BPD' before they reach 18. The Department of Health (2014) explain the term as describing young people who are at increased risk of developing a 'personality disorder' in adulthood due to having experienced abuse or disruption and been placed in care or custody during childhood.

‘Emerging BPD’ provokes debate between two camps. One argument is personality is still developing during adolescence therefore making it impossible to say with any certainty that a young person’s personality is ‘disordered’. Great concern exists about the effects the label of ‘emerging BPD’ could have on young people. These concerns include whether the label will stick and not be questioned through a person’s adulthood and whether such a label would lead to rejection from services and society (Ashead, Brodrick, Preston & Deshpande, 2012). The second camp argues that diagnosis is possible in adolescence using trait theories of personality (Ashead et al., 2012) and that waiting until 18 years old to diagnose a person with ‘BPD’ when symptoms have been evident since adolescence does not make sense clinically (Aguiree, 2013). If ‘BPD’ is recognised early it is felt that intervention can commence early leading to a better outcome. A wider debate argues that ‘personality disorders’ should be reconceptualised as “adaptive reactions to relational [childhood] traumas” (Johnstone, 2000; Bourne, 2011 p. 83). Such reconceptualisation more accurately explains why difficulties in regulating emotions and forming trusting relationships with others, for example, might exist because of negative early experiences, including childhood sexual abuse, which is less blaming for the individual (Castillo, 2000).

1.5 Young people

As the current study involves young people the following section will outline the role of development and neurobiology in their self-harm.

1.5.1 Development and neurobiology

Despite the concept of ‘adolescence’ being understood by many as a social construction created through language rather than a ‘universal truth’, some of the commonly discussed features of this age group are grounded in neurobiology. Neurobiological evidence suggests that teenagers are more likely to take risks and behave impulsively during this period of transition from child- to adulthood (Casey & Jones, 2011). Increased risk taking is said to be due to experiencing significant changes in the pre-frontal cortex and limbic system during this time (Blakemore, 2012). Studies have found the limbic system to be hyper-sensitive to the feelings derived from taking risks during adolescence whilst the pre-frontal cortex, which in later life is likely to stop one taking risks, is still developing. Teenagers’ ability to take another person’s perspective is also still developing during this period. Blakemore (2014) identified the teenage years, a time when the brain is particularly adaptable, as being a pertinent time to intervene. If self-harm and using social media are considered risky behaviours the importance of learning more about how the two relate is further emphasised.

1.5.2 Young people and internet use

1.5.2.1 A new generation of “digital natives”

In the early 2000’s people started using the internet in relation to self-harm and in recent years policy makers and researchers have become interested in how and why young people use the internet in relation to their mental health and more specifically in relation to self-harm (Byron, 2008; Messina & Iwasaki, 2011). Young people have been referred to as “digital natives” and “screenagers” having grown up immersed in technology more so than any other generation (Powell, 2010, p.368). This has arguably altered the way they communicate and interact (Prensky, 2001; Kaplan & Hainlein, 2010). Self-harm and internet use is more

common among adolescents than any other age group (Duggan & Whitlock, 2012). Internet users are now able to “share, connect and communicate with each other instantly and spontaneously” (RCP, 2014, p.23). As their internet use has increased, the way young people seek information and help regarding their mental health has changed. Forums and message boards are commonly used by young people to communicate about self-harming on the internet and researchers have strived to increase their understanding of what accessing such media offers young people (Rodham, Gavin & Miles, 2007; Jones et al., 2011; Harvey & Brown, 2012). This research will be more fully explored in section 1.8.1.

1.5.2.2 Warranted concern or over protection?

Kat Cormack (2014b), a long-term service user, someone who has self-harmed and campaigner for the charity Young Minds, highlights how in general people are very risk averse regarding online health related behaviours compared with, for example banking and shopping online. Cormack (2014b) considers such risk aversion to be over protective of young people, who are considered as vulnerable, and to be out of proportion to the risks of going online. However, there are very real concerns about young people accessing information online before they can make sense of it fully. Livingstone & Smith (2014) explain that despite policy makers focussing on raising young peoples’ awareness of the need for internet safety not much behaviour change has occurred because young people do not see social networking in the same way as adults. “[Young people’s] main aim is generally not to meet strangers or disclose personal information but to make new friends, build relationships and widen their circle of contacts” (Livingstone & Smith, 2014 p.284). However, understandably some professionals, parents and young people themselves hold concerns about the

potential harmful effects of using social media. Byron (2008) describes a "generational digital divide which means that parents do not necessarily feel equipped to help their children in this [online] space – which can lead to fear and a sense of helplessness" (p.2). Cormack (2014a) and Byron (2014) argued against trying to prevent young people using sites of concern and shutting them down in response to "moral panic". They suggested instead asking what young people need and want, why they go online and what do they find there. Section 1.8.1 more fully explores the help versus harm debate outlined in the literature.

1.6 Explanatory models of internet use

1.6.1 Disinhibition effects of interacting online

Suler (2004) identified six elements of the internet, which he names 'disinhibition effects', which enable people to behave significantly differently from how they might in a face-to-face situation. Firstly, the 'anonymity' afforded is said to enable people to feel freer and therefore able to behave differently. For those who self-harm and often feel isolated and ashamed the internet provides a space where they can connect to others anonymously (Whitlock et al., 2006). Secondly, interactions do not take place in real-time meaning social norms usually adhered to in face-to-face interactions are of less consequence therefore disinhibiting individuals. The third effect refers to users' online emotional reactions are 'invisible', which could enable people to feel more able to open up. Online we do not see others' reactions live as we do when we are face-to-face. Live reactions can impede behaviours for fear of being judged by the other. Online, a failure to receive instant feedback from people can lead to communication difficulties and misunderstandings. It is thought that internet trolls are able to taunt others

persistently due to this disinhibition effect. The fourth effect, reading online has been said to enable ‘voices in our heads’ to join with what is read, making an intimate connection. Fifthly, the internet can feel like ‘an imaginary world’ where people can be who they want and can do as they wish, which reduce the amount of responsibility people take for their actions. Lastly, Suler (2004) writes of there being ‘no police’ or authority figures evident online meaning people can feel freer to behave in unconventional ways. It was hypothesised such effects would be relevant in explaining why posts about self-harm including pictures are shared by young people on social media.

1.6.2 Possible functions and benefits of connecting online via technology

Turkle (2012) spoke of technology re-defining the way humans connect and outlined some of the possible functions of engaging via technological devices and social media. Turkle (2012) stated that people now expect less from each other and more from technology, including never having to be alone, being able to put our attention wherever we like and always be listened to and heard. In addition, Turkle (2012) posited that by using technology people are able to have control over how they present themselves, being able to edit and delete what is disliked, which is not possible in real-time conversation. However, Lee and Stapinski (2012) suggested those who believe this to be true alongside believing that they are less likely to be evaluated negatively by others are mistaken, as these factors and relational dynamics remain online as they do offline. Turkle (2012) believed that people only feel themselves by having connection, ‘I share, therefore I am’, but warned that being connected virtually does not equal having actual relationships and can in fact lead to further isolation.

The Royal College of Psychiatrists (2014) reported that the anonymity afforded by forums, websites and social media provide a conduit through which young people can explore and share difficult issues privately away from adults. Heiller & Sills (2010) outlined their view that when relating people want to feel the safety togetherness brings yet want to maintain some individuality by also being separate. Evans (2014) suggested that cyberspace appears to offer this balance, which she says is especially desired by young people. Evans (2014) suggested that using Instagram to share a photo, the 'like' button, the 'share' option and 'tagging' on Facebook and 'retweeting' on Twitter all provide recognition which individuals seek. Recognition has been explained to be a fundamental element of being human in that "to recognize is to affirm, validate, acknowledge, know, accept, understand, empathize, take in, tolerate, appreciate, see, [and] identify with" (Benjamin, 1988, p.14-15).

Liebert, Archer, Munson & York (2006) suggested cyberspace offers a seemingly safer way to interact and connect for those who have been marginalised socially, misjudged and experienced emotional trauma as it provides a buffer via distance against potential negative reactions from others.

1.7 Social media

1.7.1 History, definition, types and who uses it

Social media has been defined as "forms of electronic communication (web sites for social networking and microblogging) through which users create online communities to share information, ideas, personal messages, and other content" (Merriam-Webster online dictionary, 2013). Social media enabled users to share profiles, compile lists of friends, post messages and to share photos and other

media with other users (MySpace, 2011). Social media emerged in 1994 following (in this order) the advent of the internet, email, instant messaging, chat rooms and blogs (Myers & Turvey, 2013). Friends Reunited was the first social media site, which started in the UK in 1999 (Curtis, 2013). However, social media did not become popular until 2003 when MySpace began, followed by Facebook in 2004 therefore making current adolescents the first generation to have grown up with social media (Myers & Turvey, 2013; Best, Manktelow & Taylor, 2014). In 2010 48% of people in the US had a social media profile (Saint, 2010). The most popular site is currently Facebook with, as of the third quarter of 2014, 1.35 billion monthly active users, however growth has slowed and the site is arguably no longer considered 'cool' by many younger users (Statista, 2014). The second most popular site is Twitter, which emerged in 2006 and is now said to have 284 million monthly active users (Statista, 2014). Tumblr surfaced in 2007 and figures show Tumblr as hosting over 216 million blogs (Tumblr, January 2015). The site had to announce in 2012 that it would be banning blogs which promoted suicide and self-harm content (Tumblr, 2015). Related media reports are included in section 1.1.1. Newer forms of social media have emerged and are growing in popularity such as Instagram, Snapchat and WhatsApp. These are of interest as they are only available via mobile phone use, which perhaps young people are most likely to have access to. McGrory (2014) suggested that Snapchat emerged in response to users rejecting having a digital legacy and is thought to be used most by 13-20 year olds 70% of which are female. These figures are consistent with findings that those who communicate most via social media are adolescents (Ofcom, 2012).

1.7.2 Why do people use social media?

1.7.2.1 Control over self-representation, self-affirmation and to maintain relationships

Toma (2011) posited that social media enables those who access it to represent themselves in new and novel ways in relation to how they connect socially and their personal qualities. Toma related this to self-affirmation theory (Steele, 1988), which posits that people have a basic need to "see themselves as valuable, worthy and good" (Toma & Hancock, 2013 p. 322) stating that responses via social media to such information could reinforce a person's feelings of self-worth and well-being. Toma (2011) reported that Facebook use may be motivated, in part, by a need to reinstate self-worth as participants were more likely to spend time on Facebook when their sense of self was threatened.

Toma & Hancock (2013) considered why social media sites are so appealing to so many, and why people are spending so much time on them. They highlighted the media view that they serve to relieve boredom, aid procrastination and express 'narcissistic' drives. They also shared how motivation to use social media sites can also be relational such as maintaining relationships (Wilson, Gosling & Graham, 2012).

Strom and Strom (2012) reported that social media appeals to young people as it facilitates independence through them being able to present themselves as they wish without adult interference. Additional benefits include having their opinions

attended to by others, receiving impartial feedback on behaviours and sharing experiences with others who have had similar ones (Strom & Strom, 2012).

1.7.2.2 Enabling expression

Social media is of particular interest regarding self-harm as it is thought to enable the expression of thoughts, feelings and behaviours which might otherwise not be expressed outwardly. Social media "does not only enrich the content and scope of personal communication, it facilitates uninhibited communication and selective self-presentation of undesirable behaviour" (Fu, Cheng, Wong & Yip, 2013, p. 406). Fu et al. (2013) were interested in exploring the consequences of exhibiting self-harming behaviour using social media. Fu et al. (2013) viewed communication tools as enabling human capabilities to be extended and saw the internet as having furthered such enablement. Social media has also changed how people communicate with those close to them, which led the authors to wonder how computer-mediated communication differs from face-to-face communication. They deemed further investigation with regard to psychological processes and effects necessary (Fu et al., 2013).

Fu et al. (2013) reported social media having the "capability to enable self-disclosure of uninhibited behaviour" which might then reduce the boundary for vulnerable people (p. 407). This means that people who self-harm might be more likely to share such intentions and behaviour with others using this medium (Fu et al., 2013).

The relationship between social media and self-harm is a new phenomenon. Clinicians across services have raised concerns about the relationship between self-harming behaviour and social media and are also aware of the benefits

reported by young people. It is argued that exploring the psychological processes involved in this relationship is important.

1.8 Relevant research

1.8.1 Help or harm?

Whether the use of the internet in relation to self-harm is helpful or harmful is a dominant theme throughout the research. Daine et al. (2013) conducted a systematic review of 16 quantitative and qualitative studies that investigated how the internet influenced self-harm and suicide in young people. They found that young people used the internet most commonly to gain help by seeking support and ways to cope. However, the review stated that doing so could be harmful in that it could normalise self-harm and impede disclosure and help-seeking from professionals. It is a new field in need of further research (Lewis, Heath, Michal & Duggan, 2012; Daine et al., 2013). Little exists on how social media in particular is used in relation to self-harm and to what effect highlighting the relevance of the current study. Gradin Franzén & Gottzén (2011, p. 279-80) wrote "researchers have discussed whether self-injury websites are arenas that alleviate self-cutting, or if they contribute to a normalization of self-injurious behaviour (Whitlock et al., 2006, Rodham et al., 2007, Adler & Adler 2008, Baker & Fortune, 2008)". Broadly speaking, the reasons the internet is deemed beneficial relate to young people receiving support from peers but concerns about the harmful effects of sharing experiences and methods, introducing young people to new risks and triggering urges to self-harm also exist (Lewis et al., 2012). However, much of the research concludes that the apparent dichotomies of help and harm co-exist together. One

interviewee agreed, describing being part of a self-harm online community as "double-edged" (Adler & Adler, 2011, p. 117).

Messina and Iwasaki (2011) reviewed the literature relating to internet use and self-harming behaviour among adolescents which echoed the help versus harm debate. The validation and emotional support in a crisis that adolescents received from others who have had similar experiences was found to be helpful. However, researchers expressed concern that using the internet could normalise self-harming behaviour by enabling young people to access self-harming techniques and tips to reduce scarring.

The help versus harm theme repeats across research in the various forms of online community; websites (Baker & Fortune, 2008), Facebook groups (Niwa & Mandrusiak, 2012), forums and message boards (Jones et al., 2011; Whitlock et al., 2006) and You-tube videos (Lewis, Heath, St Denis & Noble, 2011). Research concerning websites, message boards, forums, internet searching, You-tube and social media will be now elaborated on further.

1.8.2 Websites

In light of an arguably negative dominant view of self-harm and suicide websites Baker and Fortune (2008) completed a discourse analysis of emails from young adult users. This study warrants emphasis as it is one of only a few qualitative studies which have been conducted in this area. The websites were constructed in three beneficial ways: as communities to which they felt a sense of belonging, as providing understanding and empathy and as a way to cope with psychological and social distress.

In addition, Mitchell et al. (2014) stated that despite the existence of self-harm websites the majority of young people do not access them finding the 12 month rate for visiting websites that encourage self-harm to be low at around 1%. Mitchell et al. (2014) went on to state that few websites actually encourage self-harm amongst the many online communities which relate to the behaviour (Lewis & Baker, 2011). However, exposure to self-harm websites which encouraged such behaviour was found to be associated with an 11-fold increase in the likelihood of self-harm related thoughts (Mitchell et al., 2014). The content of and sharing of experiences of self-harm with others could have the effect of normalising or reinforcing such behaviours, especially if they are repeatedly accessed (Whitlock et al., 2006; Lewis & Baker, 2011; Lewis et al., 2011).

Self-harm has been presented as an effective and justified way to manage distress and even said to be glamorised by some websites (Whiltock, Purington & Gershkovich, 2009; Lewis & Baker, 2011). It has been suggested positive portrayals of self-harm could impede help seeking therefore bolstering the harm argument. Concern exists about users of websites and forums sharing methods of and concealing self-harm (Whitlock et al., 2009). Such sharing could enable young people to learn new ways to harm themselves, and stop them seeking help as such tips might suggest there is no need to (Lewis et al., 2012). However, further research focussing more specifically on the relationship between the content of these websites and consequent behaviours is required.

A prominent clinical concern is that accessing the internet regarding self-harm can be ‘triggering’ for young people, meaning that content can cause upset therefore leading to or increasing urges to self-harm, which are then acted on (Lewis et al., 2012). Some websites contain trigger warnings to alert users. Lewis

and Baker (2011) found some young people who accessed self-harm websites developed urges to harm themselves and some did so after seeing images or reading graphic descriptions of self-harm. More needs to be known about specifically who is triggered when and in what circumstances.

1.8.3 Message boards

In another qualitative study of note due to their relative scarcity, Rodham, Gavin and Miles (2007) used IPA to analyse message board posts. They concluded that users found the communication beneficial in that it allowed distanced personal self-disclosure, which felt safer and less exposing due to the anonymity. The main theme identified was of support (seeking validation, crisis support and being able to vent). Again the help versus harm argument was presented. The researchers highlighted how different peer responses are to how a health professional would respond. Rodham et al. (2007) suggested interviewing people who self-harm so that such comments can be explored and better understood, which was this study's aim in relation to social media. Murray and Fox (2006) reported some positive effects such as reducing how often and severely they self-harmed after using a self-harm discussion board. However, almost half of their sample (n=102) harmed themselves after reading content posted on there. Caution must be taken not to generalise these findings to all self-harm sites.

1.8.4 Forums

Jones et al. (2011) reported that users of self-harm forums liked the anonymity, being able to communicate with strangers, and with those who had had similar experiences. Negative effects include concerns about normalising and learning

new behaviours. Johnson, Zastawny and Kulpa (2010) reported self-harming behaviour to decrease after becoming engaged with forums.

1.8.5 Internet search for self-harm

Swannell et al. (2010) investigated what information can be accessed if terms including 'self-harm' or 'self-mutilation' are searched for using Google. They qualitatively analysed 39 links which led to websites, books and news articles and found most of the information to be support and recovery focussed. They commented how this contrasted to pro-ana websites[2] which promote anorexia (Chesley, Alberts, Klein, & Kreipe, 2003). They did however warn that if pro self-harm was searched for, the results were likely to be less positive.

1.8.6 You-tube

Lewis et al. (2011) analysed the top 100 videos found on You-tube when self-harm was searched for. They found explicit images to be common, a high proportion of videos to contain photographs of self-harm and many of which did not warn about the nature of their content. The images were deemed to normalise and potentially reinforce self-harm behaviour but there exists little evidence that such behaviours are encouraged by the videos (Lewis et al., 2011). Mitchell et al. (2014) posited that this along with self-harm rates steadying (Muehlenkamp, Claes, Havertape & Plener, 2012) and other findings such as Rodham et al., 2007 and Baker & Fortune (2008) could suggest "that accessing

[2] Fox, Warde and O'Rourke (2005) provide further information

such websites provides support or perhaps is not consistently contributing to actual self-injurious behaviour in a large and concrete way" (Mitchell et al., 2014 p.1341).

1.8.7 Social media

Concern exists that a young person might receive significant validation and affirmation of their identity as someone who self-harms from their many, even hundreds, of 'followers' or 'friends' which might obstruct recovery (RCP, 2014). This was echoed in the media coverage of recent suicide cases (section 1.1.1).

1.9 Research hopes

The fact that self-harm is an under researched area contributes to it remaining insufficiently understood and an area which some professionals feel unsure working with (Skegg, 2005). Anxiety can surround self-harm and social media and how to respond to them occurring together. Research which focusses on the perspectives of young people giving them the chance to "speak for themselves" (Nicolson, 1995, p. 339) is lacking. It was hoped this study would highlight young people's perspectives of how and why they use social media in relation to self-harm and to what effect. This study aimed to benefit young people by providing new information to clinicians and others involved in their systems about what needs might be being met by using social media. The wish was to develop practice and enable care to become more suited as a result. It was also hoped that the findings could inform clinicians and parents further and add to this understudied area. It is important that clinicians and parents know about the

internet and social media sites young people access and how they work. This is likely to reduce the level of anxiety and uncertainty surrounding the area enabling dialogue to be opened up (Byron, 2014). Best et al. (2014) highlighted a lack of research into young people and social media, stating that much has taken place on older peers of college age. The current study aimed to contribute to the dearth of research and the area in general by interviewing young people who self-harm in order to answer the research question:

How and why do young people use social media in relation to self-harm and to what effect?

Due to recruitment yielding interviews from seven 15 to 18 year olds, an age group referred to as mid-adolescents, this term was adopted to specify the sample used in this study.

2. METHOD

2.1 Epistemology

Epistemology, the philosophy focused on the theory of knowledge, strives to outline what and how we can know (Willig, 2013). It is necessary to take an epistemological position prior to conducting research as this shapes what is possible to find out and the way this is embarked on (Willig, 2013). A critical realist epistemological stance was adopted for this research. Adopting a realist stance involves asserting that a reality exists which can be directly accessed from data gathered and explored (Harper, 2011). Self-harm is a real, embodied experience and this researched aimed to understand the processes of how and why participants do so in relation to social media. Ontologically critical realism

and realism are similar in that they agree that particular experiences do exist (Fade, 2004). In contrast, critical realism asserts that data can explain reality but this is not viewed as directly mirroring reality (Harper, 2011). The stance is critical because the extent to which experiences can be accessed and described is unclear and contextual factors affect how and what is communicated. In addition, critical realism acknowledges the role of the researcher in the co-construction of reality and that many different realities exist. In relation to the current research a critical realist reading of the data did not simply take what was said entirely at face value. Having taken a critical realist approach I speculated about what underlying psychological and social processes affected what was said going beyond the text and drawing on other evidence (Willig, 2013). The processes then enabled me to make sense of and explain the data.

2.2 Why qualitative

The decision whether to conduct quantitative or qualitative research is determined by the research questions being asked and the epistemological position that is adopted. Quantitative approaches often aim to predict, establish cause and effect relationships and involve the application of pre- and researcher-defined variables (Willig, 2013). Randomised-controlled trial studies have received the accolade of ‘gold-standard’ research and consequently dominate the field of psychological research. Such studies provide information about how large numbers of highly selected participants respond, for example, to interventions and can contribute usefully to the evidence base. However, in contrast, qualitative research enables a more thorough exploration of how individuals make sense of and experience their world (Willig, 2013). Qualitative research is

interested in the meaning made by participants and the processes by which they do so (Willig, 2013). I would argue that qualitative research enables the work clinical psychologists do in practice, in exploring, understanding and formulating, to be reflected in the research they do. In this case the research questions necessitate more in-depth exploration and analysis than would be possible with quantitative methods.

2.3 Choosing a methodology

Different methodologies draw on different epistemological assumptions. The methodology chosen was decided on by considering what method would be most appropriate in answering the research question combined with my personal epistemological stance as a critical realist. Various qualitative methodologies exist[3] but IPA was felt most appropriate in this case and the reasons why will now be elaborated on.

2.4 What is IPA and why was it chosen

IPA as a methodology aims to study human experience and how people understand these experiences (Smith, Flowers & Larkin, 2009). It involves the close exploration of, and interpretation beyond, the data to make sense of individuals' experiences.

IPA was felt to be the most appropriate method by which to answer the research question as it allowed information about an individual's experience to be explored, described and interpreted using psychological theory. What is said by a participant is taken as "a verbal expression of their mental processes" (Willig,

[3] For further exploration please refer to Willig (2003)

2013, p. 9). However, this was not a one-way process and required self-reflection as the interpretations made were influenced by my views and experiences in addition to the participants' (Smith, 1996). IPA accepts, to an extent, what a person says to reflect some of their subjective experience; however it is clearly acknowledged that accessing 'experience' is complicated and limited (Smith, 1996).

2.5 The theoretical underpinnings of IPA

IPA is informed by three areas of epistemology namely phenomenology, hermeneutics and idiography; each of which will now be outlined.

2.5.1 Phenomenology

Phenomenology, primarily concerned with studying experience and specifically about what it is like to be human, is central to IPA (Smith et al., 2009). Husserl (1927) emphasised the need to focus on experience and its perception. The importance of reflection was also highlighted by Husserl (1927) as he felt that one's understanding of experience was biased by pre-conceived assumptions held about the world. Reflection was deemed necessary to enable assumptions to be 'bracketed off' so that experience could be more fully engaged with when conducting research. Heidegger (1962) emphasised the importance of meaning and the relevance of perspective in seeing one's experience of being in the world as relative. Heidegger (1962) highlighted the inevitability and importance of interpreting when trying to understand another's methods of meaning making and therefore denied the possibility of 'bracketing off' one's assumptions. Merleau-Ponty (1962) added the view that the centrality of an individual's own perspective

in making sense of the world is due to an embodied relationship with it which another cannot ever truly understand however, others can empathise.

2.5.2 Hermeneutics

Hermeneutics is the theory of interpretation, another central tenant of IPA (Smith et al., 2009). Heidegger (1962) saw engagement with the world as occurring via interpretation. IPA aims to further the understanding of experience by making interpretations beyond the descriptive level of the data in order to make sense of the phenomena under investigation (Smith et al., 2009). Pre-existing conceptions one possesses can be amended through a process of ongoing interpretation (Heidegger, 1962). The hermeneutic circle denotes the active relationship which exists between the part and the whole. Moving between and understanding the part and the whole in relation to each another is deemed a fundamental process in IPA (Smith et al., 2009).

2.5.3 Idiography

Idiography is the third significant component of IPA and is interested in the particular meaning that IPA is in-depth, systematic and thorough (Smith et al., 2009). “Understanding how particular experiential phenomena…have been understood from the perspective of particular people, in a particular context” is prioritised in IPA (Smith et al., 2009 p.29). As a consequence generalisations are limited and made with caution.

2.6 Reflexivity

Engaging in an ongoing process of reflexion when conducting IPA is crucial (Smith et al., 2009). The ‘double hermeneutic’ of IPA (Smith & Osborn, 2003) refers to the researcher attempting to make sense of the participant making sense of the phenomenon at hand. It is important to explicitly engage with one’s own preconceptions and assumptions where possible in order to have a chance at ‘bracketing them off’. The reflexive statement which follows in an attempt to start that process.

2.6.1 Reflexive statement

Working with young women who self-harm and had received the label of ‘personality disorder’ started my interest in the phenomenon. Many of the women I worked with had experienced disruptive and abusive childhoods and had learned to cope in part by severely harming themselves. The extent of the harm often shocked and saddened me, however in the context of their experiences it could be made sense of. Some of the responses such behaviour prompted from others in society including impatience and reproach also shocked me. I wish to contribute to further understanding self-harm and to challenge unhelpful negative perceptions of why individuals do so which can serve to locate blame within the individual and cause stigma.

It is important to reflect on the similarities and differences between myself and the participants. I am similar to the young women in that I am female and white British; categories within which it is acknowledged huge variation exists. However, differences include that I am 15 years (or more) older than the participants and have not self-harmed or accessed specialist services as a result.

It is difficult to ascertain how similar we were in terms of class, past experiences and family relationships. Such information is less decipherable and deemed to fall within the realm of therapeutic rather than research conversations. In addition, I am a feminist and hold liberal views meaning I believe in and advocate for equality. I am interested in the reasons why and the ways in which women show and manage distress, for example, due to gender and structural inequalities. Throughout the research process I reflected on the effect my experiences and views had on the assumptions I made by keeping a reflexive journal.

2.7 Ethics

The study was approved by the School of Psychology Research Ethics Sub-Committee (Appendix A) and the National Research Ethics Service (Appendix B). Relevant local research and development approval was also obtained (Appendix C).

2.8 Participants

The aim was to recruit eight-ten[4] service users of a tier four specialist Dialectical Behaviour Therapy (DBT) service in London. This service was deemed appropriate for recruitment as it provides treatment to young people who have received a diagnosis of 'emerging BPD' many of whom self-harm. When clinicians from the team were approached they expressed interest in the study due to its relevance to their client group, which led to the collaboration. The DBT team and this study considered self-harm as any action intended by the individual to harm themselves. The eligibility criteria were:

[4] The IPA literature suggests a maximum of 10 participants in research to maintain the idiographic nature focussing on individual cases or events (Smith, Jarman & Osborn, 1999)

Inclusion:

- Aged between 12 and 18 years old (inclusive)
- Self-harmed more than once and within the last year
- Participants needed to identify using social media in relation to self-harm specifically when asked by their clinician

Exclusion:

- Substance dependency
- Presence of another psychiatric/psychological difficulty requiring more urgent assessment or treatment
- Previous exclusion from the DBT service within the last three months
- A moderate to severe learning disability[5]
- Those whose fluency in English was not sufficient to attend the interview without an interpreter[6]

2.9 Data collection

2.9.1 Recruitment strategy

Team meetings were attended to encourage recruitment and provide information for clinicians (Appendix D). My field supervisor was embedded within the team and stimulated recruitment. Clinicians identified eligible participants and used their clinical judgment to establish whether the young person was able to

[5] It was necessary participants were able to understand and verbally express themselves enough to engage with the research questions. A homogenous sample was also needed for IPA

[6] Unfortunately, due to the project being a thesis, insufficient resource existed to pay interpreters

participate in the study in terms of emotional stability. The clinicians introduced the research, provided information packs to those interested and gained permission for me to contact them to explain more and to schedule an interview.

Ethical and research and development approval was gained to recruit through three local Child and Adolescent Mental Health Services (CAMHS) as a contingency.

2.9.2 Using interviews

Through discussion with the field supervisors interviews were deemed a more appropriate method of data collection than focus groups with this client group. This was due to clinicians' concern that young people might hear of and access new social media sites negatively associated with self-harm. However, it is acknowledged that debate exists regarding the over use of one-to-one interviews in psychological research (Chamberlain, 2014). It was felt more useful data would be collected individually as it was hypothesised that some young people might be inhibited to share their views and experiences within a group for fear of negative responses. It is acknowledged that the literature shows that young people are drawn to the internet because of the anonymity it affords and that the current study aims to talk face-to-face about their experiences (Jones et al., 2011).

2.9.3 Developing the interview schedule

Interviews were conducted using a semi-structured schedule (Appendix E). Participants were deemed "experiential experts" on the subject (Eatough & Smith, 2008, p. 188; Smith & Osborn, 2003) so the schedule needed to enable flexibility to explore what the young person brought to the interview. Questions deemed of

interest were devised and discussed with the project and field supervisors. The way the questions were phrased was hypothesised to affect the responses received so three young voluntary service user group members were consulted. Two young men aged 17 years old, and a 21 year old young woman, were asked whether the questions seemed relevant and used accessible and age appropriate language. The schedule was amended following the consultations. For example ‘what forms of social media do you use?’ and ‘what does each provide you with?’ were changed to ‘why do you use social media?’ and ‘what do you like about them (each form of social media mentioned)?’ as the latter questions were deemed easier to understand.

2.9.4 Interview procedure

The interviews took place at the DBT service and lasted one hour. Before contacting the young people care was taken to consider whether meeting before their therapy session might be helpful in case they wanted to seek support afterwards. On meeting, consent forms were signed (section 2.9.5) and the anonymous nature of the study and confidentiality (section 2.9.6) was explained. It was made clear that the young person did not have to answer anything they felt uncomfortable answering. It was thought that it might be difficult for participants to verbalise feeling uncomfortable due to the power differential between us, for example, in terms of age and role. A way for participants to communicate discomfort, verbally or otherwise, e.g. by raising their hand, was therefore agreed. Interviews were audio recorded.

This study considered the following forms of social media of interest: Tumblr, Facebook, Twitter, You-tube and Instagram. Websites, forums or message

boards dedicated to, and offering support regarding, self-harm were not considered due to already having been researched.

Chamberlain (2014) suggested visual research methods could help participants share their experiences. With this in mind and with the hope of bringing the topic to life during the interview I asked four of the participants if they would be willing to show and talk through the forms of social media they use on a tablet. Three were not asked due to arriving late and time not permitting or not having access to a tablet at the interview location. Two did show me their social media accounts. Another had saved examples of posts and images she had encountered regarding self-harm via social media. I described some of what I saw in the write up. One participant declined to show me stating that she felt uncomfortable doing so. Despite thinking that young people might be unlikely to share their private social media account content I felt it important not to assume this would be the case, which is was not for all. If participants reported or were observed becoming triggered to self-harm or distressed I was prepared to be sensitive and to respond (section 2.9.7 contains further information).

A debrief took place after the interview finished (section 2.9.7). A £10 voucher was offered as a show of appreciation for the participants' time.

2.9.5 Informed consent

Informed consent was sought from all participants and their parent or carer. However, participants aged 16 and above could consent for themselves and participate without informing their parents although agreement by parents was encouraged. Those aged 18 did not have to provide parental consent. Participants were given copies of the information sheets (Appendices F, G & H)

and offered the opportunity to ask any questions about them before being asked to sign consent forms (Appendices I, J & K).

2.9.6 Confidentiality

The limits of confidentiality were made clear at the start of the interview. It was explained that if the participant said anything that raised concern about their or anyone else's safety then I would be obliged to share that information with a member of the DBT team who may inform their parent/carer or another relevant service.

2.9.7 Ensuring safety and managing distress

The interviews took place on the service premises so that familiar clinicians were available to respond to the young people's needs if any safety concerns arose. Participants might have felt safer to open up in the interview if they felt safe at the clinic (Greig, Taylor & Mackay, 2013).

It was considered possible that a young person might become upset during the interview due to the topic. At the start of the interview I endeavoured to build of rapport and help the young person feel comfortable through 'problem free talk' (Greig et al., 2013).

It was planned that if a participant became distressed during the interview I would be empathetic and inquire whether they would like to stop the interview allowing them to recommence if and when ready. Once the interview was completed, a debrief took place to inquire about how the participant found the experience, how they were left feeling and whether support was needed.

2.10 Participant demographics

Figure 1 outlines the characteristics of the participants recruited. Seven young females were recruited from 14 (the caseload at that time) who were approached. Six young people declined to take part. Reasons included feeling unable emotionally to take part (n=1); previous distressing experience of research (n=1) and no reason given (n=4). One young person agreed then changed their mind (n=1). The service has an average caseload of 24 per year. It is notable yet unsurprising that no males were recruited in light of the fact that on average just two males access the service each year. Also striking is that all participants were white British. At the time of recruitment two young people were of mixed white/Asian ethnicity, another young person was white/mixed European and one young person was Black British therefore the majority were white British.

Participant	Age range	Sex	Ethnicity
[7]Anna Holly Jess Louise Mollie Nicola Tara	15-18[8]	Female	White British

[7] Pseudonyms were assigned to protect participant identities
[8] Age range rather than individual ages was reported to preserve anonymity

Figure 1. Table of participant characteristics

As the researcher I knew little about the backgrounds of the participants before interviewing them. Some information I learned was not shared in the write up to preserve their anonymity and maintain confidentiality, especially as the sample was small and from one service. It is acknowledged that knowing more about the participants could have provided valuable context. Such context could have assisted in situating participants' comments and connecting them to their backgrounds and experiences therefore aiding understanding when making interpretations during analysis. However, in not knowing more about the participants, I was perhaps freed from assumptions based on what I knew of them, which could have been an advantage.

2.11 Analysis

No single method of IPA is proposed in the literature, however shared processes are suggested, as outlined in section 2.5, and have been flexibly applied in the current study as recommended by Smith et al. (2009).

2.12 Transcription

As required by IPA, interview recordings were transcribed in full and verbatim (Smith et al., 2009). IPA requires less detailed transcription than discourse analysis therefore the length of pauses was not recorded for example. However, laughter (laughs), interruptions (…/) and simultaneous talking (<…>) were denoted[9]. The same convention was used consistently throughout.

2.13 Analytic process

[9] Appendix L provides an example

2.13.1 Steps 1 and 2: Reading and re-reading

I familiarised myself in the data by first listening to an interview recording then reading and re-reading the transcript. As I did so I noted down recollections from the interviews, feelings and ideas that came to mind with the view to 'bracketing them off' to allow focussed engagement with the data itself.

Initial noting involved noting down anything of interest in the left hand margins whilst reading the transcripts. Descriptive comments were made highlighting events, processes and relationships that appeared to matter to participants and what they were like for participants were made. Linguistic notes including word repetition and metaphors. Conceptual commenting focussed more on interrogating the data and asking what it meant for the participant and to me. An ongoing process of reflexion took place thorough analysis. Initial noting formed the initial stages of interpretation.

2.13.2 Stage 3: Developing emergent themes

Working mostly from the initial notes I began summarising them to form the emergent themes, an example of which is in appendix L. This was a challenging process requiring the combination of the participants' original wording with my interpretation, going beyond the descriptive level but staying close to the original data in a concise statement.

2.13.3 Step 4: Searching for connections across emergent themes

The mapping of how emergent themes connected together formed the next step. Super-ordinate themes were identified by abstraction, where patterns between emergent themes were identified and clustered together or subsumption, where

an emergent theme was deemed to encapsulate wider themes and raised up to become a super-ordinate theme. This process necessitated continual revision. An audit of theme generation is included in appendix M.

2.13.4 Steps 5 and 6: Moving to the next case and looking for patterns across cases

The process explained above was repeated for each transcript then the process of identifying themes across transcripts was embarked on. Each emergent theme was written onto an index card and ways they connected or differed were identified by placing the cards into piles which were repeatedly reorganised until four super-ordinate themes were reached. A theme map is presented in appendix N.

3. RESULTS

3.1 Overarching concept: Accessibility and mobility of social media

The accessibility and mobility of social media was deemed an important and overarching concept necessary to understanding the phenomenon of using social media in relation to self-harm. Each young person in this research accessed social media easily, regularly, on the move via their mobile phones and affordably. The ease with which social media could be accessed is considered a starting point for how and why young people use it in relation to self-harm.

Super-ordinate theme	Sub-ordinate theme	Sub sub-ordinate theme

3.2 Themes

The themes presented are not completely distinct and are interrelated to some extent. Each super-ordinate theme and its associated sub-ordinate themes will be presented with relevant quotes to illustrate and evidence.

• Extension of everyday social media use	• Passive use of social media	• Being draw into using social media • Unclear of the purpose of using social media
	• Purposeful use of social media	• Taking action • Restraining action
	• Factors influencing how participants engaged with social media	• Emotional state • Perception by other social media users • Perception by others offline • Username • Anticipated effect on others • Changing nature of social media • The social media site and its community • Different accounts, different functions

• Unexpected pitfalls	• Relational “murkiness”	• Phenomena: Making comparisons • Competition • Interplay between on and offline relationships • Ambiguity of meaning behind social media communication • Effects: Conflict • Triggering • Worsening mood • Inability to live up to expectations • Idea to imitate self-harm
	• Exposure to “graphic” images of self-harm • Compulsion to use social media regarding self-harm: “…I’m not going to [stop]. I can’t bring myself to”	
• Expected benefits	• Enabled shift in focus • Acceptance: “I felt like people finally understood where I was coming from and that I wasn’t the only one” and safety	
• Misunderstandings: “unless you’re part of it, you wouldn’t understand it”		

Figure 2 outlines the four super-ordinate themes and associated sub-ordinate themes identified from the data.

3.2.1 Extension of everyday social media use

The participants used social media for a variety of reasons and functions including to connect with friends and to share pictures. Everyday uses and functions were often unrelated to self-harm and illustrated how significant a role social media played permeating every area of the participants' lives. It was therefore inevitable that young people also used social media in relation to self-harm; the reasons how, why and to what effect for the seven young women interviewed will now be reported.

3.2.1.1 Passive use of social media

Evident in the data was how some participants engaged with social media in a passive way. Two sub sub-themes were derived from passive use of social media: 'being drawn into using social media and participants feeling 'unclear of the purpose of using social media' which are expanded upon below. Passive use of social media refers to how participants spoke of accidentally coming across self-harm related content via social media, aimlessly engaging with it, and/or not consciously deciding to access social media in relation to self-harm. This was in contrast to 'purposeful' engagement where participants were clear about what action they were taking or restraining as illustrated in section 3.2.1.2.

3.2.1.1.1 Being drawn into using social media

It was explained that social media use could be prompted by friends or family contacting a participant via the medium. This was deemed as being drawn into using social media. Participants either received a notification or message.

Louise shared the process by which she was drawn onto using one form of social media by others:

> *"on my phone, what happens is when I get a Facebook message it pops up so then I'll check it at some point <mm hmm> so like if someone sends me a message I'll check my Facebook and I'll get at least one message a day so I'll go on at least once a day" ([10]L: 12).*

Participants shared other examples of how they were drawn on to using social media. An internet search could link to a social media account causing a user to access it as a consequence (Anna) and social media sites could 'suggest' accounts to follow based on what users were already following (Mollie).

Specifically in relation to self-harm participants spoke of unintentionally coming into contact with content, such as images of self-harm, as a consequence of following others who viewed it. For example, Tara highlighted the reciprocal act of following on social media; *"people used to follow me and I used to follow them back" (L: 426).* It seems that by returning the favour or compliment of someone following her Tara was led to be exposed to self-harm related content.

Participants spoke of using social media passively in a variety of ways. Holly spoke of being *"on it a lot. I just don't post. I just sort of scroll" (L: 102)*

[10] Quote references are presented in brackets after the quotation. 'L' indicates line followed by the number

highlighting how she viewed the content posted by others but did not actively interact with others using social media.

Encountering recovery accounts, the more positive side of self-harm related social media, was accidental for some and related to being exposed to what their friends followed as illustrated by Louise:

> *…because I was too lazy to follow people one by one [on Instagram], I pressed a button which means you can follow all of your Facebook friends <yep> and one of them was someone I met [when] I was hospitalised and she had a recovery account and this was weird. I was like, "hang on, what's a recovery account?" <mm> And it's just like people posting pictures and tips and like venting and just like letting it off their chest <mm hmm> and it was all brilliant <mm hmm> and like I really liked it" (L: 130).*

Louise appeared to have been surprised by encountering a recovery account accidently describing it as "weird" at first and not knowing what one was. Louise went on to describe how much she liked recovery accounts saying they were "brilliant" and that she "really liked" them. Louise highlighted part of what she liked about the recovery accounts was how they enabled "venting" and "letting it off their chest" suggesting that she related to the need to express feelings and its benefit. Tara shared a similar experience illustrating the positive effect connecting via social media could have.

3.2.1.1.2 Unclear of the purpose of using social media

Some participants were unclear of why they accessed social media regarding self-harm. This was considered as using social media passively again as it

contrasted to ‘purposeful’ use. Being unclear about the purpose of using social media in relation to self-harm relates to the sub-ordinate theme of ‘compulsion’ within ‘pitfalls’. Anna stated “*it’s not like “oh let me go and update my Facebook status”. It’s not like that it’s, know what I mean? …It’s just there and you sometimes just end up going on it” (L: 158).* Anna’s comment suggested the ease of accessibility of social media and how she would go on it without a specific purpose in mind.

When trying to explore why Holly used social media in relation to self-harm I commented that she appeared to be seeking something to which she replied; *“I was seeking something <yeah> but I don’t know what” (L: 578)* and repeatedly said she did not know why she followed self-harm accounts. It is possible that she felt shame for doing so or feared judgement from me which might have inhibited her sharing her reasons why or it is possible that she was unclear about the process. Nicola described using social media when she felt low as *“just something that happens really” (L: 63)* suggesting that she was unaware of seeking anything in particular from doing so. Nicola’s comment suggests that she located the locus of control externally and as something out of her hands.

3.2.1.2 Purposeful use of social media

Participants described engaging with social media in relation to self-harm in a purposeful and active way which suggested a conscious and controlled decision making process occurring. Examples of taking purposeful action included seeking understanding, care and support via social media in relation to self-harm in the same way they used it in relation to other aspects of their lives. In addition, using social media to create a profile of one’s ideal life, posting pictures of self-harm,

taking steps to filter out negative content from a newsfeed, helping others and acting against bullying were also spoken of and deemed purposeful actions.

A distinction between taking action and restraining action was noticed within this theme. These were differentiated as taking action, which referred to actively doing something, for example, intentionally triggering one's self to self-harm using social media and restraining action referred to deliberately not doing something, such as not expressing urges or negative feelings through social media. Some examples of which will now be elaborated on.

3.2.1.2.1 Taking action

Nicola spoke of actively expressing negative feelings by posting them on social media:

> *N: …I post about like my feelings, quotes, pictures <uh huh> and then sometimes I write text posts but it's all sort of about, I don't know, feelings sort of thing.*
>
> *I[11]: What sort of feelings?*
>
> *N: Sad. (L: 53).*

When feeling like she wanted to self-harm Holly also took action and posted feeling low on social media:

> *…I was like "I feel a bit shit, what do I do?" So I just like, was like I don't know, scrolling on Instagram and I put like a sad face up. I didn't even do anything and someone said "what's up?" and I replied, "I have a*

[11] 'I' indicates interviewer

headache". I didn't even say I want to kill myself, I was just like, "I have a headache and its making me want to throw up" (L: 550).

Holly posted a visual representation of feeling sad. Holly then expressed her feeling in text using a physical rather than an emotional expression and did not fully communicate her desire to end her life. I wonder whether saying she had a "headache" felt safer and whether preferring this expression could be influenced by the lack of parity between mental and physical health with physical health concerns being less stigmatising and more accepted (Scourfield et al., 2011). Holly said that she "didn't even do anything" by posting the sad face perhaps suggesting that she did not consider posting the sad face as action despite doing something active or that she was surprised at the response she received.

A process of going on social media to intentionally trigger one's self was deemed a purposeful act and was shared by Holly:

H: ... I think this is going to sound so messed up. Did you do psychology? 'Cos if you do then you'll probably <yeah>, hopefully understand <ok> I think people try to trigger themselves intentionally. I don't know why, like I have no idea why but I know that I used to when I was like younger so I think that's what Tumblr did when I was like 13.

I: Can you say a bit more about what you mean about by people wanting to <I don't>, just your view of on it/

H: I genuinely don't know why but I know that a lot of people do it and I don't think it's/

I: And do you mean by that that they want to make themselves want to self-harm?

H: No I think you already want to self-harm but you don't feel like it's justified enough so you feel like if you feel it even more then it's more justified. So maybe I think people who are sort of in a shit mood but not completely in a shit mood will sort of try and get into an even shitter mood so that they're like "well I'm in a really shit mood now so I can just self-harm and its more worthwhile than when I was slightly in a shit mood and didn't really have to but I could have" (L: 282).

Holly described going through a process of wanting to self-harm but actively using social media as a way to upset herself enough to "justif[y]" doing so. Here Holly seemed to share a belief that self-harm is only a justified response to significant as opposed to more manageable distress. By "justified" I wonder if Holly meant accepted and understood by others. Later in her interview Holly expressed dislike of the terms *"copying"* and *"spreading" (L: 663 & 667)* used to describe self-harm occurring between people in a group often referred to as contagion. Holly possibly deemed the terms an inadequate explanation for self-harm. Both comments suggest it is possible that discourses about, or her experiences of others' responses to her, self-harm have influenced her view. She spoke about the process as one she and others had engaged in and appeared to distance herself from intentional triggering by saying that it was in her past. The extract started with Holly exclaiming that what she was about to say was "messed up". Perhaps these comments are a pre-empting of and attempt to avoid judgement of what she and/or others deemed a significant degree of psychological disturbance. Judgement was noticed as a concern for Holly

throughout her interview. Holly seemed to think that someone studying psychology might be able to understand this process despite not understanding it herself, which is evidenced through her repeatedly saying she did not know why it occurred. Holly's mention of needing to be in a "shitter mood" to "justify" self-harming and using social media to achieve this suggests that she saw social media as able to worsen mood. The repeated use of "shit mood" is striking and perhaps is used to emphasise and justify how bad Holly needed to or did feel when she self-harmed.

Another participant shared a similar process. Louise also spoke of "trick[ing]" herself into looking at social media content which she knew would make her feel worse:

> *"…I almost used to like trick myself and be like "oh yeah, they'll be something really nice on [social media]" and then there wasn't, there were just bikini pictures and I was like "urgh [laughs] ok then" (L: 512).*

Louise went on to say:

> *" … when I'm in a bad place I'm more susceptible so it's easier for me to just be like, "well you know I might look at that 'cos its bound to have something really interesting on it", even though I know it won't and it's just going to upset me more. (L: 537).*

Louise said she "knows" she would not find something "nice" so might have also been engaged in a form of 'intentional triggering'. Louise indicated this process as more likely to happen when in a "bad place" due to being "more susceptible" to tricking herself. A process was highlighted that the worse Louise felt, the less

able she was to control viewing distressing social media content, which links to the ‘compulsion’ sub-ordinate theme in section 3.2.2.3.

3.2.1.2 Restraining action

It was noticed that participants spoke of holding back or restraining themselves from taking action. To illustrate, Anna spoke of deliberately not expressing urges to self-harm on social media due to not wanting people to know and respond to her:

> *… with other people, I’ve seen, they post something and then people are like “oh, what’s up”? And you know what I mean? I personally, yeah, I just wouldn’t want people knowing. Like do you know what I mean? <Mm hmm> So, I don’t know ‘cos other people do it but I just choose personally (L: 220).*

Anna appears to decide against sharing her feelings on social media suggesting that she viewed self-harm as private and did not utilise social media for the purpose of gaining a response from others. Anna said “personally” twice in this extract suggesting she differentiated herself from others which had a distancing effect.

Tara spoke of how she now refrained from expressing negative feelings about self-harm in favour of positive expression:

> *T: Um because especially from my Tumblr I used to be quite just like up front and like “I’ve just cut” but now erm I’m a lot like, oh, I’ll just basically be like “I was twelve days free of cutting and erm I had a blip but it doesn’t mean I can’t get back on track”. So I use a negative for a positive (L: 116).*

The preceding comments appear to suggest a form of self-censorship. The reason why this might have occurred will be discussed in the 'factors influencing how participants engaged with social media' sub-theme (section 3.2.1.3) and could be related to Tara's concern about not triggering others. It seemed Tara decided to purposefully post a positive comment about self-harm illustrating the processes of restraining and taking action together.

Nicola appeared to describe restraining and taking different actions based on perceived shame she felt. Nicola shared how letting others know about cutting was less shameful sharing other forms of self-harm such as head banging:

> *…'cos like there's other things that you do to self-harm that you don't really broadcast 'cos it's quite shameful I suppose…There's certain things that you'd do that people can't see from the outside. Like with scars and cutting it's quite obvious <mm hmm> erm but then I would do things like I would smack my head against the wall, I would punch myself like that sort of thing that doesn't really show <mm> and you don't really talk about that sort of element (L: 522)*

Despite cutting being more visible and perhaps harder to hide there did seem to be an act of holding back and not "broadcast[ing]" the forms of self-harm which Nicola deemed more shameful. The words "smack" and "punch" are violent and perhaps relate to the shame Nicola felt about the acts. Feeling shame here appeared to be in anticipation of judgement from others and therefore a relational concept.

3.2.1.3 Factors influencing how participants engaged with social media

Several factors appeared to influence how participants engaged with social media in relation to self-harm. The influences were emotional state; perception by others on and offline; username; anticipated effect on others; the changing nature of social media; the social media site and its community and different accounts, different functions. Each of which will be illustrated in turn.

3.2.1.3.1 Emotional state

The emotional state the participant was in appeared to influence how social media was used in relation to self-harm. Tara shared how her emotional state influenced her social media use in that it increased in likelihood the more distressed she was particularly when experiencing 'psychosis'. Tara used a character from a horror film to describe what the psychosis was like for her:

> *…this girl she walks down the stairs backwards<right> and she's green and zombified <right> and then um, I used to be really, really psychotic, like when I was in hospital because I used to like hit my head. I ended up in [12]PICU/*
>
> *I: Is that what you mean by psychotic then hitting your head?*
>
> *T: Yeah hitting my head, hearing voices <ok> um picking up glass, swallowing it like (L: 463).*

The description was vivid and involved Tara describing herself as a zombie, a frightening and disgusting creature from the dead powerfully illustrating how distressed she was.

[12] Psychiatric Intensive Care Unit

Jess also used social media more regarding self-harm when she was distressed and self-harming to search for similar others.

Participants highlighted being in a better emotional state enabled them to engage with and respond to social media differently. Jess stated:

> *Yeah, like I did once <ok> and I was like "I just wanna die" but then I got in hospital and I just looked at it and some of the other accounts do it and I thought that's so like wrong and when I was a bit better I was in a better frame of mind and I just thought like that can be so triggering for many other people (L: 206).*

Being in a better emotional state seemed to enable Jess to consider the negative effect of her actions on others and amend her behaviour. Jess attributed the change in behaviour to *"trying not to self-harm and DBT is helping me a lot" (L: 126)* and *"yeah, like now I'm in a better frame of mind. I don't really look for the bad accounts, I look for the positive ones" (L: 403).*

Louise commented how *"…when you're in a good mood it's easier to just pass through the stuff that's bad. You can go, "I'm not going to look at that". You can pass on" (L: 534).* Louise was referring to her response to social media content which could potentially trigger her to self-harm. She described easily and consciously deciding against viewing triggering content when in a good mood suggesting a link between mood and level of control over choices and behaviour. The extracts seem to suggest that participants were more aware of the impact of actions on others when they felt "better". There exists a connection between this point, the sub-theme 'anticipated effect on others' and the benefits theme of 'enabled shift in focus.'

3.2.1.3.2 Perception by other social media users

How participants felt they were perceived by others on social media appeared to influence their interaction with it. Concerns about not wanting others to know about their self-harm and or to appear attention seeking were raised. Tara shared how:

> *…if one of my friends knows what's been going on and they message me and they're like "oh how are you doing?" <mm hmm> and I don't really want to tell them "oh yeah I cut myself yesterday"<mm hmm> I want to be able to tell them "oh I'm two months cut free or something". I want to tell them good news (L: 616).*

Tara described others' perceptions as having a powerful, motivational and preventative effect on her behaviour. It appears that Tara liked and sought to be perceived favourably by her friends. Seeking affirmation could be a motivating factor in addition to or alongside avoiding negative evaluation and judgement.

Holly spoke of expressing her feelings then changing her mind for fear of others drawing undesired general conclusions about her based on a specific comment:

> *H: I'll post like "I feel shit" on like Facebook but then I'll delete it like five minutes afterwards 'cos I'm like "oh/*
>
> *I: How come?*
>
> *H: Because I don't want people to think that I feel shit all the time [laughs] (L: 370).*

Holly describes expressing an emotion on social media, quickly regretting her action and revoking it. She seemed to believe her communication would be misinterpreted and would portray her in an unfavourable or incorrect light leading her to delete it.

Holly went on to allude to feeling stigmatised, something she appeared to resist; *"…because I don't want to seem like, 'cos I'm not depressed so I don't want to seem like completely depressed all the time and then people are like "oh god, she's a wreck and I'm not" (L: 391).* Holly's use of this powerful simile resisting being perceived as a "wreck" suggests a social comparison and not wanting to appear in a worse mental state than others.

3.2.1.3.3 Perception by others offline

Concern about how the participants felt they were perceived by others offline including friends and clinicians arose as affecting how they engaged with social media regarding self-harm:

> *I: So you used a separate account to [post a picture of self-harm] <yeah> on <Instagram> and you have a different account for friends <yeah> and how come?*
>
> *J: 'Cos I think my friends and that will judge me.*
>
> *I: Why do you think they'll judge you?*
>
> *J: 'Cos they wouldn't understand.*
>
> *I: What do you think they would think?*
>
> *J: That I'm just doing it for attention <really?> yeah (L: 223).*

Jess shared how she felt her actions were misunderstood by her friends and responded by having separate social media accounts each with different functions and audiences. ‘Misunderstanding of social media use’ is discussed further in section 3.2.4.

Holly shared how the nature and closeness of a relationship affected her fear of judgement which impeded discussion about this issue:

> *H: …because I’m probably never going to see you again I was like “oh whatever” [laughs] <laughs>but I think that if it’s your clinician, like if, if, I don’t know. I wouldn’t go to [clinician’s name] and talk about it/*
>
> *I: About social media? <mm, and self-harm> Can you share why?*
>
> *H: ‘Cos it’s just sort of, I don’t know. I think I’d be judged (L: 904).*

Holly appeared to go through a process of weighing up risk of judgement. Holly seemed to be saying she took part in the research as there was less at stake in talking with me than with her clinician about the topic. As Holly and I were unlikely to meet again the impact of a negative judgement, if I were to make one, would be less affecting for her. Holly went on to say:

> *H: So I think if I went to see [clinicians name] about it, [clinicians name] would be like, “oh my god, what’s this girl involved in?”*
>
> *I: But what do you think they would think? <I don’t know> Do you think they would be like “god/*
>
> *H: “She’s an idiot” (L: 394).*

Holly shared her fear that she would be negatively and derogatorily evaluated as an “idiot”. This could suggest that she perceived herself in this way and therefore predicted others also did. If Holly did feel that using social media regarding self-harm and the difficult interactions that she said took place as a consequence are idiotic, not talking about it with her clinician might imply feeling ashamed.

3.2.1.3.4 Username

Username appeared to play in role in influencing participants’ use of social media and influencing others’ communications with participants. How participants used social media also appeared to influence the username they employed. I was struck by what I interpreted as the distress and pain participants experienced, summed up and displayed via their usernames. Nicola explained that she decided on her (what I first described as an ‘upfront’) username *“because everyone has these sort of up front names so you know what you’re following <ok> when you follow that” (L: 123).* Unfortunately usernames cannot be shared to preserve anonymity. The usernames I heard indicated what participants wanted to do in terms of self-harm, described distress they felt and what I would perceive as derogatory descriptions of themselves. Tara described her previous username as *“something really deeply depressing” (L: 429)* and explained people followed her partly based on it and then she would follow them back. This illustrates how username influenced interactions and how they were perceived by other users as influencing who followed who and what was viewed on social media.

3.2.1.3.5 Anticipated effect on others

Several participants' use of social media in relation to self-harm seemed to be shaped by what they anticipated the effect on others to be. Consideration not to trigger other users to self-harm was prominent in the participants' talk. Mollie explained that it was possible to express feelings of wanting to self-harm without triggering others by tagging posts as containing self-harm, something she did and approved of. If another user 'blacklisted' self-harm for example they would not be exposed to posts which contain it and had been tagged accordingly. Nicola no longer posted pictures of self-harm and said that *"I think I've become more aware of what I actually post, even though I don't know the people on [social media] its still, like that could still be triggering for someone" (L: 99).* Nicola not posting self-harm pictures demonstrated an ability to reflect on actions and take another's perspective.

Parts of Louise's interview extract have been highlighted boldly to illustrate my experience of her as speaking in a forceful and definite way. I took this delivery as an expression of vigilance about not posting potentially triggering pictures:

> *L: I do not post pictures that are at **all** triggering <ok>. I do not do **that sort of thing** <mm hmm>. Like you see girls, like a lot of the girls I know, they'll be outside and it will be summer and [inaudible]. Even if I do wear a t-shirt, no one is **allowed** to take pictures cos if it gets on the internet or anything where it's just really, I just know that someone out there might find it really triggering so **I just don't** (L: 350).*

Triggering others appeared to be strongly against Louise's values. Elsewhere in her interview Louise shared how she could be easily triggered by others' posts

and so appeared to reflect on her reaction and apply it to her behaviour assuming others would feel similarly. Louise spoke of it being difficult to hide self-harm scars but still maintained awareness of the possible negative effect seeing these could have on others:

> *… I have to be really careful and if people get out their cameras when I'm nearby in a t-shirt or something I'll be like,* ***"put that camera away"*** *<mm hmm>. I'm just like,* ***I won't do it*** *(L: 367)*

Both extracts highlight the strong effect anticipating a negative effect on others can have on participants' social media use in relation to self-harm. Holly shared how anticipating a negative effect on others influenced her use of social media regarding self-harm and the support she sought:

> *…you can't, I don't expect people to get it but then I don't want to go to people who have mental health problems 'cos if I tell them that I'm really triggered and I want to take an overdose then that could be unhelpful for them so then that sort of eliminates my friends <yeah> and then it sort of, I don't know, maybe that's why when I was younger I'd use social media a lot 'cos that sort of leaves just people you don't know on the internet who…you can just find through social media. I think it depends on who your friends and family are (L: 854).*

Holly's use of the word "eliminates" is striking as it strongly conveys how she feels unable to seek support from friends. Holly referred to therefore seeking support from "people you don't know" which perhaps suggests that she was able to express a different side of herself with 'friends' on social media than with her real-life friends.

3.2.1.3.6 Changing nature of social media

Participants spoke of how the changing nature of social media influenced their use of it. Mention was made to the change in popularity of the sites used most for expressing and engaging regarding self-harm over time. Holly described Tumblr as *"pretty hard core" (L: 436)* in 2011/12 and commented *"I think it's moved from Tumblr and Twitter to Instagram" (L: 633)* citing Instagram as currently being the *"one that's really messy" (Holly L: 57).*

3.2.1.3.7 The social media site and its community

According to some participants the social media site and its community can influence how it is engaged with. This point connects to participants using social media passively and could also be considered a 'pitfall'. Louise shared; *"the problem with social media is that you get good and bad things filtered in through your news feed" (L: 520)* suggesting that she is not in control of what she is exposed to and that it is determined by the social media site.

Mollie described how what was accepted by different sites, or the communities using those sites, varied from supportive to bullying in relation to self-harm. Mollie felt this influenced how sites were used by people:

> *I: Do you think that's a difference between the sites then and might affect your use of them?*
>
> *M: And how people think they can use them.*
>
> *I: So not just you but what's more widely accepted <yeah> or expected maybe?*

M: Facebook and Twitter are very prone to cyberbullying and stuff like that (L: 312).

Mollie seems to be suggesting a culture developed which shaped how people used different sites. Mollie said “if I wrote some things that I wrote on [Tumblr] on Facebook people would be a bit like, “oh, she’s a bit mad” illustrating how different communities and sites have different levels of acceptance and tolerance to self-harm related content. There also exists overlap here with ‘restraining’ process of censoring, illustrating the interconnectedness of the themes.

3.2.1.3.8 Different accounts, different functions

Participants shared how most of them had different accounts for different uses. One participant had a personal and an anonymous account and another had a recovery account and an account they expressed self-harm on. Which account they used influenced how they interacted and what they expressed via social media and had different audiences.

3.2.2 Unexpected pitfalls

The term pitfall means a hidden or unsuspected danger or difficulty (Oxford dictionaries, 2015). It was deemed an appropriate title as the theme conveys how participants experienced unexpected effects of using social media regarding self-harm. Within pitfalls the following sub-ordinate themes were identified and will be outlined in turn; ‘relational “murkiness”’, ‘exposure to “graphic” images’ and ‘compulsion to use social media regarding self-harm: “…I’m not going to [stop]. I can’t bring myself to”’.

3.2.2.1 Relational "murkiness" (Holly L: 673)

Within this sub-ordinate theme a number of different codes appeared to connect together to reflect a psychological process based on interactions with others via social media. Participants spoke of once on social media comparing themselves with others regarding self-harm; experiencing competition in relation to self-harm; being affected by the interplay between on and offline relationships; trying to decipher the ambiguity of social media communications and feeling responsible for other users' safety. These phenomena seemed to have effects including; conflict, triggering urges to self-harm, worsening mood, feeling unable to live up to the expectations of social media and the idea to imitate self-harm. Self-harm often followed and could be perpetuated by the social nature of interactions on social media. I will now endeavour to elaborate on and illustrate some of these ideas. The phenomena and effects are not entirely distinct from one another and appeared to be non-linearly inter related. Figure 3 and the following elaboration of ideas are an attempt to explain this complex and "murky" relationship in as clear a way as possible.

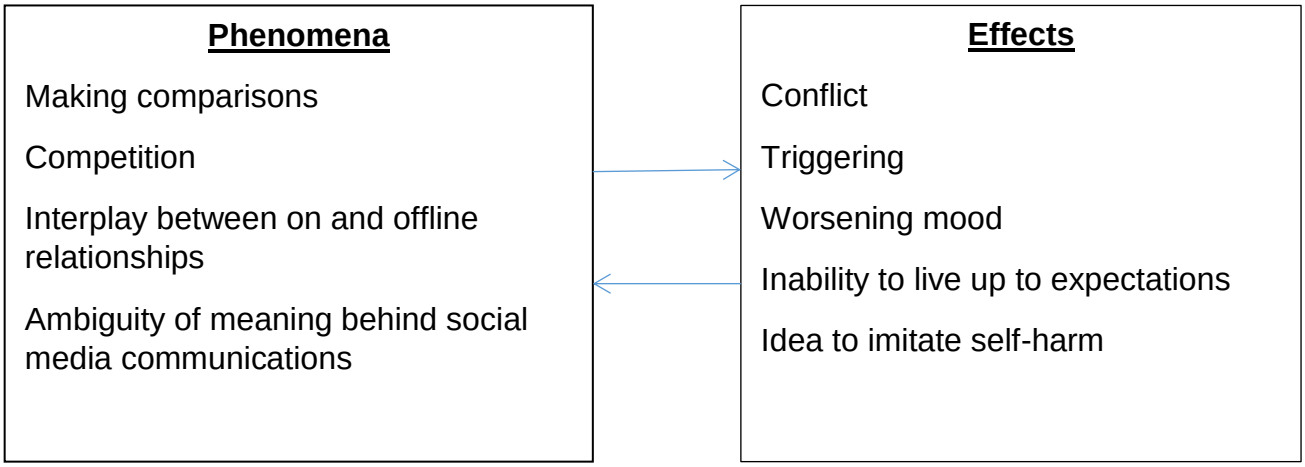

Figure 3. Process of relational "murkiness"

3.2.2.1.1 Phenomena: Making comparisons

It was noticed that participants made comparisons between themselves and other social media users in relation to self-harm, usually with negative effect. Making comparisons with others seemed closely linked with and a precursor to competition between users. Nicola shared how it *"can be quite triggering if you see pictures, even of old scars and you think "oh that's deeper than I've cut" (L: 493)* showing how seeing others self-harm led to her assess hers by comparison. Nicola goes onto to say that the effect of such a comparison is that she *"would just sort of think I'm a bit pathetic" (L: 501)* suggesting a negative impact on her sense of self and arguably worsened mood. Nicola's comments provide an example of how the phenomena of making comparisons related to the effects of triggering urges to self-harm and a worsening of her mood. Tara shared what it meant to her to see others' who had cut deeper than her; *"it kind of meant that they were stronger than me" (L: 494).* Tara went on to describe the past effect on her of seeing others deeper cuts as *"how most people wish to like have a bike for Christmas I would wish to cut deeper" (L: 499).* Tara vividly described her desire to cut deeper by likening it to something many people can relate to from their childhoods; a deep longing for a particular gift. Tara also said that if she cut deeper *"that I would be strong" (L: 502).* Tara's comments suggest she was making an upward social comparison; comparing herself with others who she wished to emulate. She implied that she is not, or is less, strong than those who cut deeper than her. Louise highlights the negative effect comparing herself with others via social media had on her:

…when I'm in a bad place because my voices are even louder than normal like social media almost confirms what they're saying. Like "you're disgusting, you're fat, all these beautiful people looking so lovely. You have no friends, no one loves you. Look at all these people at parties" and me having like no party invitations like…it cements everything (L: 578).

Louise describes social media as something that confirms her derogatory self-view. The use of the word "cement" suggests that such comparisons compound it in a permanent way.

3.2.2.1.2 Competition

Competition was spoken about as a feeling between social media users in relation to self-harm. Holly exclaimed how competition played a significant role in perpetuating self-harm on social media; *"people just compete and it eggs everything on I think…oh my god people compete" (L: 628).* Holly linked competition and triggering on social media to the perpetuation of self-harm:

…I think that it can be competitive… I think like everyone triggers each other and everyone feeds off each other's triggers and everyone like feeds off, like the illness and then it just keeps people stuck being ill…Like I know it's competitive, you can see it <mm>, like "I'm the illest here and all your feelings are irrelevant" (L: 724)

The way Holly described the process, speaking a stream of connections one after the other, suggested the interrelatedness of components. This, combined with how she spoke quickly, gave the sense that this process was dizzying. She explained the competition as being about who was the "illest" and if that title was

not achieved the only alternative was being “irrelevant” suggesting an all-or-nothing dichotomy. In addition, competing to be the “illest” might suggest competing to possess an identity. Perhaps competing to be the most prolific at self-harming seems like the only option if being irrelevant is the alternative. Holly also shared; *“I see people who are like, “ah I’ve been an inpatient like eight times” and I’m like “you’ve only been, you’re like thirteen” (L: 711).* Holly seems to express surprise at seeing such an advertisement of mental health history displayed on a profile. Displaying one’s mental health history could suggest some young people see their mental health experiences as core to their social media identity.

3.2.2.1.3 Interplay between on and offline relationships

The connection or *“knock on effect” (Holly L: 544)* between relationships offline and online stood out as an effect and exacerbating factor of social media on self-harm. Holly described being affected by social media *“if there’s like other factors affecting it like if someone is arguing with me…and then it moves onto social media sort of thing” (L: 881).* She continued to describe the connection as *“entangled”* and *“messy” (L: 525)* implying feeling caught up in the blurred on and offline relationship overlap. Holly wondered whether the role social media played exacerbated difficult interactions and conflicts:

> *…strengthening the messiness? Like really, like when people argue, say on social media and then things get messy offline but that results in people saying “I’m going to kill myself because this girl hates me” and it’s like [sighs] <so> so I think social media can be like a trigger maybe even if*

there's no self-harm on social media I think it can definitely trigger things (L: 528).

This extract also highlighted the serious effect interpersonal conflict can have on those involved. Holly sighed possibly suggesting exasperation at what she perceived to be an extreme response or perhaps as an expression of bewilderment. Nicola echoed how on and offline relationships could interact leading to conflict and *"sort of trigger a load of bitchiness and arguments and that sort of thing" (L: 341).*

3.2.2.1.4 Ambiguity of meaning behind social media communications

Some participants appeared to find it difficult to decipher the meaning behind certain communications others made via social media. A connection between the ambiguity of meaning behind social media communications and on and offline relationships and how they interact was shared:

Holly: …she must have seen [a sad face posted on social media after a disagreement offline] and been like, "oh my god, is that about me?" So she posted two pictures on her Instagram <of what?> and I was like "this is so fucked up". Of like her crying and I was like, "this is so fucked up", of her crying and then in one she's like, "ah I just want to kill myself" and I was like, "oh Jesus, that's so obviously because of me like so obviously because of me" and it's just messy. It's really messy. It's a real, it's really grotty and I'm like, "oh my god" (L: 555).

Holly repeated how "fucked up" and "messy" she experienced the interaction as suggesting she found it difficult to understand and it having had a significant

emotional effect on her. Holly also repeated exclamations of “oh Jesus” and “oh god” suggesting surprise or alarm at her inadvertent impact on another. The other person in the interaction is described as asking whether the communication is about her, seemingly leading to significant distress which she expressed via social media. The ambiguity of the communication appears to have played a role, something Nicola also spoke about disliking:

> *N: Like say someone’s upset someone they will then write a tweet about that person and then that person will see and be like “is that about me? Is that not about me?” And they don’t know whether it’s about them or not.*
>
> *I: So it’s not very clear?*
>
> *N: No <right> it leads to them being paranoid and then even if they ask the person “was that about me?” Then the person will be like “oh well maybe it’s about you, maybe it wasn’t” (L: 330).*

Highlighted here is the uncertainty surrounding who social media communications are directed towards. Nicola remarked how this uncertainty led to “paranoi[a]” which even when investigated offline with the person making the comment with the hope of gaining certainty, was not provided. This potentially highlights a contrasting, negative side of the safety distance via social media can afford as being on the receiving end appeared more distressing. Power is also relevant here as it was held by those making the ambiguous comments on social media, in contrast, those trying to decipher the comments perhaps felt powerless.

3.2.2.1.5 Effects: Conflict

Participants spoke of conflict arising due to misunderstandings on social media about self-harm:

> *Holly: …there was this big argument on Instagram yesterday because this one girl was like, "oh my god, you've all got Munchausen's because you're all like rubbing dirt into your wounds and trying to get them infected and trying to get like serious, like medical intervention for what", [inaudible] slated this girl and said "who the hell are you to say that?" That's how it's murky (L: 669).*

The user in this extract suggests some self-harm to elicit care or attention by comparing their actions to Munchausen's syndrome, where a person pretends to be experiencing a condition to elicit the aforementioned response (NHS, 2015). This perhaps constituted a negative judgement and implied disingenuous distress. Holly described how an argument ensued and upset at the comment was expressed. She referred to the exchange as "murky" possibly suggesting she found it unclear, hard to understand and unpleasant.

3.2.2.1.6 Triggering

A pitfall effect of these relational mechanisms appeared to be the triggering of emotional reactions and urges to self-harm. At seeing an image of a hand filled with pills on social media Louise said *"it makes me feel like I want to get some drugs and do that. It's like I want to die, I'm worthless and stuff and I'm like, well that's how I feel. I mean if they're doing it, why can't I?" (L: 269).* Holly says something similar; *"some girl was like "I just swallowed a hundred paracetamol"*

and I was like "I want to swallow a hundred paracetamol" so I got a bit triggered and was like "how come she can do it and I can't?" (L: 770). Both comments highlight a triggering effect and suggest social comparison led to a desire to emulate another's actions. This again highlights the inter relatedness of the phenomena and effects noticed in participants' talk. In the extracts both participants asked themselves a question about why they could not also behave in this way. This questioning illustrated a comparison to the other person and implied a felt sense of unfairness as a result. Louise shared how triggering seeing graphic images of self-harm was; *"it's really difficult and…It makes me feel like I want to do it again but it makes some people feel really guilty or upset and it's just not, it doesn't really have a positive effect" (L: 216).* Louise explained how she was triggered unexpectedly and unintentionally; "it's really difficult for someone like me because I self-harm and it's really difficult when this stuff just pops up on your news feed and you don't even realise and you're like, *"oh my god, look at that" (L: 198).*

Holly described the disagreements on social media as "witch hunts" (L: 739) and that people "will proper pounce" (L: 742) on those they disagree with via social media. I was struck by these descriptions which to me suggest hunting to attack and/or capture. Animals pounce on their prey. This gives an impression of using social media in relation to self-harm as a frightening, dangerous experience.

3.2.2.1.7 Worsening mood

Common in participants' talk was the worsening effect using social media in relation to self-harm had on their mood. Tara said *"I was probably at a like a moderate depressed level <mm> but I think definitely going on Tumblr made me*

worse at times" (L: 441). Louise described a process of feeling low so going on social media and then feeling lower as a consequence of what she saw:

> *…if I'm feeling miserable…I'd go on Facebook and then someone's bikini picture would pop up on my newsfeed…then like you'd sort of scroll past and then another one pops up …like, you know, when you get into a downward spiral, I just find it really hard to get out and its almost easier to just stay in that downward spiral (L: 494).*

This extract also shows how a variety of posts on social media triggered a worsening of mood for participants. Louise described a process of feeling low, using social media then it playing a part in activating or perpetuating a "downward spiral". This conjures an image of being on a slide; being at the mercy of its downward direction.

Tara shared how she sought and received understanding from others on self-harm related social media but in hindsight how that effect was double-edged as it worsened her mood. Tara said using social media *"probably just made me more depressed because I was talking to depressing people" (L: 554).*

In addition, other effects were shared by the participants. Nicola commented how *"It's difficult to like, I don't know when it's going to affect my mood and how it's going to affect it <mm hmm> I don't know" (L: 235)* suggesting unpredictability. She repeated not knowing two times emphasising the point. Holly also shared how the effect of using social media in relation to self-harm could vary:

> *There been times when I thought it wouldn't affect me and then it has and I've been like "oh, that was a stupid idea" [laughs] but erm, yeah there has*

been times when I've gone on stuff and like been in a really rubbish mood and then been in a really, like better mood afterwards 'cos I might have spoken to someone or something so um, yeah" (L: 815).

Tara described the effect of seeing images of self-harm as making her feel *"sick" (L: 191)* and *"disgusted" (L: 172)* both of which are more physical, bodily responses than emotional. The powerful descriptions offered by Tara indicate the significant adverse effect seeing images had on her.

3.2.2.2 Exposure to "graphic" images of self-harm (Louise L: 152 & Tara L: 712)

Common to the participants' accounts was the pitfall of seeing graphic images of self-harm via social media. Tara shared how she never intended or wanted to be exposed to such images because *"13, 14 year olds shouldn't be looking at that and it didn't really do me many favours" (L: 419).* The extract illustrates how Tara disagreed with her and others aged 13 or 14 seeing such images.

Louise shared some images of self-harm in the interview she had come across using social media which included bleeding cuts, pictures of blades, scissors, and a pile of different pills. She described; *"I remember there was one and I nearly vomited. It was like this girl had cut straight, right through to the bone and you <wow> could see it all and it was just like, this is absolutely horrid" (L: 210)* and the triggering effect this had on her. Louise described the aversive effect seeing such an image had on her, one of physical revulsion.

Holly also shared some examples of graphic images she had seen on social media:

It could be like old scars. It could be …like bruising, it could be like fresh cuts and stuff…like pictures of people with like loads of pills in their hand just like overdosing <oh ok> and pictures of nooses but that's more like s.., or ligature tying that could <uh huh> be self-harm but literally anything that comes under the umbrella of self-harm <mm hmm> was like really bad for a while (L: 452).

3.2.2.3 Compulsion to use social media regarding self-harm: "…I'm not going to [stop]. I can't bring myself to" (Mollie L: 746)

A compulsion or drive to use social media in relation to self-harm referred to feeling the need to do so despite potential negative consequences and arose in several ways. The following extract showed how Mollie spoke of not ceasing to follow a self-harm related account regardless of concerns that it might lead her to self-harm after a period of not having done so and others' contrary opinions "*…I'm not going to [stop]. I can't bring myself to. I don't know why but I'm not going to any time soon" (L: 746).* The extract suggests that something made it hard for Mollie to cease but she was unaware of what. Saying she "can't bring" herself to stop suggests she cannot bear to lose whatever following this person provided her. Louise spoke of becoming *"obsessed" (L: 414)* with looking through photos of others which she knew would upset her and feeling *"sometimes I don't want to make changes. Sometimes I want to go on Facebook and look at all these really pretty people with all their lovely friends and how amazing and popular they are" (L: 623).* Holly expressed feeling unclear as to why she followed social media self-harm accounts and feeling some discomfort when doing so; *"I don't know I was always a bit like "this is weird. Why am I on it?" But I'd still go on*

it <ok> um, it was a bit weird. I don't know" (L: 462). Holly used the word "weird" twice in this extract seemingly emphasising that she did not understand the process taking place. These comments suggest a somewhat uncontrolled, undeliberate process taking place luring participants into behaving in ways they did not intend. A parallel exists with 'passive use of social media' and 'intentional triggering'.

3.2.3 Expected benefits

Many benefits of using social media in relation to self-harm were identified by participants. They have been organised into the sub-ordinate themes of 'enabled shift in focus' and 'acceptance: "I felt like people finally understood where I was coming from and that I wasn't the only one" and safety'.

3.2.3.1 Enabled shift in focus

Participants seemed to benefit from social media as it enabled them to move on from a negative inward focus to a more positive external focus. For example, Anna shared her experience of social media as a helpful distraction; *"if you're feeling down just flicking through and that, it just takes your mind off things doesn't it <mm hmm> that's what social media does, it's just takes your mind off things" (L: 131).* Louise found supporting others who self-harm via social media a *"positive" (L: 313 & 344)* shift in focus; *"…I can help someone, you know, I can forgot about being mentally ill for a bit <mm>. You know it's not about me being mentally ill, it's about the person needing help being mentally ill (L: 347).* She described the act of supporting others as enabling her to step out of a "mentally ill" role. Her comment implies that was something she wanted to do possibly due associated stigma.

Participants shared how by engaging with recovery accounts (Tara & Nicola), reading inspirational quotes (Jess & Anna) and positive posts by other users (Tara) they were provided an alternative, hopeful view; one of life after self-harm. Nicola's description painted a vivid picture of feeling trapped in an ongoing situation and how recovery accounts helped:

> *…it can feel like it's never going to end and you can't visualise a life without doing it <mm hmm> and if there's someone who's actually been in the same position that you're in now and now they're getting better then that sort of gives hope <great> where there's not any before (L: 427).*

Tara said positive posts could *"motivate" (L: 162)* her and make her think *"if they can do that then I can do that as well" (L: 163).* Both extracts show participants making comparisons with others who were in a position they aspired to be in to positive effect.

Social media was talked about in a way that suggested it could provide opportunities for self-development. Holly spoke of being able to *"branch out" (L: 176)* via social media signifying a positive shift in how she used it in relation to self-harm. By talking with others about her experiences of self-harm she said "*it sort of boosts your confidence" (L: 183).* Tara shared how social media and self-reflection enabled her to change the way she expressed self-harm on it allowing her to express her feelings without triggering others:

> *Um by looking at what other people were posting and what I was finding triggering…and sort of thinking I don't really want to trigger people so maybe I need to use a better dialogue to show how I'm feeling instead of just quite abruptly "I've cut" (L: 125).*

Tara was able to see the effect of her actions from another perspective, namely how she experienced them, and changed her behaviour accordingly.

3.2.3.2 Acceptance: "I felt like people finally understood where I was coming from and that I wasn't the only one" (Tara L: 525) and safety

Participants appeared to benefit from feeling accepted by others and safe on social media. Acceptance included feeling understood and in the company of like-minded others. Feeling safe referred to being safe to express feelings, safety from judgement and from interference, and safety due to anonymity. An example of one participant feeling accepted was how social media was spoken about as a place to find others who had similar experiences and feelings which was *"comforting to know that you're not the only one" (Jess L: 147).* Jess' comment could imply that she felt alone offline illustrating how social media can provide what cannot be found offline. Nicola was not seeking a reply and said engaging on social media regarding self-harm was *"…not about building relationships with [others] it's just having somewhere to put [her feelings] and people, knowing that people feel the same" (L: 214).* Of note is how this contrasts with other participants. Nicola stated specifically that social media was not about building relationships for her. Being not the only one suggests seeking understanding which also featured as something sought by participants in 'purposeful use of social media'. Jess said she looked for other people who self-harmed *"just to see like, 'cos I just thought I was going crazy and I thought it was just me" (L: 314)* perhaps suggesting a normalising effect of social media. Tara described how social media provided what she sought; *"because I felt like people finally understood where I was coming from and that I wasn't the only one" (L: 525).*

These comments suggest participants achieved a sense of acceptance and belonging by using social media.

Some spoke of social media being a place where feelings related to self-harm could be expressed. Part of the benefit of doing so appeared to be related to the anonymity it afforded. Nicola described this making her feel *"safe in the fact that nobody knows who you are" (L: 720).* She went on to say:

> *'Cos I can write like "I'm going to kill myself" and I can be intending to and I may go and take an overdose…but nobody interferes with that. I can write that and nobody will be like "oh well I'm going to stay with you for the rest of the day" (L: 726).*

Nicola's definition of "safe" relates to safety from "interference". This is likely to be in opposition to a clinical definition but indicates why Nicola used social media and the function it served for her. Nicola said if she expressed her desire to end her life in real-life then someone would stay with her illustrating a fundamental difference between on and offline relating. Nicola appears to appreciate the freedom from interference social media affords which is also alluded to by Jess who said she used social media *"to have somewhere that's just, be, do what I want…like not really post how I feel but like express myself sort of" (L: 45).* Several participants shared how they liked to express their feelings via social media similarly to Tara who described the reason for doing so *"to relieve stress, like to get it, to put it somewhere. It's like a virtual diary" (L: 714).* She highlighted the benefit she gained from expressing her feelings outwardly which had a positive effect on her stress levels. The use of the word *"vent" (Nicola L: 44 & 715)* could be interpreted as having a similar function.

The idea that anonymity evaded judgement was noticed. Nicola shared how anonymity via social media and in particular when using an anonymous account specifically in relation to mental health concerns meant *"you don't have to worry about what people are going to think" (L: 172).* The comment suggests that ordinarily Nicola would be concerned about how others perceived and judged her and a preference to avoid judgement. Nicola shared why she used an anonymous account illustrating anonymity evading seemingly unwanted negative judgement:

> *"…it's sort of like somewhere that I vent…without people knowing who I am and that sort of thing. Because if I wrote somethings that I wrote on [Tumblr via her anonymous account] on Facebook then people would be a bit like, "oh, she's a bit mad" (L: 44).*

More power can be wielded from behind the screen than in real-life as explained by Jess:

> *…like its easier [to express herself from] behind a screen. You just type… <so, what, you think> and you can't really get negative, well you can but like, you can delete them and in real life people will judge you more and they'll judge you to your face, whereas on Facebook and Instagram, I don't care if they judge me 'cos if they judge me then they're gonna judge me but not to my face (L: 52)*

Jess highlights how on social media she can act in ways in response to being judged that are not possible in offline life such as deleting disliked comments. How much perceived judgement is able to affect Jess on social media is

lessened by the reduced proximity and the fact that she and those she interacts with cannot see each other's faces.

Mollie's comments extended this point to illustrate how anonymity via social media evaded judgement and misunderstanding that was experienced in her offline life:

> *Talking to someone anonymously is much easier 'cos they can't judge you as much <uh huh>. They can't look at you and say "but you have all these wonderful things in your life <mm hmm> why are you complaining?" They can just hear your problems and sort of go "that sucks" (L: 635).*

Mollie highlights how she sought and appreciated validation via social media which she was not receiving offline due to people misunderstanding her feelings based on their appraisal of her life as "wonderful". Mollie saying that people can "just hear your problems" illustrates how she was able to edit what she shared via social media and present a particular picture.

Additionally, participants shared how social media offered what was not accessible in their offline lives including help, care, understanding and a space to talk and do so anonymously.

Support received by participants was identified as a beneficial function which took the form of messages inquiring how participants were, wishing them better and sharing tips to stay on track with recovery. Mollie remarked *"that there are so many people out there who are willing to help you and there are a lot of people going through problems as well that are willing to talk and are willing to be open about them (L: 111).*

3.2.4 Misunderstandings of social media use: "unless you're part of it, you wouldn't understand it" (Holly L: 915)

This theme conveyed a sense that participants felt misunderstood by others including the media, other social media users and clinicians regarding their social media use in relation to self-harm. It was felt that participants wanted others to better understand their use of social media. Mollie spoke of the media only portraying the negative side of social media. She shared how she felt positivity blogs were under recognised and seemed annoyed by and to deem unfair how sites were blamed for Tallulah Wilson ending her life:

> *"you can't just blame the whole site for this one girl. Yeah it was really sad and yeah it was super shit that she killed herself but it wasn't the sites fault (L: 775)* and *"[Tumblr] was all over the newspaper and it was blamed a lot and it pissed me off" (L: 760).*

Holly appeared to also express strong dislike at media portrayal of self-harm as contagious via social media. Contagion is the idea that self-harm can catch on between people (Cornell research program for self-injury recovery, 2015). The phenomenon has been reported in community (Nock, Prinstein, & Sterba, 2009) and inpatient populations (Rosen & Walsh, 1989). Holly shared an incident of a girl on Instagram who inserted objects to self-harm which she described as leading others to self-harm in the same way:

> *H: …now loads of people insert things so I'm like "oh I hate it when people say that self-harm spreads", that's the whole thing in the news that there's this epidemic of self-harm. I hate it when people say that/*

I: Why do you hate it?

H: I hate it when people are like "oh they're copying". I don't know. It just gets to me 'cos it's not like that but on Instagram there are now a lot of people who insert things (L: 662).

Holly appears to highlight how the particular behaviour was imitated by others after seeing it via social media. Simultaneously Holly expressed intense dislike by using the word "hate" at what she appears to consider an inadequate understanding of this phenomenon as copying stating "it's not like that" and "it just gets to me". Holly appears to resist the contagion or "epidemic" discourse which exists in the literature and some clinical settings. The perceived resistance could be a response to the arguable implication of the contagion discourse that self-harm is not a genuine response to distress but a copied behaviour between peers; a potentially invalidating explanation.

Louise spoke of other social media users' misunderstanding expressions of self-harm via social media as *"attention seeking" (L: 174), done to be "cool" (L: 175)* and judging them as *"not very normal" (L: 177),* which she found *"offensive" (L: 184).* Each description appears judgemental and derogatory and Louise's expression of feeling offended portrays the environment she entered into as hostile. Jess spoke of disliking other users making fun of posts related to self-harm;

"It just makes me think, "Why are you laughing at that? I've gone through that, I know how it feels and it's not funny", like, yeah. If they went through it then I don't think they'd find it as funny" (L: 104).

The way Jess asked the question implies that it is difficult for her to comprehend the mocking users' position which could suggest a reciprocal process of misunderstanding.

Not feeling fully understood by their clinicians was raised by some participants. In the context of fearing she would be judged if she spoke about her self-harm social media use Holly said:

> *H: So basically unless <You wouldn't talk about it with your clinician?> you're part of it you wouldn't understand it. Literally you wouldn't understand it. Even what I've said, like, it's too, it's really complicated so you wouldn't actually like get it (L: 915).*

The perceived misunderstanding links to the 'influencing factors' sub-theme and how participants are perceived by others shaping social media use; both of which contained talk about fear of judgement.

4. DISCUSSION

Data analysis led to the identification of four super-ordinate themes; extension of everyday social media use; unexpected pitfalls; expected benefits and misunderstandings: "unless you're part of it, you wouldn't understand it". The findings are considered in relation to the research questions and the themes explored with reference to existing research. Strengths and limitations of the study and its methodology are considered and personal reflections on the process will be offered. Clinical implications and suggestions for future research are presented.

4.1 Summary of findings

The ease of accessibility and mobility of social media means young people use it for many reasons in their day-to-day lives. For the participants, using social media in relation to self-harm was deemed an extension of this everyday use. Social media was used in various ways and its use was influenced by many factors. Participants appeared to be drawn into using social media in relation to self-harm by others and unclear about why they did so. Using social media in this way highlighted the occurrence of a passive or unintentional process. In contrast, participants spoke of using social media in a more purposeful way to either 'take action' or to 'restrain action'. Many factors were seen to influence the extension of everyday social media use. Participant emotional state, felt perception by others on and offline, concern about the anticipated effect of their actions on other users and username affected use, interactions and what they were exposed to. The popularity of sites and what the culture of the site allowed to occur and accepted and the finding that participants used different accounts for different reasons also influenced the participants' use of social media.

Super-ordinate themes 'unexpected pitfalls' and 'expected benefits' mirrored one another. 'Pitfalls' were encountered by participants and these could lead to self-harm. Difficult relational dynamics or "murkiness" appeared to exist and influenced phenomena including participants making comparisons and competing with others leading to effects such as conflict, becoming triggered and feeling worse in mood. Other 'pitfalls' included unexpectedly seeing "graphic" images of self-harm and feeling 'compelled to use' social media in relation to self-harm despite negative effects. Participants also described benefits which they were expecting to gain. Social media appeared to enable a shift in focus from an

internal negative focus to a more positive outward focus, for example, by viewing recovery accounts. Participants appeared to benefit from feeling accepted and safe on social media. Lastly, it was noticed that participants' felt their social media use was misunderstood by others including the media, other users and clinicians.

4.2 Situating the findings within the wider research context

Research question:

How and why do young people use social media in relation to self-harm and to what effect?

How the study answered the research questions will now be outlined. The evidence, models and theories referred to here will be expanded on more fully later in this section as each theme is situated within the wider research context. Firstly, in answer to how young people, deemed mid-adolescents, who participated used social media in relation to self-harm, they did so as an 'extension of their everyday social media use'. This extension, which involved using social media 'passively', could be made sense of by drawing on theories of peer conformity, which suggest young people feel a pressure to fit in and therefore conform with others (Durkin, 1996) and locus of control, where some participants felt uncertain about the purpose of using social media in relation to self-harm and saw it as something that just happened to them (Rotter, 1975). The extension of everyday social media use to self-harm related use also involved using social media 'purposefully' to, for example, express negative feelings. Expressing emotions via social media appeared to serve a similar function to self-harming which can provide emotional relief (Brown et al., 2002; Gratz, 2000).

Behavioural explanatory models of self-harm concerned with reinforcement can help us understand a reason why social media is used in relation to self-harm in that it could make participants feel better (Nock, 2010).

The ‘purposeful’ act of participants using social media to intentionally triggering self-harm to justify doing so, corresponds with Jacobs (unpublished) finding and could be a response to feared judgement. This finding contributed to answering how and why social media was used in relation to self-harm. The findings cited next contribute towards helping us understand how participants who faced difficult experiences growing up and received diagnoses of ‘BPD’ used social media regarding self-harm. Research has shown difficulties to exist in those diagnosed with ‘BPD’ in making social judgements based on facial expressions (Nicol, Pope, Sprengelmeyer, Young & Hall, 2013). This finding connected to another that individuals diagnosed with ‘BPD’ experiencing a heightened sensitivity to perceived threat possibly due to previous trauma (Nicol, 2013; Herpertz & Bertsch, 2014). This trauma could also have increased their sensitivity to rejection (Schmahl et al., 2014). How participants used social media in relation to self-harm was influenced by numerous factors. These factors included, for example, ‘emotional state’. The more distressed a participant felt seemed to correlate with an increase in self-harm related social media use. The Experiential Avoidance Model (EAM) of self-harm (Chapman et al., 2006) could be applied here to help explain how both acts regulate emotions.

Why young people, or the mid-adolescents as the participants were deemed in this study, used social media in relation to self-harm was also answered in part by the finding that it was an ‘extension of everyday social media use’. For these participants the fact that social media was so accessible and mobile contributed

to them using it in relation to most areas of their lives, which therefore included self-harming. Additionally, why participants used social media in relation to self-harm was to gain some of the benefits using it afforded. Benefits included an 'enabled shift in focus' achieved through distraction, by helping others and engaging with recovery accounts via social media. Distraction by using social media served a similar function to distraction by self-harm, both operating to regulate emotions (Brown et al, 2002; Chapman et al., 2006). A benefit of using social media and reason why participants did so in relation to self-harm was that upward social comparisons (Collins, 1996) were being made which motivated and inspired participants enabling them to 'shift their focus' from a negative inward one to an outward more positive one.

Other benefits included 'acceptance and safety' and social media enabled participants to connect with others and consequently feel understood and supported. This corresponded with other study findings (Baker and Fortune, 2008; Hunt, 2015; Jones et al., 2011; Messina and Iwasaki, 2011). Participants spoke of using social media because of the benefits it afforded, including enabling them to feel safe. Anonymity afforded safety from judgement, interference and to express feelings. Suler's (2004) disinhibition effects, one of which is anonymity, Liebert et al's (2006) findings and again, emotion regulation theories (Brown et al., 2002; Chapman, 2006; Gratz 2000; Linehan, 1993), are all helpful in understanding why social media was used in relation to self-harm.

The findings which formed the 'pitfalls', 'benefits' and 'misunderstandings' themes contributed to answering the question to what effect young people, or mid-adolescents in this case, used social media in relation to self-harm. Firstly, one effect and 'pitfall' of using social media in relation to self-harm was making

comparison with others. Social comparison theory (Festinger, 1954), that people evaluate themselves in relation to others, was useful in understanding this phenomenon and that doing so was unhelpful for several participants.

The social interactions outlined in the relational “murkiness” sub-ordinate theme involved making comparisons, competition and miscommunication leading to conflict, worsened mood and self-harm. Linehan’s (1993) biosocial model is a useful model in helping make sense of such relational interactions. It conceptualises ‘BPD’ as a difficulty in regulating emotions, which can lead to the development of unhelpful responses to challenging situations and emotional events. It appears that difficulties in relating in everyday life also transferred to social media interactions.

One effect of relational “murkiness” appeared to be the perpetuation of self-harm. Again, emotion regulation theories are helpful here as self-harm can serve to enable one to escape aversive emotional states which can negatively reinforce the self-harm (Chapman et al., 2006). Drawing on the self-harm addiction literature can help understand another effect which is ‘compulsion to use social media regarding self-harm’ (for example, Harvey & Brown, 2012; Tatum & Whittaker, 1992; Washburn et al, 2010). The effect of being ‘exposed to “graphic images of self-harm’ corresponds with Lewis and Baker’s (2009) finding that images of self-harm were triggering for the young people in their study.

The content from within the ‘benefits’ theme discussed above also helps answer to what effect using social media in relation to self-harm had on participants. The theme of ‘misunderstandings’ contributed to answering what other effects of using social media in relation to self-harm were found. Stigma research regarding

self-harm appears to be relevant here. Young Minds and Cello (2015) found adult views of youth self-harm to be unsympathetic and negative, perhaps helping to explain why participants in this study shared feeling misunderstood. This study found the effects of using social media to be numerous and opposing. The fact that there were significant benefits to doing so but that these were in parallel and intertwined with some serious pitfalls, including feeling 'compelled' to do so and being 'exposed to "graphic" images', made navigating social media with regard to self-harm very challenging. This is perhaps illustrated too by the finding and theme that participants felt their use of social media in relation to self-harm was misunderstood by other social media users, the media and clinicians.

Relevant theory and research findings will now be considered in relation to themes to understand and contextualise the current study's findings. The current research findings provide information about how social media is used in relation to self-harm. Existing research on functions and explanatory models of self-harm will be utilised where relevant as some parallels and overlap between the functions of self-harm and of using social media in relation to self-harm were found. This is a novel area of research and therefore an established evidence base does not yet exist.

4.2.1 Extension of everyday social media use

4.2.1.1 Passive use of social media

How participants were drawn onto using social media by others highlights the social nature of it. It suggests that some participants did not intend to use social media, at times doing so in response to the needs of another, perhaps in an involuntary or non-deliberate way. It was unclear what drove participants to

respond to others' requests but possible explanations include curiosity, a desire to please or conform, or courtesy, for example by following the accounts of individuals who followed them reciprocally. Peer conformity and peer influenced behaviour might help understand this as adolescents can feel a pressure to fit in and a desire to conform regarding appearance and taste (Durkin, 1996) perhaps also engaging via social media in response to others.

The finding that some participants stumbled across recovery accounts and liked how they enabled feelings to be vented shows what a helpful resource social media can be. A parallel appears to exist between the benefit of recovery accounts reported by participants and support appreciated by message board users in Rodham et al.'s (2007) study. Support, included seeking validation and being able to vent, was deemed a main theme.

Some participants were uncertain about the purpose of using social media in relation to self-harm. Some appeared to explain the process of engaging with social media as just happening. Locus of control theory seems relevant here which concerns the extent to which individuals think they can control events they are involved in (Rotter, 1975). Control appeared to be located externally in this instance connecting to research which found low mood and external location of control to be been linked (Benassi et al., 1988).

4.2.1.2. Purposeful use

Participants took purposeful action to express negative feelings on social media. Emotional expression appeared to be a reason why participants used social media regarding self-harm. Emotional relief is deemed a principal function of self-harm (Gratz, 2000; Brown et al., 2002) and emotional expression via social

media appears to serve a similar function. Fu et al. (2013) wrote of how social media can enable increased communication of feelings. It is unclear whether the feelings participants spoke of expressing would have been expressed in other ways offline. However, Suler's (2004) disinhibition effects including anonymity and invisibility afforded by interacting online could be relevant in understanding differences in expression on and offline. Participants reported that expressing feelings via social media made them feel better. This could be understood in terms of intrapersonal reinforcement outlined in the behavioural four function model (Nock, 2010). Interpersonal reinforcement could have maintained participants' emotional expression via social media when met with another's caring, attentive response (Nock, 2010).

A process of seeking self-harm related content to intentionally trigger and justify self-harm was talked about by participants partly answering how and why participants used social media in relation to self-harm. Another qualitative study found young people going online specifically to find images of self-harm to influence how they felt, prompting self-harm (Jacobs, unpublished). Participants said they were unsure why they intentionally triggered themselves. A possible explanation could be that it enables self-harm to occur with reduced or absent feelings of guilt or shame or without feeling judged by oneself, others and society. Concern about judgement from others featured across themes. Participants shared having experienced judgement and stigma in their lives due to mental health difficulties and self-harming, which will have influenced their expectations of future judgement. Individuals diagnosed with 'BPD' have been reported to struggle with making social judgements based on the facial expressions of others (Nicol et al., 2013). Difficulty making social judgements highlighted a possible

heightened sensitivity to perceived threat, potentially a result of past trauma (Nicol et al., 2013). A heightened sensitivity to threat could help explain and contribute to participant concerns about being judged for self-harming and using social media as they might be more likely to perceive or fear judgement from others. Intentional triggering might also connect to research about self-punishment (Favazza, 1996).

This study's findings could correspond with a review of research which stated that individuals diagnosed with 'BPD' can be hypersensitive to social threat (Herpertz & Bertsch, 2014). Interpersonal difficulties associated with 'BPD' including rejection sensitivity can be a result of altered emotional processing and developmental experiences such as insecure attachment or abuse which can affect social cognition and influence emotion regulation (Gross, 2002). A frequently reported factor of interpersonal relationships in individuals diagnosed with 'BPD' is the experience of social rejection (Schmahl et al., 2014). The fear and avoidance of being judged by others noticed in this study could relate to experienced social rejection.

It is possible that restraint was exerted regarding participants' post content due to feelings of shame. Participants spoke of wanting to keep self-harm private and made decisions about what forms of self-harm to express via social media based on the associated shame they felt. Shame has been deemed the most central emotion in 'BPD' and the emotion most linked with self-harm, anger and impulsivity (Rüsch et al., 2007).

4.2.1.2 Factors influencing how participants engaged with social media

Emotional state was thought to influence how social media was engaged with as the more distressed participants were, the more likely they were to use social media in relation to self-harm in a way that might trigger or perpetuate it. It appears that participants used social media as a way to regulate feelings of distress akin to emotion regulation explanations of self-harm such as the Experiential Avoidance Model (Chapman et al., 2006).

Participants appeared more able to think and act differently when less distressed as they could make decisions not based solely on feeling that way. Emotions are known to influence decision making; as emotions intensify they can take control of and impede 'rational' decision making (Loewenstein & Lerner, 2003).

Perception by other social media users appeared to influence participants' social media use. Social media enables individuals to control how they represent themselves (Toma, 2011). The desire to want to share the good news of not having self-harmed expressed by one participant could be made sense of in connection to Toma and Hancock's (2013) findings. Toma and Hancock (2013) applied self-affirmation theory (Steele, 1988) to social media and stated that responses from others via social media could reinforce an individual's sense of worth improving well-being. A wish to avoid negative evaluation could have also been relevant here, a feeling commonly associated with social anxiety (APA, 2013).

The deletion of a comment by one participant for fear of judgement demonstrated the control individuals can have over how they portray themselves on social media in comparison to offline portrayals as highlighted by Turkle (2012).

Concern about fear of and/or experience of negative judgement was noticed throughout the research which could highlight stigma experienced by the participants.

Anticipated effect on others influenced participants' use of social media with regard to triggering. This finding suggests that participants were able to mentalize, meaning they could adopt the perspective of another and understand their mental state, amending their behaviour accordingly (Fonagy et al., 2002), not using social media in a way that could trigger others. The consideration and awareness of triggering others could be a result of participants' DBT engagement. Concern about triggering others appeared to lead one participant to seek support from strangers online. Social media appeared to allow the participant to be another version of herself and Suler's (2004) disinhibition effects, including the anonymity and invisibility afforded by interacting online, could help understand this finding.

4.2.2 Unexpected pitfalls

The research relevant to the use of social media in relation to self-harm focusses on internet use including forums and websites as social media research is lacking. The theme of 'unexpected pitfalls' in this research echoes the 'harmful' side of the wider research findings debate.

4.2.2.1 Relational "murkiness"

Participants spoke of becoming triggered, for example on seeing "graphic" images of self-harm. Similar findings were reported by Lewis and Baker (2011)

with websites. Murray and Fox (2006) also reported that over half their sample self-harmed after reading self-harm related content on a discussion forum.

Competition with others could trigger and perpetuate self-harm in participants. The effect of seeing a self-harm image appeared related to social comparison, leading some to become triggered and desire to emulate another's actions.

The process explained in the 'relational "murkiness"' sub-ordinate theme (figure 3) involved a number of phenomena and subsequent effects. Some of the most resonant will now be considered. Firstly, participants shared how they compared themselves with others via social media and how doing so led to competition and participants feeling worse about themselves and their self-harm. Social comparison theory (Festinger, 1954) suggests that people make comparisons with others in order to evaluate themselves. A process of making upward social comparisons, comparing one's self with someone deemed to be doing better in some way (Tesser, Millar & Moore, 1998), appeared to occur between participants. Comparisons were predominantly with others who had more seriously self-harmed; something the participants wanted to do. Making upward social comparisons is said to be "ego deflating" (Collins, 1996, p. 53) or to enhance self-esteem (Wheeler, 1966). In the current study participants spoke of feeling pathetic, less strong and worse about themselves comparatively, suggesting a negative impact.

A process of social interactions occurred including comparisons, competition and miscommunication with others which led to conflict, distress and self-harm. This was encapsulated in the 'relational "murkiness"' subordinate-ordinate theme. This finding might connect in particular the difficulties young people who access the

DBT team seek and receive help for. Difficulty forming and maintaining social relationships is highlighted as a feature of ‘BPD’ in DSM-V (APA, 2013). Linehan’s (1993) biosocial model conceptualised ‘BPD’ as a difficulty in regulating emotions which can lead to the emergence of unhelpful responses to challenging situations and emotional events. Adrian, Zeman, Erdley, Lisa and Sim (2011) reported 99 adolescent girls admitted to a psychiatric hospital experienced emotional dysregulation as a result of interpersonal conflict with peers which increased self-harm risk. Adrian et al.’s (2010) research connects to the current finding regarding social media interactions with participants’ peers causing distress and self-harm. The relational "murkiness" shared by participants could illustrate how difficulties in relating in everyday offline life also occurred on social media. This connects to social media regarding self-harm being an ‘extension of everyday social media use’.

Relational “murkiness” appeared to be a ‘pitfall’ of using social media and led to conflict and distress for participants. Difficult relational interactions appeared to perpetuate self-harm as it was utilised to reduce distressing emotions. Emotion regulation theories are relevant here. The EAM (Chapman et al., 2006) can help understand self-harm in response to relational “murkiness” as it posits a process of negative reinforcement maintaining self-harm as one seeks to escape aversive emotional states.

Ambiguous social media communications appeared to cause worry and “paranoia” amongst participants. Intolerance of uncertainty, a cognitive construct specific to worry in adults (Dugas, Gagnon, Ladouceur & Freeston, 1998) and more recently adolescents (Boelen et al., 2010) seems relevant. The disinhibition effects interactions via social media can afford could help explain the power

employed by those making ambiguous comments online (Suler, 2004). Online, a failure to receive instant feedback from people can lead to communication difficulties and misunderstandings (Suler, 2004).

4.2.2.3 Exposure to "graphic" images

Participants shared how they were exposed to distressing and triggering "graphic" images via social media, which corresponds to Lewis and Baker's (2009) content analysis of self-harm websites where users reported being triggered by images and descriptions of self-harm.

4.2.2.4 Compulsion to use social media regarding self-harm: "…I'm not going to [stop]. I can't bring myself to"

Compulsion to use social media regarding self-harm in this study could be made sense of by drawing on the self-harm addiction literature. Engaging in self-harm has been conceptualised as an addictive behaviour due to a number of proposed similarities with other addictive behaviours. Self-harming has been reported to provide a feeling of relief (Tatum & Whittaker, 1992), can be preceded by strong urges (Washburn et al., 2010) and can stimulate a reduced endogenous opioid system in individuals diagnosed with 'BPD' (Sher & Stanley, 2008; Stanley et al, 2010) although the latter hypothesis has been contested (Lee & Stanley, 2009). The increase in negative emotions that can occur prior to self-harming has been likened to distressing withdrawal symptoms experienced by drug users (Faye, 1995). It is unclear what was gained by using social media which could not be given up by participants in this study but engagement persisted despite it risking or leading to upset and disagreements with others. Similarly to this finding, young

people described self-harming as compulsive and addictive in Harvey and Brown's (2012) study.

Compulsion to use social media could be explained by reinforcement theories if one's use of social media reduces unwanted emotions including the behavioural four function model (Nock, 2010) and EAM (Chapman et al., 2006).

One participant spoke of wanting and feeling compelled to at times expose herself to pictures she knew would upset her. This finding could be understood in relation to self-punishment research (Favazza, 1996) and extended to the use of social media. One explanation could be that viewing pictures leads to social comparison, which leads to feeling worse due to not perceiving oneself to be as attractive and popular as others on social media. Self-criticism (Glassman et al., 2007), self-directed anger or hatred (Nock, 2010) may precede self-harm which was then utilised to reduce these unwanted feelings (Chapman et al., 2006) and punish the self. Psychodynamic theory also explains self-harm as a form of self-directed anger (Favazza & Conterio, 1989) which could connect to this finding.

4.2.3 Expected benefits

An understanding of the many benefits reported may contribute to answering why participants used social media in relation to self-harm and to what effect. Some of the functions of self-harm highlighted by existing research studies could potentially help to understand the beneficial functions of using social media in relation to self-harm.

4.2.3.1 Enabled shift in focus

Distraction, reported as a self-harm function by more than 70% of the women in Briere and Gill's (1998) study, was a highlighted benefit of using social media in this study. The benefit seemed to be distraction from feeling low which could lead to self-harm if distraction was not employed, suggesting social media might be used instead of and be able to prevent self-harming by aiding emotion regulation, a commonly held explanatory view of self-harm (Brown et al, 2002; Chapman et al., 2006).

Recovery accounts, inspiring quotes and positive posts by other users led some participants to make upward social comparisons, culminating in feelings of hope, inspiration and motivation to not self-harm (Collins, 1996). Upward social comparisons in this instance differ from those highlighted when participants compared their self-harm with more severe self-harm in 'unexpected pitfalls'.

4.2.3.2 Acceptance: "I felt like people finally understood where I was coming from and that I wasn't the only one" and safety

Social media appeared to benefit participants as it enabled them to realise they were not alone and consequently felt understood. This could be viewed as normalising which is presented in the literature as a harmful effect of using the internet regarding self-harm thought to perpetuate use (Whitlock et al, 2006; Lewis & Baker, 2011; Messina & Iwasaki, 2011). This highlights an interesting difference in perspective between researchers and participants. Participants appeared to utilise social media to connect with others who also felt distressed. It is unclear whether doing so perpetuated self-harm or whether it served to benefit them. Alternatively, the finding could connect with Baker and Fortune's (2008)

study where young adults felt a sense of belonging and understood by engaging with self-harm websites. Feeling validated and supported by young people who had similar experiences was deemed helpful in Messina and Iwasaki's (2011) review and in the current study. Forum users also reported that they liked being able to communicate with others who had similar experiences (Jones et al., 2011). A discourse analysis of a small number of Tumblr self-harm community blogs over two months deemed them to provide valuable support to young women who self-harmed (Hunt, 2015). The community appeared to foster 'solidarity' and allowed the young women to "create and control their own discourse of self-harm" (p.12). It created a system of peer support from others who had shared experiences and understanding, gave the young women autonomy and a chance to define their own experiences (Hunt, 2015).

Being able to express feelings via social media anonymously was a benefit for several participants. Anonymity seemed to enable freedom from outside interference, freedom of expression, stress relief and judgement evasion. This finding connects with Brown et al.'s (2002) finding of emotional relief as the main function of self-harm for the majority of women in their sample, all of whom had diagnoses of 'BPD', and Gratz (2000) highlighting social media and self-harm to share similar functions for these participants. If emotional expression equated to emotional relief in this study, Chapman's (2006) EAM model could help explain a possible function of using social media. Regulating emotions can be difficult for individuals with a diagnosis of 'BPD' (Linehan, 1993). Consequently being able to express emotions via social media rather than offline could be preferred by individuals diagnosed with 'BPD' and appeared to be so by some participants.

Participants were seen to benefit from the safety of expressing emotions via social media due to the afforded anonymity; one of the six disinhibition effects of interacting online presented by Suler (2004) which is said to enable freer expression and interaction. Invisibility accompanies anonymity when using social media which can also facilitate being more open than one might be offline Suler (2004). Freedom from outside interference when expressing self-harm feelings was sought by one participant by using social media. Suler (2004) stated the non-existence of authority figures online can lead individuals to behave unconventionally. Posting pictures of self-harm could be deemed unconventional and being able to do so without castigation or consequence is likely to have appealed to the aforementioned participant.

Fear of being judged was repeatedly raised as a concern. Using social media behind a screen appeared to enable negative judgements to be responded to with increased control and power. Suler (2004) stated invisibility online means that another's reactions cannot be seen which offline can impede behaviours for fear of being judged. Turkle (2012) highlighted one difference between on and offline life; the former enabling the ability to edit and delete and ultimately control what is presented or in the case of one participant's comment, which judgements are accepted or deleted. Social media appeared to provide something different and of benefit, for example being able to portray a desired image of one's self, from what participants experienced offline. The current study finding that social media is beneficial as it affords safety and protection from judgement via anonymity echoes Liebert et al's (2006) finding. They posited individuals who had been marginalised and misjudged perceived connecting online as safer due to its buffer from negative judgements.

The safety and feeling of acceptance included safety from judgement, not feeling alone and feeling understood. The behaviour of self-harm can receive negative judgement in society (Jeffrey, 1979; Arnold, 1995). This is likely due to inadequate understanding of why individuals self-harm, perception that self-harm functions to gain attention and do so of their own volition. What participants sought and at times gained by using social media they did not appear to receive in their offline lives suggesting they felt alone, judged and misunderstood. This finding could infer a wider problem of stigma in society.

4.2.4 Misunderstanding of social media use: "unless you're part of it, you wouldn't understand it"

Some participants believed their use of social media was misunderstood by the media, other social media users and their clinicians. Social learning theory (Bandura, 1977) and its role in self-harm contagion (Jarvi et al., 2013) could be helpful in explaining how, for example, insertion appeared to spread after one girl blogged about doing so. However, the one participant appeared to resist the potentially inadequate, invalidating discourse of contagion. Participants shared feeling misunderstood in derogatory ways including being told they were attention seeking and fearing being negatively judged. Research regarding self-harm stigma could be helpful here and extended to understand stigma experienced via social media. Young Minds and Cello (YMC, 2015) reported findings from a survey conducted with parents, teachers and GPs regarding their views of youth self-harm. 47% of survey participants saw self-harm as a way to manipulate others, 34% as fashionable, 32% as copycat behaviour, 27% as a phase and 16% that young people could easily stop if they chose to (YMC, 2015). It was not documented how many people were surveyed but these findings highlight an

unsympathetic discourse in existence which could help understand why participants in the current study felt misunderstood.

4.2.5 The role of gender

It feels pertinent to acknowledge and reflect on the fact that all the participants and the majority DBT service clients are female. Self-harm and 'BPD' are considered predominantly female expressions of distress; both are heavily steeped in stigma (Aviram, Brodsky & Stanley, 2006; Scourfield et al., 2011; Time to change, 2015). Feminist self-harm theory conceptualises self-harm as an act of resistance against oppression (Gilligan, 1982). The current study did not seek to explore the participants' earlier life experiences so their experiences of trauma and/or abuse are unknown. However, it has been suggested that there exists a need to reconceptualise 'BPD' as "adaptive reactions to relational [childhood] traumas" (Johnstone, 2000; Bourne, 2011 p. 83) as it is felt by some to better explain the commonly experienced difficulties of this population. Participants are likely to have experienced oppression whether in their early lives and/or more recently through the stigma self-harm receives. It is possible that self-harm and using social media in relation to self-harm served to enable participants to regain power and control in their lives. Social media appeared to provide an environment where participants felt able to express themselves more freely away from misunderstanding and negative judgement.

4.3 Critical review

This section will consider the strengths and limitations of this study and offer my reflections on the process.

4.3.1 Strengths

The sample was homogenous in terms of sex, ethnicity, nationality, therapy, diagnosis, age range and self-harm behaviour. No known published research interviewing young people who self-harm about social media use regarding self-harm has taken place before.

4.3.1.1 Assessing quality and validity in qualitative research

Assessing quality and validity in qualitative research requires different methods of evaluation from those used for quantitative research (Smith et al., 2009). The following four criteria proposed by Yardley (2000) will be used in the current study: sensitivity to context; commitment and rigour; transparency and coherence; impact and importance.

Sensitivity to context

Firstly, by choosing to interview young people about a topic little is known about and using IPA to strive to understand what the experience was like for participants, I have aimed to be sensitive to the context. Ethical issues were carefully considered from the throughout the study with the DBT team due to the sensitive nature of the research and the potential vulnerability of participants. Careful consideration and planning of the interview schedule occurred including several revisions via consultation with young service users and the DBT team. Considerable thought and effort was made to put participants at ease and attend to the power differential at interview (as discussed in section 2). The extensive use of transcript extracts to support the claims made also illustrated sensitivity to context. Time and care were taken to stay close to the data in the hope of giving voice to participants' experiences and to ensure interpretations could be

scrutinised (Smith et al., 2009). Claims, interpretations and conclusions were not definitive but tentative. Findings have been located within the wider research context and additional research has been incorporated to further enable current findings to be understood.

Commitment and rigour

Commitment was evidenced by the care and time taken to recruit participants according to clinician recommendations. Participant welfare was paramount. Interviews were cancelled and rescheduled if participants felt emotionally unable to attend. I was flexible regarding meeting participants and typically did so before they attended a therapy session so support was easily. I ensured participants were fully informed about the study and endeavoured to help them feel comfortable throughout. None of the participants appeared or reported feeling distressed during the post interview debrief which could suggest they felt comfortable. Rigour was demonstrated throughout the research by the homogeneity of and appropriateness of the sample to answer the research questions. Smith et al. (2009) stated rigour is demonstrated by conducting IPA thoroughly and ensuring a level of interpretation is reached beyond description, which I aimed to achieve. I have included extracts from all participants which are hoped to best demonstrate the themes reached.

Transparency and coherence

Transparency has been demonstrated by outlining in section 2 the steps taken in conducting the study including participant selection, interview schedule construction and conduction and data analysis. An extract of an annotated transcript (Appendix L) and a theme map (Appendix N) are included. Coherence

between the research and the underpinning assumptions of IPA was hopefully demonstrated through acknowledgement of the hermeneutic and interpretative components throughout. An independent audit was conducted where the validity of my annotations was checked by another researcher and themes were discussed to ensure IPA adherence and enable skill development. The process of the independent audit (appendix M) is felt to demonstrate commitment to quality and validity (Smith et al., 2009).

Impact and importance

Yardley (2000) deemed validity to be truly demonstrated by whether an IPA study produces important, interesting or useful findings. It is felt that this study offers additional understanding of a new, highly publicised and yet to be researched area of clinical relevance. It felt important to hear the perspective of young people themselves and their contribution was deemed useful and interesting. The clinical implications of the findings have been outlined in section 4.4 demonstrating the study utility.

4.3.2 Limitations

One of the limitations of the current study was the very specific sample recruited through a specialist DBT team. The seven participants were all young women who had received a diagnosis of 'BPD'. Despite generalising findings not being a key aim of qualitative research, caution must be exercised in considering the current study's findings in relation to other young people who self-harm. However, it is hoped that the current research will be clinically useful in relation to young people diagnosed with 'BPD' who self-harm. All participants were engaged in a programme of DBT which would have influenced the narratives and methods

of meaning making they drew upon when interviewed. The participants appeared psychologically articulate which was perhaps influenced by the therapy they engaged with and might not be representative of all young people. The participants' ability to access and articulate their experiences and psychological states influenced the analysis in that they often spoke of psychological constructs which suggested analysis at the conceptual level. The sample was all female and white British. The majority of young people who access the DBT service are female which fits with research that young women are 1.5-3 times more likely to self-harm than young men (Whitlock et al., 2006). The current study sample is not representative of the demographic where the service is based which potentially raises a question about service accessibility. The youngest participant was 15 demonstrating how no 12 to 14 year olds took part the findings therefore represent mid to late teenage years only.

The recruitment target was eight to ten participants, but only seven agreed to take part. However, the IPA literature suggests ten participants as the maximum number in research in order to maintain the idiographic nature (Smith et al., 1999). Those who agreed to interview appeared happy to discuss their experiences. It is acknowledged that their accounts could differ from those who declined to take part.

Data collected was not naturally occurring. Interviews are considered an overused method of collecting data and limited in the information they provide (Chamberlain, 2012; 2014). Consideration was given to conducting focus groups to overcome such criticism however, doing so was not deemed clinically appropriate as discussed in section 2. The interview schedule was semi-

structured which could have limited responses. However, open questions were asked in an attempt to minimise the shaping of responses.

Attempts were made to include visual methods by inviting participants to show their social media accounts during interview to bring the topic to life, however only two young participants agreed to.

4.3.3 Reflection

I enjoyed interviewing the participants who were open and thoughtful. My apprehension about participants becoming distressed by the process was unfounded and although I felt great empathy for them, the content discussed felt manageable to bear.

I kept a reflective journal to capture feelings, thoughts and questions which arose throughout the research process. Reflective conversations took place with other IPA researchers in an attempt to bring forth assumptions and make bias explicit. During analysis I took care to notice and note down the effect reading the transcripts had on me and on the assumptions I was making whilst immersing myself in the data (Appendix O). The aforementioned reflective processes enabled assumptions to be ‘bracketed off’ as far as this is consciously possible.

At points during analysis I felt overwhelmed and uncertain of the process. I felt initially that as a novice IPA researcher there was a pull to get it ‘right’. This pull is something I often recognise in myself but was exacerbated due to time and academic pressure. Initially I attempted to analyse the transcripts in great detail according to my interpretation of IPA guidance which was extremely time consuming and challenging. Chamberlain (2014) criticised being wedded to a chosen methodology and following prescribed steps as this can sacrifice true

engagement with the data. Through discussion in supervision I altered my approach from overly focussing on conceptual, descriptive and linguistic commenting to a less rigid method. I freed myself up to comment on what I found interesting and what was being said by the participants, the more conceptual analysis occurring throughout the theme identification and write up. It felt important and necessary to step away and return with a fresh perspective at regular points as this enabled focussed engagement with the data. Holding the research questions in mind and perpetually returning to them throughout coding and compiling themes helped to focus and attend to what was relevant from interviews.

4.4 Implications and recommendations

4.4.1 Implications for future research

The current study offers seven young women's perspectives' of and has increased knowledge of how social media is used by these young people in relation to self-harm. Further research into this new area about which little is known is recommended. Researching young people from the general population or generic CAMHS who self-harm could enable a broader understanding. Recruiting more diverse samples and investigating how experiences of using social media in relation to self-harm differ according to different contexts in terms of ethnicity, gender, socio-economic status and age range is recommended. Different methods of data collection could be employed to enable more naturally occurring data to be acquired, for example via focus groups, the internet or social media. Conducting the research via the medium being investigated could enable more representative data to be collected that more closely reflects the way young

people talk together about the phenomena. Research into the views of clinicians, other professionals involved in young people's lives such as teachers, and parents might be helpful in increasing knowledge about the views of social media and self-harm in the system around young people.

Further investigation into the process of intentional triggering and the link between emotion regulation and using social media in relation to self-harm and social media is recommended.

4.4.2 Implications for clinical practice

4.4.2.1 At the level of direct clinical intervention

Social media use in relation to self-harm was found to be an extension of everyday social media use. This finding supports the recommendation for routine assessment of social media use by clinicians as highlighted by Lewis et al., (2012) and the 'Managing self-harm in young people' recommendation 13 (RCP, 2014). Assessment could increase knowledge and help open dialogue about self-harm and social media use and through therapeutic engagement could enable ongoing conversations, gathering of knowledge and support around the issue to occur.

The 'passive' engagement with social media by some participants led to exposure to self-harm related content and negative effects. Attempts to inform young people of the potential risks of using social media has occurred at a policy level but with little behaviour change (Livingstone & Smith, 2014). Ongoing attempts to raise awareness of the potential 'pitfalls' is recommended at the level of clinical intervention. For example, it would be helpful to raise awareness in relation to the graphic images and content young people might unintentionally

encounter and the effect having a particular username could have on who and what they come across could be helpful. However, based on these findings, maintaining and conveying a balanced view including the benefits associated with social media use regarding self-harm is advised.

Clinicians having a greater understanding of some of the factors which influenced participants and their social media use could help focus intervention or enable it to be considered during intervention if it was not previously.

The influence of shame, the seeking of affirmation and self-worth and the compulsive use of social media all arose as areas worthy of clinical attention in relation to self-harm and social media.

A reported benefit was feeling motivated and hopeful after viewing recovery accounts, which were stumbled across, suggesting participants were unaware of them to search for as a source of support. Recovery accounts could potentially be promoted by clinicians as examples of hope and the possibility of overcoming self-harm. A danger is that participants said some accounts claim to focus on recovery but can be triggering. Clinicians could familiarise themselves with chosen recovery accounts prior to recommending their use to reduce this risk.

Some participants reported feeling their social media use was misunderstood by others including clinicians which highlights the potential benefit of opening up a dialogue about social media use in relation to self-harm. A fear of being judged by clinicians for being involved in ‘relational “murkiness”’ was shared. Alongside intervention focussing on helping young people to make sense of and manage feelings of judgement, clinicians could ensure they are explicit about taking a non-judgemental stance towards this issue. One participant suggested that all

clinicians should expect service users to use social media and therefore ask about it non-judgementally. Another commented “unless you’re part of it, you wouldn’t understand it” so clinicians familiarising themselves with sites such as Tumblr, Twitter and Instagram could enable further clinically useful understanding of social media to be gained. Another participant suggested the service set up a group focussed on social media and self-harm to enable related discussion and support.

4.4.2.2 Service user involvement and peer support

The benefits of using social media in relation to self-harm including recovery accounts highlighted the power of sharing experiences with others who have experienced something similar. Consideration by services of how to utilise peer and service user support specifically in relation to the issue could be of benefit; for example on or offline peer led mentoring with individuals who in self-harm recovery. The peer support model is recommended by the National Institute for Clinical Excellence (2014) and implemented in services for people experiencing psychosis and could be beneficial to other populations.

Feeling understood and not alone were consistently raised benefits which participants sought and benefitted from through using social media in relation to self-harm. Consideration of how young people who self-harm could belong to additional communities where they feel understood if they do not in real-life could be valuable. Some participants shared how they were involved in self-harm charity organisations. Service user participation could help engender a sense of belonging, self-worth and empowerment (Tait & Lester, 2005).

One participant shared how she would like to start a campaign saying "*I just wish there was something we could do to like stop it all, some of this negative stuff…just letting people know that like the negative side to some of it*" (Louise L: 666). Services could consider how to support young people in service user participation.

4.4.2.3 Public awareness and intervening at the macro level

Engagement with the media by clinicians working with young people who self-harm regarding their social media use is encouraged especially raising awareness about the negative effect media portrayals can have on young people. A counter view to the dominant discourse of risk and negativity could be presented. It is possible that negative media portrayals play a role in impeding young people's ability to discuss their social media use for fear of judgement.

The judgement and misunderstanding expressed by some of the participants is likely, in part, to reflect wider societal judgements of individuals who self-harm. It is acknowledged that this research involved a small and specific sample but social media and self-harm is known to be a wider issue for young people. For example, #cut4zayn, a call on Twitter by young One Direction fans for others to self-harm in response to a member's band departure in the hope doing so would make him stay. If research into this area is conducted with more diverse populations and similar findings are reached, public health intervention could help to raise awareness and increase understanding in an effort to reduce stigma.

4.5 Conclusion

In conclusion, the perspectives' of seven females in their mid-adolescence about how they used social media in relation to self-harm and to what effect were

explored. Under the overarching concept of the accessibility and mobility of social media four main themes were derived. Participants spoke of using social media ‘passively’, ‘purposefully’ and how they did so was influenced by numerous factors therefore extending their everyday social media use to also incorporate their self-harm. They experienced ‘pitfalls’ including ‘relational “murkiness”’, feeling ‘compelled to use social media’ and being ‘exposed to “graphic” images’. In contrast, participants experienced ‘benefits’ including a ‘shift to an outward focus’ and feeling ‘accepted and safe’. Participants also shared how they could feel misunderstood by other social media users, the media and clinicians.

This study has contributed some new understanding and knowledge of this emerging and clinically important area. Explanatory models and functions of self-harm and other relevant literature and theory have been useful to drawn upon in making sense of the participants social media use in relation to self-harm. However, as this is thought to be the first piece of research exploring the use of social media in relation to self-harm in this population the findings are deemed to be novel. In particular, that the use of social media in relation to self-harm is an ‘extension of everyday social media’ use might appear to be an obvious finding, however, I have not come across it in the literature. In addition, I have not encountered literature pertaining to social media being used ‘passively’ in the ways described in this study in relation to self-harm. Participants shared their experiences of encountering pitfalls and misunderstandings. However, many benefits to using social media regarding self-harm were imparted demonstrating a dichotomy and the complexity of navigating this relational medium. Further research is necessary and encouraged. It is hoped it will further understanding to ensure the exciting world of social media is being discussed, considered and

made sense of when working with young people experiencing psychological distress and self-harm.

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6. APPENDICIES

Appendix A: UEL School of Psychology Research Ethics Sub-Committee ethical approval

ETHICAL PRACTICE CHECKLIST (Professional Doctorates)

SUPERVISOR: Neil Rees **ASSESSOR:** Dori Yusef

STUDENT: Lucy Brett-Taylor **DATE (sent to assessor):** 06/03/2014

Proposed research topic: How and why young people use social media in relation to self-harm and to what effect.

Course: Professional Doctorate in Clinical Psychology

1. Will free and informed consent of participants be obtained? YES / NO

2. If there is any deception is it justified? YES / NO / N/A

3. Will information obtained remain confidential? YES / NO

4. Will participants be made aware of their right to withdraw at any time? YES / NO

5. Will participants be adequately debriefed? YES / NO

6. If this study involves observation does it respect participants' privacy? YES / NO / NA

7. If the proposal involves participants whose free and informed consent may be in question (e.g. for reasons of age, mental or emotional incapacity), are they treated ethically? YES / NO / NA

8. Is procedure that might cause distress to participants ethical? YES / NO / NA

9. If there are inducements to take part in the project is this ethical? YES / NO / NA

10. If there are any other ethical issues involved, are they a problem? YES / NO / NA

APPROVED

	YES, PENDING MINOR CONDITIONS	

MINOR CONDITIONS:

Researcher to provide evidence of both of the below to the research supervisor.

- How exactly will the researcher ensure before hand / before the research interview that indeed "a team therapist, if possible, one who regularly works with the young person, will be on hand if any clinical issues or need arises".
- Likewise re: the debriefing.

The reviewer requests to a copy of the invitation letter to participants and to guardians; more information about the planned de-briefing process.

Assessor initials: Dr. Dori Yusef Date: 4/04/2014

RESEARCHER RISK ASSESSMENT CHECKLIST (BSc/MSc/MA)

SUPERVISOR: Neil Rees **ASSESSOR:** Dori Yusef

STUDENT: Lucy Brett-Taylor **DATE (sent to assessor):** 06/03/2014

Proposed research topic: How and why young people use social media in relation to self-harm and to what effect.

Course: Professional Doctorate in Clinical Psychology

Would the proposed project expose the researcher to any of the following kinds of hazard?

1 Emotional YES **/ NO**

2. Physical YES / **NO**

3. Other YES / **NO**

(e.g. health & safety issues)

If you've answered YES to any of the above please estimate the chance of the researcher being harmed as: HIGH / **MED** / LOW

APPROVED

YES		

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: Dr. Dori Yusef Date: 4/04/2014

For the attention of the assessor: Please return the completed checklists by e-mail to ethics.applications@uel.ac.uk within 1 week.

SCHOOL OF PSYCHOLOGY
Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

UEL
University of East London
www.uel.ac.uk

School of Psychology

Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ
tel: +44 (0)20 8223 4966 fax: +44 (0)20 8223 4937
e-mail: mno.davies@uel.ac.uk web: www.uel.ac.uk/psychology

Appendix B: NHS ethical approval letter

NHS
Health Research Authority

NRES Committee London - Riverside
Level 3 Block B
Whitefriars
Lewins Mead
Bristol
BS1 2NT

Telephone: 0117 342 1385
Fax:0117 342 0445

15 September 2014

Miss Lucy Brett-Taylor
30B Cephas Avenue
London
E1 4AT

Dear Miss Brett-Taylor

Study title:	**How and why young people use social media in relation to self harm and to what effect?**
REC reference:	**14/LO/1313**
IRAS project ID:	**151848**

Thank you for your letter of , responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Miss Tina Cavaliere, nrescommittee.london-riverside@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation [as revised], subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

You should notify the REC in writing once all conditions have been met (except for site

approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see

"Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance document]	2	04 April 2014
Interview schedules or topic guides for participants [Interview schedule]	2	07 July 2014
IRAS Checklist XML [Checklist_05092014]		05 September 2014
IRAS Checklist XML [Checklist_05092014]		05 September 2014
IRAS Checklist XML [Checklist_01092014]		01 September 2014
IRAS Checklist XML [Checklist_09092014]		09 September 2014
Other [Information for clinicians]	1	30 June 2014
Participant consent form [Young person assent form 12-15]	1	18 August 2014
Participant consent form [Parents consent form]	6	18 August 2014
Participant consent form [Consent form for young person 16-18]	1	18 August 2014
Participant information sheet (PIS) [Information sheet for young people 12-15]	6	18 August 2014
Participant information sheet (PIS) [Young person information sheet 12-15]	6	18 August 2014
Participant information sheet (PIS) [Information sheet for young people 12-15]	6 clean version	18 August 2014
Participant information sheet (PIS) [Information sheet for young people 12-15]	6	18 August 2014
Participant information sheet (PIS) [Information sheet for young people 16-18]	1	18 August 2014
Participant information sheet (PIS) [Parent information sheet]	6	18 August 2014
Participant information sheet (PIS) [Information sheet for young people 12-15]	6 tracked	18 August 2014
REC Application Form [REC_Form_09072014]		09 July 2014
Research protocol or project proposal [Thesis proposal]	1	18 June 2014
Response to Request for Further Information		
Summary CV for Chief Investigator (CI) [CI CV - Lucy Brett-Taylor]	1	18 June 2014
Summary CV for supervisor (student research) [Research supervisors CV]	1	01 July 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at
http://www.hra.nhs.uk/hra-training/

14/LO/1313	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

Pp

Dr Sabita Uthaya
Chair

Email: nrescommittee.london-riverside@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Professor Neville Punchard*
Jennifer Liebscher, South London and Maudsley NHS Foundation Trust

Appendix C: Research and development approval

Institute of Psychiatry, Psychology & Neuroscience

Research and Development Office

Box P005
De Crespigny Park
Denmark Hill
London SE5 8AF
Tel +44 (0)2078480790
Fax +44(0)2078480147
http://www.kcl.ac.uk/ioppn/research/office/index.aspx

Miss Lucy Brett-Taylor
30B Cephas Avenue
London E1 4AT

10 October 2014

Dear Miss Brett Taylor

Trust Approval: R&D2014/090
Title: How and why young people use social media in relation to self harm and to what effect.
REC Reference: 14/LO/1313

I am writing to confirm approval for the above research project at South London and Maudsley NHS Foundation Trust. This approval relates to work in the Child and Adolescent Mental Health Services CAG and to the specific protocol and informed consent procedures described in your R&D Form. Any deviation from this document will be deemed to invalidate this approval. Your approval number has been quoted above and should be used at all times when contacting this office about this project.

Amendments, including extending to other Trust directorates will require further approval from this Trust and where appropriate the relevant Research Ethics Committee. Amendments should be submitted to this R&D Office by completion of an R&D Amendment form together with any supporting documents. A copy of this is attached (R and D Amendment Form V3.doc), but is also available on the R&D Office website.
King's College London - Research and development approval

I note that the University of East London will be taking on the role of Sponsor for this study.

Approval is provided on the basis that you agree to adhere to the Department of Health's Research Governance requirements including:

- Ethical approval must be in place prior to the commencement of this project.
- As Chief Investigator and/or Principal Investigator for this study you have familiarised yourself with, and accept the responsibilities commensurate with this position, as outlined in the Research Governance Framework

  http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4122427.pdf.

- Compliance with all policies and procedures of the Trust which relate to research, and with all relevant requirements of the Research Governance Framework. In particular the Trust Confidentiality Policy.

http://www.slam.nhs.uk/media/107386/confidentiality%20policy.pdf

.

- Co-operating with the Trust R&D Office's regular monitoring and auditing of all approved research projects as required by the research governance framework, including complying with ad hoc requests for information.
- Informing the Trust's Health and Safety Coordinators and/or the Complaints Department or of any adverse events or complaints, from participants recruited from within this Trust, which occurs in relation to this study in line with Trust policies. Contact details are available from the R&D Office if required.
- Sending a copy of any reports or publications which result from this study to the Trust Departments involved in the study if requested.
- Honorary Contracts must be in place prior to patient contact for all relevant members of the research team. Advice on this will be provided by the R&D Office at the point of obtaining R&D approval and on an ongoing basis for new members of staff joining the research team.
- Sending a copy of the annual reports and end of project notification submitted to ethics.

Failure to abide by the above requirements may result in the withdrawal of the Trust's approval for this research.

If you wish to discuss any aspect of this research approval with the R&D Office, please contact Jenny Liebscher jennifer.liebscher@kcl.ac.uk in the first instance.

I wish you every success with this study.

Yours sincerely

Adriana Fanigliulo

Adriana Fanigliulo
Research Governance Facilitator
SLaM/IoPPN R&D Office

Enc. R&D Approval Amendment Form

Appendix D: Information for clinicians

South London and Maudsley NHS Foundation Trust

UEL University of East London

Research project: How and why do young people use social media in relation to self-harm and to what effect?

Researcher: **Lucy Brett-Taylor**, Trainee Clinical Psychologist, University of East London.
Local collaborator: **Dr Claire Hepworth**, Clinical Psychologist, DBT team, SLaM.

Phone no: **xxxx** Email: **xxxx**

Dear clinician,

I am looking to recruit young people from your service to interview about how they use social media in relation to self-harm and to what effect for my clinical psychology doctoral thesis. It's a new and very topical area in need of researching to increase understanding and to hopefully further inform clinicians and parents. Your help to do so will be much appreciated!

If you feel able to help with this research please identify young people you work with who:

- Are aged between 12 and 18 years old
- Self-harm and have done so more than once in total and once within the last six months
- Who when asked "do you use social media[13] in any way to do with self-harming[14]?" say yes.

If you are working with a young person who meets the criteria:

- Please ask them if they are interested in taking part in this study
- Please provide them with the information pack
- Please let them know that the interview will take an hour and take place at your service at a time convenient for them
- Inform them that they will receive a £10 voucher for taking part
- Please ask if I can contact them and/or their parent/ guardian to explain more and answer any questions (by agreeing they are not tied into taking part)
- If they agree, please add their details to the form below please and call/email me. I will also call a named clinician in your team every few days so if it is easier you can let them know you have someone identified.

Many thanks, Lucy.

Young person's name: ……
Age:…….

Parent/guardian's name:
……

[13] Eg Twitter, Facebook, Tumblr, Instagram etc.
[14] [14] In any way eg to communicate, share pictures, seek support, tell others how they feel.

If 16+, YP's phone number: …… If <16, parent/guardian's number:……..

Clinicians' name…….Email address……

Appendix E: Interview schedule

Final Interview schedule

Begin with problem free talk.

Emphasise it is anonymous.

Explain confidentiality

Explain don't have to answer anything feel uncomfortable about and agree signal can display if feel so and unable to say eg put hand up

Social media in general

- What forms of social media do you use (in general)? (if need prompting eg Facebook, Tumblr, Twitter, Instagram, Snapchat, Whatsapp, BBM)
- When would you use [social media]?
- Why do you use them?
- What do you like about them? Are there things you don't like about them?

Re self-harm

- How do you use [insert form of social media given] eg just to look at posts and/or pictures/to interact/to get help not to self-harm/to get tips on how to?
- What sorts of social media do you use to express feelings of self-harm? Or what social media do you use to post feelings? (ask to be shown using the tablet. *Nb if show must explain in confidentiality that if see anything which raises concern re someone else at risk, obliged to act on*)
- *Which sites were positive and which were negative?*
- Why?
- How do you self-harm? *Or how have you self-harmed in the past?*

What leads to using social media in relation to self-harm

- How do you end up in said online space and why?
- *Do you access certain spaces when feeling certain way?*
- Are there times when you are more likely to use social media in relation to self-harm than others? When is this?

When using

- How do you portray yourself on [social media]? Eg as yourself or someone else?
- If someone else, do you use another name? If yes, why and what effect do you think that has on you and the way that people think about you or talk to you?

Effect

- What do you get from using each form of social media? (what are the positives and negatives of each?)
- How do they make you feel? *Are there times when they have led you to feel something unexpected?*
- How does one affect you compared to another? When would you choose one over another?
- In what ways do they help you?
- *Has this changed over time?*
- What, if anything, does using [form of social media] give you that other ways of talking with friends/family/others do not eg other internet use, speaking with family or friends?
- What are the good *(helpful)* things, not so good and bad things *(unhelpful)* about using social media in relation to self-harm?
- Do you have any worries about using social media in this way? If so, have you tried to stop? How did that go?

Support

- Apart from social media what other forms of support do you use?

Others

- Who else knows that you use social media in relation to self-harm? What do they think about it?

- Do you know other people that use social media in this way? Why do they use it in this way?

Ending

- What else would you like to say about using social media?
- Do you think you will carry on using social media in this way?
- *What do you think is important for professionals to take from this?*
- *Do you have any questions?*

- *Thanks for taking part. Where would you like your voucher for? Open to be contacted to share findings with?*

Appendix F: Information sheet for young people 12-15

INFORMATION SHEET FOR YOUNG PEOPLE (AGED 12-15)

Project Title: How and why do young people use social media in relation to self-harm and to what effect?

UNIVERSITY OF EAST LONDON

School of Psychology, Stratford Campus, Water Lane, London, E15 4LZ

The Principal Investigator

Lucy Brett-Taylor, Trainee Clinical Psychologist, E-mail: uxxxx@uel.ac.uk

Consent to Participate in a Research Study

The purpose of this letter is to give you information that you need to consider when deciding whether to take part in this research study. If you think you might like to take part, a copy will also be given to your Mum, Dad, or carer. This is because they will also need to decide whether they agree to you taking part.

The study is being conducted as part of my Professional Doctorate in Clinical Psychology at the University of East London.

What does the project involve?

The aim of this project is to explore the reasons young people use social media in relation to self-harm. For example, topics of discussion might be: What forms of social media do you use in relation to self-harm and what effect does using them have? In what way do you use social media in relation to self-harm? How would you end up in what online space and why?

Previously research in this area has looked at posts written by young people on internet discussion forums or asked them about why they use them or self-harm websites. This project is different as it aims to interview young people to gain their views about using social media in relation to self-harm in particular which has not been researched in this way before and is thought to be interesting because of how many young people use social media.

The interviews will take up to one hour and be audio recorded so that what is talked about can be written up and analysed. If you do not feel happy about having the interview recorded then I am afraid that you will not be able to take part as it is essential so that what is said can be analysed alongside other interviews from other young people. The recordings will be uploaded onto an encrypted memory stick and the written account will be anonymised so that it is not clear that it was you talking so for example your name will not be anywhere on the written document.

You will be asked if you would feel comfortable and happy to show the researcher some of the social media sites you use (such as Facebook or Tumblr) in relation to self-harm on a tablet or computer when we meet. It is thought that this might help gain more of an understanding and make the interview more interesting and interactive. However, if you do not want to do this, it is your choice and an interview can still take place without looking at the social media you use. It is entirely up to you. The researcher will not show you any forms of social media during the interview.

If you tell the researcher something which causes concern about you or anyone else being in or at risk of harm the researcher will be legally obliged to report this to the appropriate services and support will be provided accordingly.

Talking about self-harm can be upsetting but that is not the aim of the interview. However, if you do feel upset you can stop the interview at any point. The interviews will take place at the Michael Rutter Centre, where you come for DBT, and a clinician that you know will be available when you have your interview in case you need some support during or afterwards. If you agree I will share a summary of the analysis with you afterwards to gain your feedback about it as your view will be greatly appreciated.

The interviews will be analysed using a method called Interpretative Phenomenological Analysis or IPA. This is a method of looking at what people say about their experiences and thinking about what might be meant by it using psychological theory and ideas. The project will be written up as a doctoral thesis at the University of East London and may be published in an academic journal.

What if I don't want my parents to know?

When young people are asked to take part in research, a parent or carer also has to agree to this. There is a good reason for this as they are responsible for keeping you safe and helping you to make important decisions. However, I realise that some people might not feel able to talk to their parents about this topic. Unfortunately, if this is the case for you and you are under 16 years old, you will not be able to take part in this study even if you would like to yourself.

Do both my parents have to agree?

Only one parent or carer has to agree to you taking part, though if possible it would be good for everyone to agree together. However, there are a number of reasons

why this might not be possible, for example if you are in a single-parent family, or only one of your parents knows that you self-harm. The important point is that an adult who has parental responsibility for you agrees to you taking part, whether this is your Mum, your Dad or another adult who has parental responsibility for you.

Where will the project take place?

The interviews will take place at the Michael Rutter Centre, where you come for DBT.

Will other people know I am taking part?

Your clinician will have mentioned the study to you, so they will know and the DBT team will know too but otherwise, no one else will be informed by the researcher.

What happens to the things I share? Will they be kept private?

The interview recordings will be kept on an encrypted memory stick. The transcripts of the interviews will also be kept on there. This is so the content can be analysed and be accessed if necessary for writing up the research for publication. These copies as well as any personal information will also be deleted when it is no longer needed for the research.

Quotes and extracts from things you have said may be used in the analysis of the research. However, no details will be shared which would mean other people could identify you (e.g. your name or where you live).

Will I get anything for taking part?

You will be given a £10 high street voucher for participating.

Do I have to take part?

You do not have to take part in this study and should not feel under any pressure to do so. You are free to change your mind at any time and withdraw from the study. If you choose to withdraw from the study you may do so without disadvantage to yourself and you do not need to give a reason.

If you withdraw, things that you have already shared or written will not be used in the write-up of the study or any further analysis that may take place.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form before you can take part. You Mum, Dad, or carer, will also be asked to sign a consent form. Please keep this invitation letter in case you want to look at it again in the future.

If you have any questions or concerns about how the study has been carried out, please contact:

The study's supervisor: Dr. Neil Rees, Professional Doctorate in Clinical Psychology, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Tel: 020 8223 4475. Email: n.rees@uel.ac.uk)

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

Thank you for considering taking part in this project.

Yours sincerely,

Lucy Brett-Taylor, Trainee Clinical Psychologist (August 2014)

Appendix G: Information sheet for young people 16-18

South London and Maudsley NHS Foundation Trust

UEL University of East London

INFORMATION SHEET FOR YOUNG PEOPLE (AGED 16 – 18)

Project Title: How and why do young people use social media in relation to self-harm and to what effect?

UNIVERSITY OF EAST LONDON

School of Psychology, Stratford Campus, Water Lane, London, E15 4LZ

The Principal Investigator

Lucy Brett-Taylor, Trainee Clinical Psychologist

E-mail: uxxxx@uel.ac.uk

Consent to Participate in a Research Study

The purpose of this letter is to give you information that you need to consider in deciding whether to take part in a research study. You can also take a copy for your parents or legal guardians if you are 16 or 17 years old and if you would like to discuss it with them. If you are 18 years old consent to take part is not required from your parents.

The study is being conducted as part of my Professional Doctorate in Clinical Psychology at the University of East London.

What does the project involve?

The aim of this project is to explore the reasons young people use social media in relation to self-harm. For example, topics of discussion might be: What forms of social media do you use in relation to self-harm and what effect does using them have? In what way do you use social media in relation to self-harm? How would you end up in what online space and why?

Previously research in this area has looked at posts written by young people on internet discussion forums or asked them about why they use them or self-harm websites. This project is different as it aims to interview young people to gain their views about using social media in relation to self-harm in particular which has not been researched in this way before and is thought to be interesting because of how many young people use social media.

The interviews will take up to an hour and be audio recorded so that what is talked about can be written up and analysed. If you do not feel happy about having the interview recorded then I am afraid that you will not be able to take part as it is essential so that what is said can be analysed alongside other interviews from other young people. The recordings will be uploaded onto a computer and kept in a password protected file and the written account will be anonymised so that it is not clear that it was you talking so for example your name will not be anywhere on the written document.

You will be asked if you would feel comfortable and happy to show the researcher some of the social media sites you use (such as Facebook or Tumblr) in relation to self-harm on a tablet or computer when we meet. It is thought that this might help gain more of an understanding and make the interview more interesting and interactive. However, if you do not want to do this, it is your choice and an interview can still take place without looking at the social media you use. It is entirely up to you. The researcher will not show you any forms of social media during the interview.

If you tell the researcher something which causes concern about you or anyone else being in or at risk of harm the researcher will be legally obliged to report this to the appropriate services and support will be provided accordingly.

Talking about self-harm can be upsetting but that is not the aim of the interview. However, if you do feel upset you can stop the interview at any point. The interviews will take place at the Michael Rutter Centre, where you come for DBT, and a clinician that you know will be available when you have your interview in case you need some support during or afterwards.

The interviews will be analysed using a method called Interpretative Phenomenological Analysis or IPA. This is a method of looking at what people say about their experiences and thinking about what might be meant by it using psychological theory and ideas. The project will be written up as a doctoral thesis at the University of East London and may be published in an academic journal.

Do my parents have to agree?

If you are aged 16 or over, your parents or carers do not need to consent to you taking part. However, if at all possible, I would encourage you to discuss taking part in this project with them first as it is an important decision. However, I realise that some people would not feel able to talk to their parents about this topic. If you are 18 years old, your parents do not have to agree to you taking part for you to do so.

Where will the project take place?

The interviews will take place at the Michael Rutter Centre, where you come for DBT.

Will other people know I am taking part?

Your clinician will have mentioned the study to you, so they will know and the DBT team will know too but otherwise, no one else will be informed by the researcher.

What happens to the things I share? Will they be kept private?

The interview recordings will be kept on an encrypted memory stick. The transcripts of the interviews will also be kept on there. This is so the content can be analysed and be accessed if necessary for writing up the research for publication. These

copies as well as any personal information will also be deleted when it is no longer needed for the research.

Quotes and extracts from things you have said may be used in the analysis of the research. However, no details will be shared which would mean other people could identify you (e.g. your name or where you live).

Will I get anything for taking part?

You will be given a £10 high street voucher for participating.

Do I have to take part?

You do not have to take part in this study and should not feel under any pressure to do so. You are free to change your mind at any time and withdraw from the study. If you choose to withdraw from the study you may do so without disadvantage to yourself and you do not need to give a reason.

If you withdraw, things that you have already shared or written will not be used in the write-up of the study and any further analysis that may take place.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form before you can take part. If you are 16 or 17 years old your Mum, Dad, or carer, will also be asked to sign a consent form. Please keep this invitation letter in case you want to look at it again in the future.

If you have any questions or concerns about how the study has been carried out, please contact:

The study's supervisor: Dr. Neil Rees, Professional Doctorate in Clinical Psychology, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Tel: 020 8223 4475. Email: n.rees@uel.ac.uk)

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

Thank you for considering taking part in this project.

Yours sincerely,

Lucy Brett-Taylor, Trainee Clinical Psychologist

August 2014

Appendix H: Information sheet for parents/carers

INFORMATION SHEET FOR PARENTS / CARERS

Project Title: How and why do young people use social media in relation to self-harm and to what effect?

UNIVERSITY OF EAST LONDON

School of Psychology, Stratford Campus, Water Lane, London, E15 4LZ

The Principal Investigator

Lucy Brett-Taylor, Trainee Clinical Psychologist

E-mail: uxxxx@uel.ac.uk

Consent for My Child to Participate in a Research Study

The purpose of this letter is to give you information that you need to consider in deciding whether you agree to your child taking part in a research study. Your child has also been giving a copy of this information and both of you need to agree for him or her to take part.

The study is being conducted as part of my Professional Doctorate in Clinical Psychology at the University of East London.

What does the project involve?

The aim of this project is to explore the reasons young people use social media in relation to self-harm. For example, topics of discussion might be: What forms of social media do you use in relation to self-harm and what effect does using them have? In what way do you use social media in relation to self-harm? How would you end up in what online space and why?

Previously research in this area has looked at posts written by young people on internet discussion forums or asked them about why they use them or self-harm websites. This project is different as it aims to interview young people to gain their views about using social media in relation to self-harm in particular which has not been researched in this way before and is thought to be interesting because of how many young people use social media.

The interviews will take up to one hour and be audio recorded so that what is talked about can be written up and analysed. If you do not feel happy about having the interview recorded then I am afraid that your child will not be able to take part as it is essential so that what is said can be analysed alongside other interviews from other young people. The recordings will be kept on an encrypted memory stick and the written account will be anonymised so that it is not clear that it was your child talking so for example their name will not be anywhere on the written document.

Your child will be asked if they would feel comfortable and happy to show the researcher some of the social media sites they use (such as Facebook or Tumblr) in relation to self-harm on a tablet or computer when we meet. It is thought that this might help gain more of an understanding and make the interview more interesting and interactive. However, if they do not want to do this, it is their choice and an interview can still take place without looking at the social media you use. It is entirely up to them. The researcher will not show your child any forms of social media during the interview.

If your child tells the researcher something which causes concern about them or anyone else being in or at risk of harm the researcher will be legally obliged to report this to the appropriate services and support will be provided to the participant accordingly.

Talking about self-harm can be upsetting but that is not the aim of the interview. However, if they feel upset they can stop the interview at any point. The interviews will take place at the Michael Rutter Centre, where they come for DBT, and a clinician that they know will be available when they have their interview in case you need some support during or afterwards.

The interviews will be analysed using a method called Interpretative Phenomenological Analysis or IPA. This is a method of looking at what people say about their experiences and thinking about what might be meant by it using psychological theory and ideas. The project will be written up as a doctoral thesis at the University of East London and may be published in an academic journal.

Why am I being asked about this?

When young people are asked to take part in research, a parent or carer also has to agree to this. There is a good reason for this as they are responsible for keeping their child safe and helping them to make important decisions.

Do both parents have to agree?

Only one parent or carer has to agree to a young person taking part, though if possible it would be good for everyone to agree together. However, there are a number of reasons why this might not be possible, for example if you are a single-parent family, or you know about your child's self-harm and their other parent(s) does not. The important point is that an adult who has parental responsibility agrees to the young taking part, whether this is their Mum, Dad or another adult who has parental responsibility for them.

Where will the project take place?

The interviews will take place at the Michael Rutter Centre, where your child comes for DBT.

Will other people know my child is taking part?

Your child's clinician will have mentioned the study to them, so they will know and the DBT team will know too but otherwise, no one else will be informed by the researcher.

What happens to the things my child shares? Will they be kept private?

The interview recordings and the transcripts of the interviews will be kept on an encrypted memory stick. This is so the content can be analysed and be accessed if necessary for writing up the research for publication. These copies as well as any personal information will also be deleted when it is no longer needed for the research.

Quotes and extracts from things your child has said may be used in the analysis of the research. However, no details will be shared which would mean other people could identify them (e.g. their name or where they live).

Will they get anything for taking part?

Your child will be offered a £10 high street voucher as a show of appreciation for their participation.

Do they have to take part?

Your child does not have to take part in this study and should not feel under any pressure to do so. You are also under no obligation to agree to them taking part, even if they would like to do so themselves. Both you and your child are free to change your mind at any time and withdraw them from the study. If your child withdraws from the study they may do so without disadvantage to either of you and there is no need to give a reason.

If your child withdraws, things that they have already shared or written will not be used in the write-up of the study or any further analysis that may take place.

Please feel free to ask me any questions. If you are happy to continue your child will be asked to sign a consent form. You will also be asked to sign a consent form before he or she can take part. Please keep this invitation letter in case you want to look at it again in the future.

If you have any questions or concerns about how the study has been carried out, please contact:

The study's supervisor: Dr. Neil Rees, Professional Doctorate in Clinical Psychology, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Tel: 020 8223 4475. Email: n.rees@uel.ac.uk)

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

Thank you for considering taking part in this project.

Yours sincerely,

Lucy Brett-Taylor, Trainee Clinical Psychologist (August 2014)

Appendix I: Assent form for young people 12-15

ASSENT FORM FOR YOUNG PEOPLE (AGED 12-15)

Project title: How and why young people use social media in relation to self-harm and to what effect

Name of Researcher: Lucy Brett-Taylor

Young person to circle if agree:

Has somebody else explained this project to you?	Yes/No
Do you understand what the project is about?	Yes/No
Have you asked all the questions that you want?	Yes/No
Have you had questions answered in a way you understand?	Yes/No
Do you understand it is ok to stop taking part at any time?	Yes/No
Are you happy to take part?	Yes/No

If any answers are 'no' or you don't want to take part, don't sign.

If you do want to take part then write your name below.

Your name_____ Date_____

Name of person who
explained to you_____Date_____

Appendix J: Consent for young people 16-18

CONSENT FORM (AGED 16-18)

Project title: How and why young people use social media in relation to self-harm and to what effect

Name of Researcher: Lucy Brett-Taylor

	Please initial box
1. I confirm that I have read the information sheet dated 18.8.14 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	☐
3. I understand that relevant sections of data collected during the study, may be looked at by individuals from the University of East London, or from the South London and Maudsley NHS Trust involved in the study, where it is relevant to my taking part in this research. I give permission for these individuals to have access to the data.	☐
4. I agree to take part in the above study.	☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

Appendix K: Consent form for parents

CONSENT FORM FOR PARENTS / CARERS

Project title: How and why young people use social media in relation to self-harm and to what effect

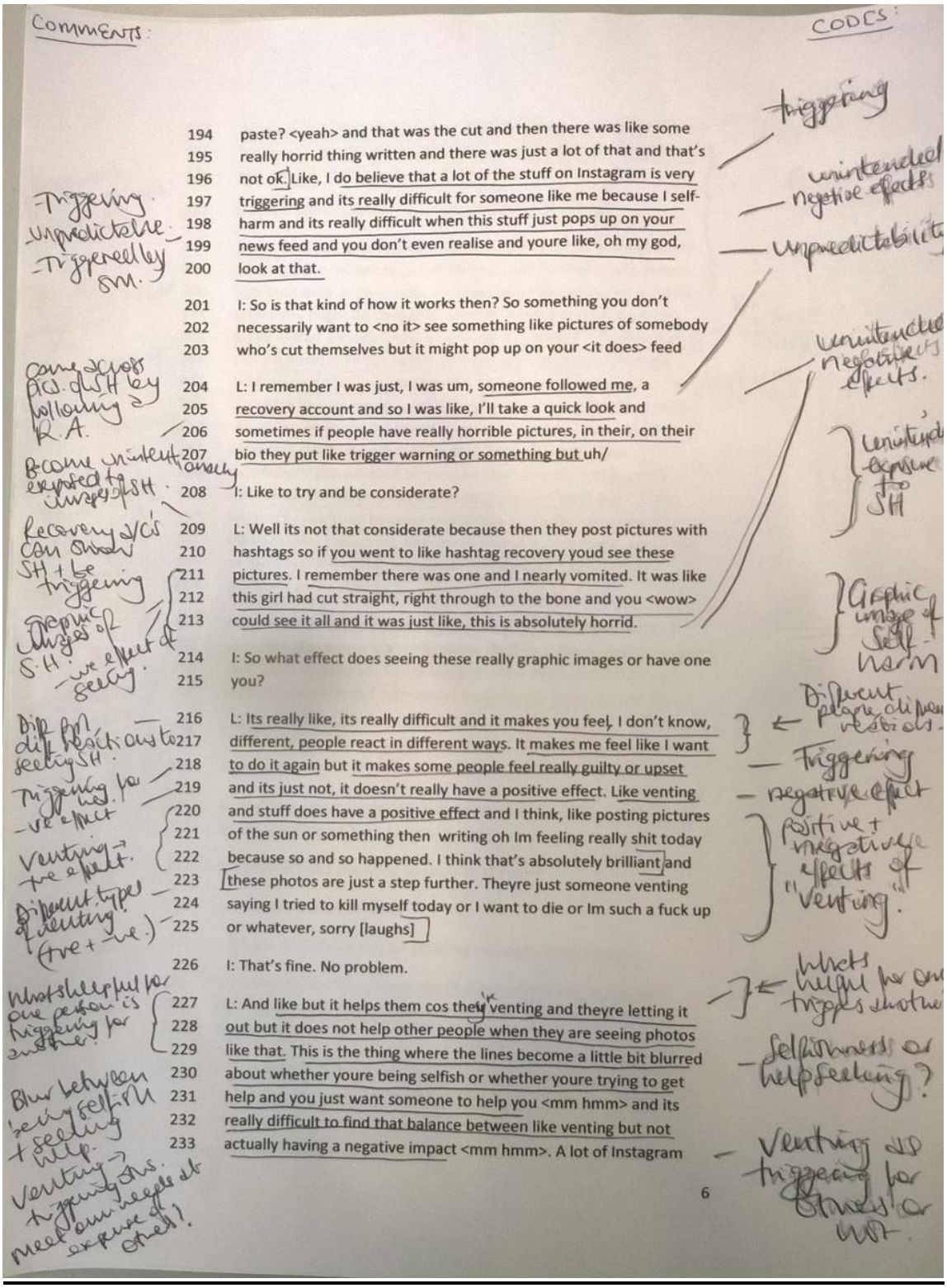
Name of Researcher: Lucy Brett-Taylor

	Please initial box
5. I confirm that I have read the information sheet dated 18.8.14 (version 6) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
6. I understand that my child's participation is voluntary and that he/she is free to withdraw at any time without giving any reason, without his/her medical care or legal rights being affected.	☐
7. I understand that relevant sections of data collected during the study, may be looked at by individuals from the University of East London, or from the South London and Maudsley NHS Trust involved in the study, where it is relevant to my child taking part in this research. I give permission for these individuals to have access to the data.	☐
8. I agree to take part in the above study.	☐

Name of Participant	Date	Signature

Name of Person taking consent	Date	Signature

Appendix L: Extract of an annotated transcript



paste? <yeah> and that was the cut and then there was like some
really horrid thing written and there was just a lot of that and that's
not ok. Like, I do believe that a lot of the stuff on Instagram is very
triggering and its really difficult for someone like me because I self-
harm and its really difficult when this stuff just pops up on your
news feed and you don't even realise and youre like, oh my god,
look at that.

I: So is that kind of how it works then? So something you don't
necessarily want to <no it> see something like pictures of somebody
who's cut themselves but it might pop up on your <it does> feed

L: I remember I was just, I was um, someone followed me, a
recovery account and so I was like, I'll take a quick look and
sometimes if people have really horrible pictures, in their, on their
bio they put like trigger warning or something but uh/

I: Like to try and be considerate?

L: Well its not that considerate because then they post pictures with
hashtags so if you went to like hashtag recovery youd see these
pictures. I remember there was one and I nearly vomited. It was like
this girl had cut straight, right through to the bone and you <wow>
could see it all and it was just like, this is absolutely horrid.

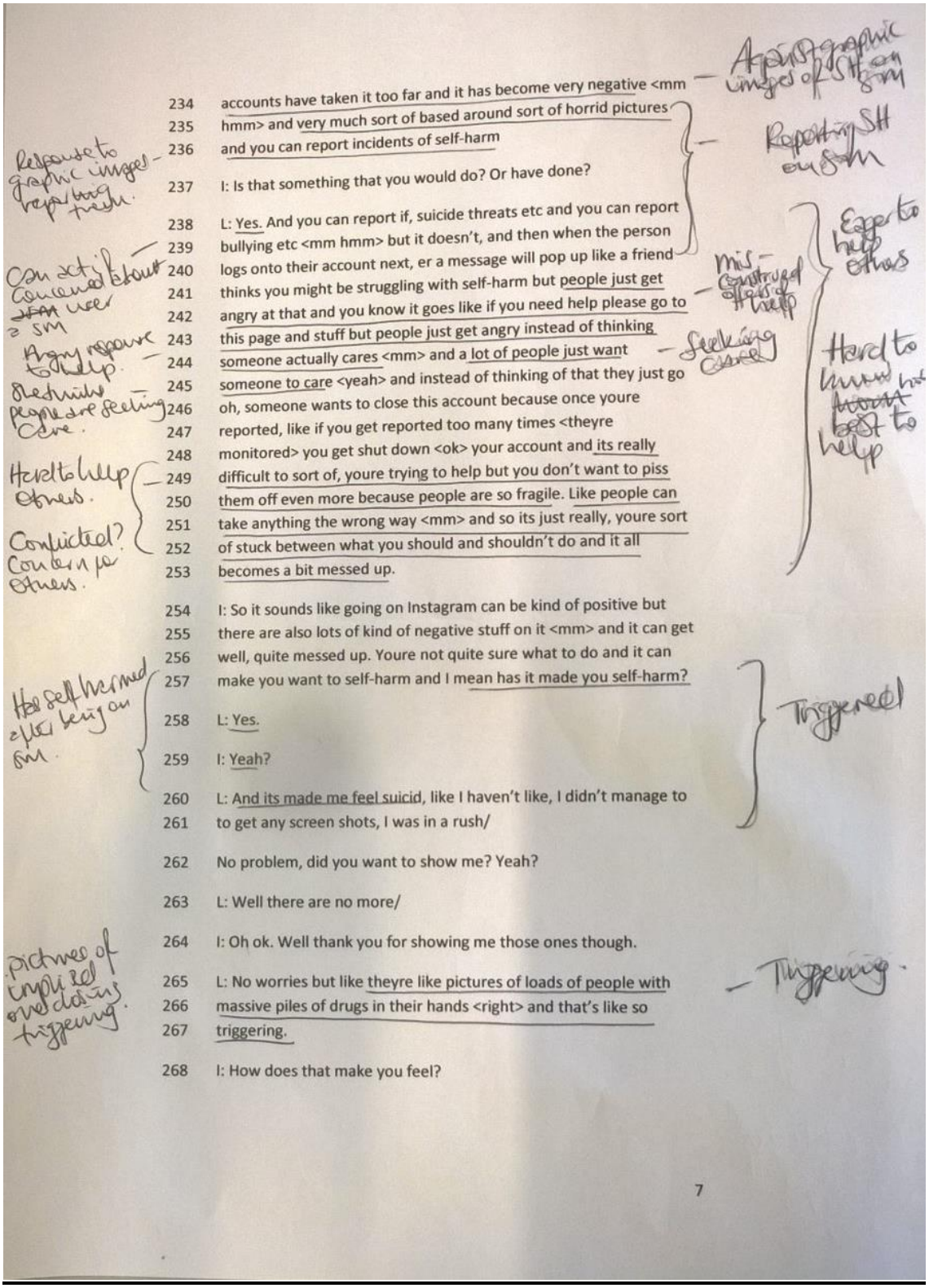
I: So what effect does seeing these really graphic images or have one
you?

L: Its really like, its really difficult and it makes you feel, I don't know,
different, people react in different ways. It makes me feel like I want
to do it again but it makes some people feel really guilty or upset
and its just not, it doesn't really have a positive effect. Like venting
and stuff does have a positive effect and I think, like posting pictures
of the sun or something then writing oh Im feeling really shit today
because so and so happened. I think that's absolutely brilliant and
these photos are just a step further. Theyre just someone venting
saying I tried to kill myself today or I want to die or Im such a fuck up
or whatever, sorry [laughs]

I: That's fine. No problem.

L: And like but it helps them cos they're venting and theyre letting it
out but it does not help other people when they are seeing photos
like that. This is the thing where the lines become a little bit blurred
about whether youre being selfish or whether youre trying to get
help and you just want someone to help you <mm hmm> and its
really difficult to find that balance between like venting but not
actually having a negative impact <mm hmm>. A lot of Instagram

6



234 accounts have taken it too far and it has become very negative <mm
235 hmm> and very much sort of based around sort of horrid pictures
236 and you can report incidents of self-harm

237 I: Is that something that you would do? Or have done?

238 L: Yes. And you can report if, suicide threats etc and you can report
239 bullying etc <mm hmm> but it doesn't, and then when the person
240 logs onto their account next, er a message will pop up like a friend
241 thinks you might be struggling with self-harm but people just get
242 angry at that and you know it goes like if you need help please go to
243 this page and stuff but people just get angry instead of thinking
244 someone actually cares <mm> and a lot of people just want
245 someone to care <yeah> and instead of thinking of that they just go
246 oh, someone wants to close this account because once youre
247 reported, like if you get reported too many times <theyre
248 monitored> you get shut down <ok> your account and its really
249 difficult to sort of, youre trying to help but you don't want to piss
250 them off even more because people are so fragile. Like people can
251 take anything the wrong way <mm> and so its just really, youre sort
252 of stuck between what you should and shouldn't do and it all
253 becomes a bit messed up.

254 I: So it sounds like going on Instagram can be kind of positive but
255 there are also lots of kind of negative stuff on it <mm> and it can get
256 well, quite messed up. Youre not quite sure what to do and it can
257 make you want to self-harm and I mean has it made you self-harm?

258 L: Yes.

259 I: Yeah?

260 L: And its made me feel suicid, like I haven't like, I didn't manage to
261 to get any screen shots, I was in a rush/

262 No problem, did you want to show me? Yeah?

263 L: Well there are no more/

264 I: Oh ok. Well thank you for showing me those ones though.

265 L: No worries but like theyre like pictures of loads of people with
266 massive piles of drugs in their hands <right> and that's like so
267 triggering.

268 I: How does that make you feel?

7

Appendix M: Audit of theme generation

Super-ordinate theme	Sub-ordinate theme	Sub sub-ordinate theme	Emergent themes
Extension of everyday social media use	Passive use	Being draw into	[15]Passive use of social media (1x2[16],2,4,7x3,) Brought to social media via internet searching (1) Reciprocal following (5) Passive/observer role (2) Came across recovery accounts by chance (4) Exposed to what friends look at (5) Using one form of social media led to using other forms (1) Different was come across positive & self-harm blogs (5)
		Unclear of the purpose of using social media	Unclear purpose of following self-harm accounts (2) No clear pattern of social media use (1) Non deliberate action (6) Uncertain what seeking (2)
	Purposeful use of social media	Taking action	-Intentional triggering as common (2) Intentional triggering (2) Tricks self re self-harm content (4) Tricks self to alleviate judgement (2) -Purposeful use of social media (2,4) Able to control judgement receive on social media (3) Social media as a way to have "control" (4) -Posting self-harm via social media seen as seeking care (7) Desire to be cared for (4) Seeking care (4) -Reciprocal support function (3) Seeking support (1,5X2) -Sought understanding (7)

[15] Participant is indicated by a number: (1) Anna, (2) Holly, (3) Jess, (4) Louise, (5), Molly, (6) Nicola, (7) Tara

[16] The number denotes the of times that emergent theme presented

			Importance of feeling understood (2) Shared experience as shared understanding (2) Actively seeking alterative help via social media (7) -Express feelings (6, 2, 7) Express stress (7) Diary function (7) Post quotes (1,6) Need to vent (6) -Distraction (7) Social media as helpful distraction (1) Quotes as coping mechanism (1) Quotes as “helpful” distraction (1) -Social media enabled to “live ideal life” (4) Enables contact from distance/on own terms (3) -Take action to top bullying (3) Reporting self-harm on social media (4) Has positively influenced what sees of social media (4) -Posted self-harm pictures (3,6) -Actively searched for recovery accounts (3) -Helping others (4x5,3)
		Restraining action	Declined to share on social media (1) Underplays social media use to clinician (5) Doesn’t express self-harm via social media (1) Influence of shame on what shares (6) Restrained expression (7) Desire to connect on own terms (2) In control of social media use(1x3) Ignores advice of those close re use (5)
	Factors influencing how participants	Emotional state	-Changed in social media use as feels better (4) Mood affects what searches

	engaged with social media		for on social media (3) Relationship between awareness of impact on others & emotional state (3) Response to triggering changed over time (3) -Mood dictates ability to skip upsetting content (4) Increased social media use when “psychotic” (7) Increased use when self-harming (3) Factors affecting response to self-harm posts (6) What searched depended on state of mental health (3)
		Perception by other social media users	Concerned re inaccurate evaluation (2) Cuts less so can share good news (7) Posts feelings then deletes (2) Feared misunderstanding affects actions (2) Doesn’t want others to know re self-harm (1) Doesn’t want to appear attention seeking (7) Desire to be seen way perceives self (2)
		Perception by others offline	Perceived judgement barrier to talking (2x2) Doesn’t discuss self-harm on accounts known on (5) Judged in real life (5) Separate account for self-harm to avoid friends judgement (3) Seeking acceptance, not judgement (2) Fear of judgement related to relationship closeness (2)
		Username	Distress/mental health related usernames (5,6) Username denotes content of social media account (6) Impact social media username has on who follows (7) Description of self totally defined by mental health (2)

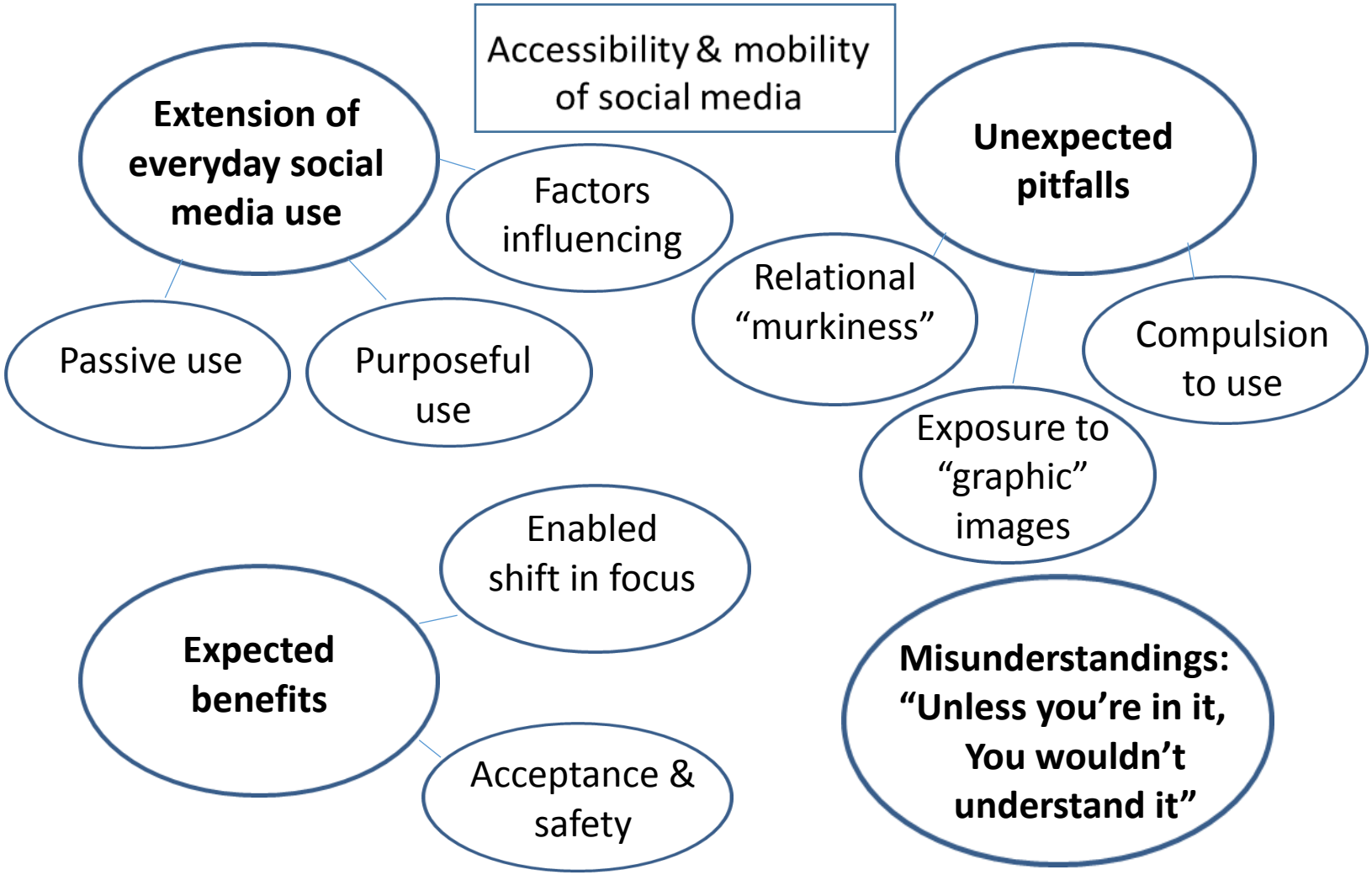
		Anticipated effect on others	Considerate re triggering others (2x2,6) Vigilant re triggering (4) How to express self & avoid triggering others (5) Support from strangers on social media safest (2) Consideration for others (7x2)
		Changing nature of social media	Changing fashion/popularity of social media (6x2, 2x3) Reduced prevalence of self-harm on certain social media (2) Home of self-harm on social media changes (2)
		The social media site and its community	Different site, different content & responses (2,4,5x3) Different sites, different levels of acceptance (2,6) Self-harm condemned of certain social media (2)
		Different accounts, different functions	Different accounts, different functions (2,5x2,6,7)
Unexpected pitfalls	Relational "murkiness"	Phenomena: Making comparisons	Social comparisons caused triggering (3,6) Severity of self-harm comparisons caused triggering (7) Comparison led to jealousy (7) Upward social comparisons (4x2) Negative effect of comparisons (4,6) Social media "cements" negative view of self (4)
		Competition	Competition to be "illest" (2) Competition (2) Prioritising own illness over others (2)
		Interplay between on and offline relationships	Online/offline relationship blur (6) Affected by social media if blurs with offline relationships (2x3) Social media relationships trigger self-harm (2) Negative effects of social

			media (6)
		Ambiguity of meaning behind social media communication	Ambiguity of meaning behind social media communication (2) Ambiguity led to “paranoia” (6) How others use social media (6)
		Effects: Conflict	Conflict as a result of misunderstanding (2) Motives questioned (2) Unsupportive responses (5) Derogatory comments (4x3) Different opinions not tolerated (2)
		Triggering	Triggering (2x4,4x3,6x2,7x3) Bullying led to triggering (3) Negative effect (4) Sense of unfairness if others self-harm (4) Desire to emulate others (2) Envy others (2)
		Worsening mood	Worsened mood (4,7x2) Images of self-harm led to tears/self-harm (7) Unhelpful seeing images of self-harm (7) Disgusted by images of self-harm (7) Social media contributing to being stuck in “downward spiral” (4) Effect of bullying via social media (7x2) Sad to see others fail in recovery (7)
		Inability to live up to expectations	Cannot meet unrealistic expectations of social media (2) Social media as accusing (2) Social media as unforgiving (2)
		Idea to imitate self-harm	Self-harm on social media led to self-harm in life (2) Gave ideas (3)
	Exposure to “graphic” images of self-harm		Graphic images (2,4x2,7,) Examples (4) Against pictures of self-harm (3,4)
	Compulsion to use social		Questioned own social media use (2)

	media regarding self-harm: "…I'm not going to [stop]. I can't bring myself to"		Compelled to continue following (5) Continued use despite feared relapse (5) Wants to compare self to others (4) "Obsessed" looking at photos of others (4) "Wrong but did it anyway" (4)
Expected benefits	Enabled shift in focus		Helping others positive shift in focus (4x4) Recovery accounts as helpful (4,5,6,7) Social media as motivational (7) Quotes give hope (3) Quotes as distraction (1) New self-development opportunities via social media (2) Reflection changed self-harm expression (7)
	Acceptance: "I felt like people finally understood where I was coming from and that I wasn't the only one" and safety		Not alone (3,7) Sense of belonging (2,5) Share feeling with others who feel same (3,6,7) Safe to express feelings (3,6x2) Safety in anonymity (6x2) Anonymity evades judgement (3,6) Freedom in anonymity (5,6) Vent/express feelings (2,5,6 Positive relationships (2) Normalising (3) Space where felt understood (3,7) Support (2,3,4,5,7) Social media offers something offline doesn't (2,3,4,5)
Misunderstandings: "unless you're part of it, you wouldn't understand it"			Against mocking self-harm (4) Jokes re self-harm on social media make feel misunderstood (3) Questions those who joke (3) Copying as inadequate understanding (2) Dislikes negative connotations of contagion (3) Annoyed by medias negative

			portrayal of social media (5) Defends social media sites (5) Can't understand if haven't experienced it (3) Same people run self-harm & social media blogs (5)

Appendix N: Theme map



Appendix O: Extract from reflective journal

On listening to an interview

Was I too focussed on social media rather than self-harm? Is You-tube a form of social media? She posts then deletes – interesting, surprising?

Talks about social media being judgemental/condemning of self-harm. What does that say about society's view of self-harm? Suggests intolerance? Am I noticing this especially as I have an interest in it and it fits with my past experiences of others being judged in this way?

I felt sorry for her regarding her friend who kept saying she would kill herself. It made me think of the responsibility on her to keep her friend safe. Made me think of the responsibility I take on for others in my life. Empathised. I wonder about the effect that had on her own feelings and mental health? Further discussion of difficult relationships makes me remember how messy, stressful and painful teenage relationships can be. Again I feel empathy for her age and experiences. Careful not to assume too much similarity and over identify. Remain curious and in touch with her experience when analysing and interpreting.

Is the interview accessing enough about her subjective experiences? I'm hearing a lot about her experiences but also about her views of others experiences too. Discuss in supervision.

Extract from analysing

I'm grappling with whether I've put too much of me and my thoughts in. Am I interpreting too much and pulling in information from other parts of a transcript to help make sense of a quote to put in context rather than it being purely

descriptive? How much of myself, my own opinions and thoughts should I be putting in when explaining? I am concerned about balancing the descriptive (which alone is dull) and the interpretative (just my views, therefore not theirs?) Am I just summarising participants concerns rather than conceptualising? How do I conceptualise but keep close to data rather than my views?

A dance between taking analysis up to a conceptual level and bring it back down to the data to illustrate and evidence it takes place. Conceptualising also occurs during the write up.

I'm finding it hard to keep the themes in mind. When rejigging them and collapsing subthemes/codes together it feels hard to keep track of them. It's overwhelming. They can be carved up in so many ways. It seems so subjective and a cognitively demanding process. Lots of uncertainty and reflection involved.