ANGLIA RUSKIN UNIVERSITY

"IT'S A SAFE SPACE":

THE ROLE OF SELF-HARM SELF-HELP / MUTUAL AID GROUPS

Melanie Boyce

A thesis in partial fulfilment of the
requirements of Anglia Ruskin University
for the degree of Doctor of Philosophy

Submitted: December 2015

ACKNOWLEDGEMENTS

The generation and completion of this thesis could not have been realised without the invaluable input, support and encouragement of a number of people.

First and foremost I would like to thank the group members and participants who so generously gave me their time and shared their experiences and insights. I am incredibly grateful in being allowed to have entered such unique spaces and meet some truly inspiring people.

Also big heartfelt thanks to my supervisors, Professor Carol Munn-Giddings and Professor Jenny Secker, who throughout this six-year journey have shared and always offered their expertise in such an encouraging and stimulating manner. They have been a consistent source of emotional and practical support over the years, which has been invaluable. I am truly grateful and much indebted to your patience, generosity and understanding.

Warmest thanks also to Dr Patience Seebohm who has provided invaluable advice, reassurance and support all the way through, and to Dr Andy McVicar for your insightful and detailed critical read. Further thanks is also due to my employer, Anglia Ruskin University, who have funded this programme of study and my sabbatical award that made the timely completion of this thesis possible.

And finally, to my two beautiful children, Livia and Rudy, who made their appearance mid-way and towards the end of the completion of this thesis. Thank you both for unintentionally keeping me grounded! Also Mum and Dad thank you for your support and invaluable childcare provision in recent years! Lastly my deepest thanks to David, my husband, for always being there and for your never-ending, unwavering support and encouragement, which has kept me going over the years.

ANGLIA RUSKIN UNIVERSITY

ABSTRACT

FACULTY OF HEALTH, SOCIAL CARE AND EDUCATION
DOCTOR OF PHILOSOPHY

"IT'S A SAFE SPACE": THE ROLE OF SELF-HARM SELF-HELP/MUTUAL AID GROUPS

Melanie Boyce

There has been very little research that has explored self-help groups (SHGs) in relation to self-harm. Yet, from the limited research undertaken self-harm SHGs appear to provide a valuable and much needed source of support. This study explores the perspectives of those who attend and support such groups with the aim of building a more comprehensive understanding of the role of these groups.

The research is framed within an interpretative paradigm of inquiry and guided by a qualitative case study approach. The first phase involved working with two self-harm SHGs to gain an in-depth understanding of the strengths and challenges specific to these groups. In the second phase, semi-structured interviews were undertaken with four individuals who had experience of supporting self-harm SHGs directly and/or at an organisational level to gain broader insights into the running and development of such groups.

A thematic approach to the analysis of the findings illustrated that these groups provide a safe, non-judgmental space where those who self-harm can meet, listen and talk to others who share similar experiences for mutual and reciprocal peer support. Participation in the groups was found to offer direct individual benefits and wider gains, along with external and internal challenges.

Despite a current interest in the value of peer support in mental health services, the thesis illustrates that this is largely missing for those who self-harm. Concerns about the risk of peer support for those who self-harm remains a barrier affecting the development of self-harm SHGs, which is further constrained by a privileging of an individualistic approach in mainstream services. The thesis contributes new evidence about the value of collective peer support for those who self-harm. In addition it provides a more nuanced theoretical understanding of the paradoxical meaning of 'safe space' in a SHG for those who self-harm.

Key words: Self-harm; Self-help groups; Peer support; Qualitative case study.

List of Tables

Table of Contents

Appendices

Copyright

Chapter One
Introduction

1.1 Chapter overview

In this chapter I briefly describe the background and rationale to this study, by examining the research context and considering my personal interest and motivation. The aims of the research are then presented and this introduction concludes with an overview of the layout of the thesis and chapter content.

1.2 Background and rationale of the study

1.2.1 The research context

In recent years there has been a growing interest in and recognition of the value of peers supporting one another as a means of aiding recovery and improving psychological well-being in the area of mental health (Loat, 2011). Peer support can occur in a wide variety of different formats from informal friendships to employed peer support mental health workers (Faulkner & Kalathil, 2012). Another common format is through peers supporting one another in a self-help group (Bott, 2008).

There remains no conclusive definition of a self-help group, despite this it is possible to discern core characteristics that are generally agreed upon as essential, and the possession of most of which would point to a group's classification as a self-help group (ESTEEM, 2011). These characteristics consist of members sharing a similar condition or life situation; the group being run for and by its members; the provision of mutual support being offered by and for group members; the self-organising and voluntary nature of membership to the group (Seebohm, Munn-Giddings & Brewer, 2010).

Despite the growth and expansion of self-help groups since the 1970s they have mostly received limited attention within a UK context. Instead, our understanding has largely been formed by empirical evidence from the USA and Northern Europe (Munn-Giddings, 2003; ESTEEM, 2011). Nonetheless, from the research that is available there appear to be wide-ranging benefits associated with being an active member of a self-help group. These

include personal gains, such as increased self-esteem, improved relationships, better ability to cope and decreased levels of isolation (Gray et al, 1997). There is also growing evidence that participation in self-help groups can lead to improved health outcomes (Pistrang, Barker & Humphreys, 2008; Seebohm et al, 2013).

Self-help groups are found in a wide and varied range of areas that span, for example, physical illness and mental health to carers' and social issues (Wann, 1995). In relation to self-harm self-help groups however, the numbers that meet on a regular face-to-face basis are not considered to be widespread in the UK (Arnold, 2006). Whilst the reasons remain unclear there is evidence to suggest that stigmatised conditions or experiences can affect the formation of such groups (Chaudhary, Avis & Munn-Giddings, 2010). This is hindered further by the concerns some professionals have expressed about the value of these groups and their potential to escalate an individual's self-harm through meeting others and sharing and comparing techniques (Parker & Lindsay, 2004; Sutton, 2007).

Although the numbers of self-harm self-help groups are not considered to be widespread in the UK, those with direct experience have reported many benefits of being a member of such groups (Shaw, 2009; Inckle, 2010; Foster, 2013). Despite this there have been few studies that have explored self-help groups in relation to self-harm, with two notable exceptions, by Smith and Clarke (2003) and Corcoran, Mewse and Babiker (2007). In both studies the individual perspective was sought, rather than an examination of all members at a group level and little or no examination was given to the potential challenges facing the groups. Nonetheless both studies found that self-harm self-help groups were highly valued and a much needed source of support by those who attend them.

1.2.2 Personal interest and motivation

In the spring of 2008 I attended a seminar on mental health and social inclusion. During the process of the day's event the area of self-harm was raised by some clinical practitioners who worked within A&E departments. I remember being struck by how quickly the atmosphere and tone of the seminar shifted from one of tolerance and compassion to judgement and resentment. Frustrations and weariness were expressed by these clinical practitioners who were attending the seminar in having to care for those who had hurt themselves through an act of self-harm. Patients were considered less deserving of treatment for having inflicted their injuries themselves, often multiple times, especially

within a context of staff and resource constraints. I remember I found the discussion very difficult to listen to and I felt disappointed that the facilitator of the seminar did not question these negative attitudes.

Concurrent with my attendance of this seminar, I was working in a voluntary capacity at a charity that offered respite stay for people in suicidal crisis. Whilst the organisation recognised the distinction between acts of self-harm to end life and those as a means to survive intolerable distress as not always being clear, it had adopted a harm minimisation approach to self-harm as a means of coping with distress. This meant guests were allowed to self-harm on the premises, but they were expected to inform staff and to do this safely and discreetly. During my year volunteering at the organisation however, incidents of self-harm were very rare as the emphasis was on listening with compassion and peer support.

It was also around this time, in my professional role as a researcher at Anglia Ruskin University, that I began working on a number of externally funded research projects involving user-led organisations and self-help groups, primarily in the area of mental health. Undertaking funded research in these areas again highlighted to me the value of peers being able to support one another. My growing interest in this field and initial reading of the literature indicated to me that there was limited empirical research around peer support in the area of self-harm, particularly within a group capacity. Hence the basis for this thesis emerged from my interest and motivation to further understanding in these areas.

1.3 Aims of the research

The initial aims of this research were to examine the role self-help groups might play in the development of members' strategies to manage their self-harm. However, my early meetings with the groups illustrated that such a focus did not match the main aims and priorities of the groups. Hence, the focus of the research shifted to be more exploratory in nature by looking at the role of self-harm self-help groups generally. The limited research undertaken in this area, particularly at a group level, meant this study aimed to explore the role of self-harm self-help groups from the perspective of group members and those who support such groups. In doing so, my intention was to contribute to building a more

comprehensive understanding of the role of these groups from an individual and wider perspective. My final research question was thus:

What is the role of self-harm self-help/mutual aid groups from the perspective of group members and those who support such groups?

My objectives were therefore to:

- Explore the benefits of self-harm self-help groups from the perspective of group members and those that support such groups.

- Examine the wider context of the issues facing the running and development of self-harm self-help groups from the perspective of group members and those who support such groups.

An interpretative paradigm of inquiry and qualitative case study approach underpinned the research, which involved two phases of data collection. The first phase involved working with two self-harm self-help groups and the second phase entailed the participation of those who support these groups. The strengths and challenges facing the groups were examined in both phases and provided an in-depth and nuanced understanding at an individual and wider perspective on the value of and tensions within self-harm self-help groups.

1.4 Structure of thesis

This thesis, including this introductory chapter, is presented in seven chapters. This chapter situates the thesis and outlines my rationale for undertaking the research. In Chapter Two the multiple ways of framing and understanding self-harm are discussed. I begin by discussing the definitional difficulties with my use of the term self-harm. A descriptive overview of the area provides a contextual background and highlights the prevailing assumptions that exist in this area. I consider the multiple ways of framing and understanding self-harm from an individualistic model of understanding that currently dominates mental health services within the UK, with a wider social-political focus. The

different ways of managing and supporting those who self-harm are framed and discussed within these different models of understanding and I argue that as a peer-based source of support, self-harm self-help groups remain very much on the periphery despite those with direct experience reporting the many benefits associated with being a member of these groups.

In Chapter Three the individual and collective features of self-help groups are presented and examined. I consider the core characteristics of self-help groups in comparison to other types of self-governing groups. The reasons for the expansion of self-help groups since the 1970s are outlined. I argue that this rise has not been equal in stigmatised areas such as self-harm, which has since greater expansion online than in face-to-face groups. Concerns and reservations about the negative effects of self-harm self-help groups are considered along with wider criticisms of self-help groups generally, concerning their tendency to look inward, rather than outward. Gaps in the literature, particularly at a group level, about self-harm self-help groups are discussed, highlighting the study's original contribution to knowledge.

In Chapter Four the philosophical underpinnings, dilemmas and assumptions of the study are considered. The qualitative case study approach that guides the research design of the study is then discussed, alongside the key decisions in the data collection methods and analytical process. The trustworthiness and ethical considerations raised during the process conclude the presentation of this chapter.

In Chapter Five the findings from the study are presented and discussed. The findings are organised in three parts: a descriptive background of the groups, its members and their experiences; the contribution of self-harm self-help groups; and the challenges facing the groups.

Chapter Six draws together the findings presented in Chapter Five by **c**ontextualising the findings within two frameworks of inquiry. The first framework examines the individual and wider gains of participation in self-harm self-help/mutual aid groups. The second framework considers the competing tensions and dilemmas specific to the running and development of self-harm self-help mutual aid groups. The implications of the findings are then presented in relation to self-harm self-help/mutual aid groups, self-help/mutual aid

groups generally and the area of self-harm specifically. This then leads to a discussion of the implications of the findings in relation to the barriers affecting the development of self-harm self-help/mutual aid groups. The practice implications for funders, practitioners and groups themselves are then examined. A reflection on my own personal learning from undertaking this research, then concludes the chapter.

Chapter Seven closes this thesis with a discussion on the limitations of the study and its contribution to knowledge. Recommendations for further research then conclude the chapter and thesis.

Chapter Two
Multiple Ways of Framing and Understanding Self-Harm

2.1 Introduction

This chapter begins by outlining my reasons for using the term self-harm throughout this thesis and considers the definitional difficulties with this term. A contextual background is then provided that considers rates of self-harm and prevailing assumptions. Frameworks to understanding self-harm are differentiated between those that locate explanations within the individual and those that emphasise a wider, social-political focus. This is then followed by a consideration of the different ways of treating and supporting those who self-harm within these distinct frameworks of understanding.

2.2 Defining self-harm

2.2.1 Ambiguities and inconsistencies

There are, as Sutton (2007) identifies, a plethora of different terms used to describe the act of hurting oneself that includes self-harm; deliberate self-harm; self-injury; self-mutilation; self-inflicted violence; self-injurious behaviour. This is not an exhaustive list as other terms that are applied are self-wounding (Sharkey, 2003), nonsuicidal self-injury (Nock, 2009), self-hurting (West, Newton & Barton-Breck, 2013) and parasuicide (Skegg, 2005). Some of these terms are associated with particular disciplines, as in the field of learning difficulties, where the term self-injurious behaviour has largely been used (Matson & Turygin, 2012), whereas in the field of psychiatry, nonsuicidal self-injury and self-injury are often applied (Muehlenkamp, 2006).

The use of many of these terms is not without criticisms (Chandler, Myers & Platt, 2011). Firstly, negative connotations are associated with some, as by prefixing self-harm with ‘deliberate’ suggests a degree of premeditation that intrinsically implies an individual could refrain if they tried (Pembroke, 1994; Allen, 2007). Other terms, such as self-mutilation have been criticised on the grounds of the inherent stigmatising and pathologising connotations (Inckle, 2007). Secondly, definitional ambiguity and inconsistencies are not uncommon, particularly with the use of the term self-harm.

Therefore the next sections examine these inconsistencies and a summary of my definitional interpretation of the term, which informs this thesis, is provided.

2.2.2 Self-harm as a continuum

Self-harm continues to be defined in divergent and often conflicting ways, due to a lack of agreement around what it involves. In its broadest and most inclusive positioning, self-harm is placed on a continuum that encompasses any activity that harms the self, directly or indirectly (Rayner & Warner, 2003).

In the continuum model, self-harm is not viewed as a discrete disorder or phenomenon. Instead, Pembroke (2006a) argues, it exists on a continuum where everyone is situated at different points, but what distinguishes some types of harm from others is the degree to which they are regarded as socially acceptable. Socially acceptable forms of self-harm, which Pembroke (1994:2) identifies might include "excessive smoking, drinking, exercise, liposuction, bikini-line waxing, high heels and body piercing", whilst unacceptable acts would include self-cutting, burning and hitting, amongst others.

The broadness of this definition is questioned by Turp (2003) who suggests that if the term self-harm is to retain any specific meaning a distinction needs to be made between those acts that are physically harmful, yet commonplace, and those that cause physical harm and which fall outside acceptable limits. Acknowledging that every society tolerates certain permissible harms, Turp (2003) terms these 'cashas' (culturally accepted self-harming acts/activities). Being culturally and generationally bound, cashas provoke only mild disapproval and concern, such as smoking. The meaning and functions of a cashas are viewed similarly to those behind conventionally assumed acts of self-harm, such as self-cutting, as both offer opportunities for expression and potential self-soothing. The difference is at a certain point one goes beyond what is regarded acceptable, and through doing so transgresses established cultural rules. The dividing line between a cashas and an act of self-harm Turp (2003:10) proposes is the level "of desperation and emotional distress involved" and the negative response it elicits.

As proponents of a continuum model of self-harm both Turp and Pembroke distinguish self-harm from suicidal intentions. This distinction is clearly differentiated by Pembroke who argues that self-harm with suicidal intent is about ending life, whereas self-harm

without suicidal intent is about "coping with the uncopeable" and is more about self-preservation and survival (Pembroke, 1994:1). This clear distinction is also widely supported in the literature by a range of authors (Harrison, 1995; Smith, Cox & Saradjian, 1998; McAllister, 2003; Smith & Clarke, 2003; Simpson, 2006; Allen, 2007; Sutton, 2007; Inckle, 2014).

2.2.3 Self-harm linked to attempted suicide

Chandler, Myers and Platt (2011) argue that in many clinical studies, particularly in the UK, a distinction is rarely made between self-harm and attempted suicide. Instead, acts of self-harm as a means of coping with distress and acts of attempted suicide are subsumed within the same term, with little consideration or distinction made between differences in meaning and intent.

The basis for this broad interpretation of the term is partly linked to where the majority of research on self-harm has taken place. Overall this has mostly been conducted in hospital emergency settings where acts of self-poisoning are categorised as self-harm and are found to be more common than self-cutting (Jeffery & Warm, 2002). For example, Gunnell et al. (2004) report that overdoses accounted for 79% of episodes of self-harm in 31 Accident and Emergency Departments in England. Similarly, Hawton et al. (2003) found 90% of episodes for self-harm in the same setting were a result of self-poisoning[1]. The predominance of self-poisoning in hospital setting statistics means self-harm is often conflated with attempted suicide, where the intent behind the act is usually about ending life, rather than a means of coping with distress. Such an interpretation however fails to take into account that for many self-harm is a private act where medical treatment is not necessarily needed or sought (Babiker & Arnold, 1997; MHF, 2006).

Straiton et al. (2013) argue that caution needs to be taken when deriving intent from the potential lethality of the method or the seriousness of the injury, as the method or outcome may not always reflect the intention. For example, self-poisoning can also be used as a way of coping with overwhelming feelings through distraction by getting high, along with being used to end life (Warner & Spandler, 2012).

[1] In this context self-poisoning relates to the intentional self-administration of more than the prescribed dose of any drug, along with overdoses of recreational drugs and severe alcohol intoxication.

The continuing conflation of self-harm with attempted suicide is further supported by the prevailing view that a history of self-harm is the greatest predictor of eventual suicide. The systematic review by Owens, Horrocks and House (2002) is often referenced as evidence for this relationship. In this review the authors examined published follow-up data of those that presented at general hospitals for an incident of non-fatal self-harm. The analysis of data from 90 studies suggested that after one year between 0.5% and 2% resulted in a suicide, which rises to above 5% after nine years. The authors thus conclude that there is a strong connection between self-harm and suicide.

Consequently, in the UK the term self-harm is often applied as an umbrella term to any harm that does not result in death (Chandler, Myers & Platt, 2011). Hawton and Harris (2008) argue that to ascribe pre-defined intentions and motives to a dimensional and complex phenomenon is too risky and problematic. This position is supported in national guidelines, as recent reviews undertaken by the National Institute for Clinical Excellence (NICE) in the short (NICE, 2004) and longer-term (NICE, 2011) care and management of self-harm similarly favours a broad unitary definition with self-harm defined as "any act of self-poisoning or self-injury carried out by an individual irrespective of motivation" (NICE, 2011:14).

Yet such a broad definition is problematic, as by not considering any distinction in the meaning and intent behind an act of self-harm inevitably associates self-harm with suicide, which creates specific challenges for those involved in providing supportive care (Simpson, 2006). Mainly if no distinction is made then it is likely, Spandler and Warner (2007) argue, that all self-harm will be treated as attempted suicide, resulting in potentially more controlling and risk aversive practices.

A closer consideration of the Owens, Horrocks and House (2002) review also reveals that in the vast majority of cases the outcome of suicide from self-harm is very low. This is not to deny any relationship between self-harm and suicide as there are emotional similarities, and indeed the distinction at times can become blurred (Spandler, 1996; Spandler & Warner, 2007; Straiton et al, 2013). The pertinent issue Simpson (2006) raises is the continuing and interchangeable use of self-harm as a means of coping with distress, and attempted suicide as if they are always one and the same thing.

2.2.4 Excluding suicidal intentions

Resolution of this issue has been achieved through the application of terms that are more explicit in definition of intent, most commonly with the use of the term self-injury. Favazza (2011:197) states that self-injury is "*the deliberate, direct alteration or destruction of healthy body tissue without an intent to die"* (italics authors' own). Intentional and direct injury to the outside of the body, mainly through cutting, burning or hitting, typifies interpretations of self-injury (Klonsky, 2007; Chandler, Myers, Platt, 2011). Thus immediacy and unequivocal intentions differentiate self-injury from broader definitions of self-harm and for these reasons self-poisoning is often excluded in definitions on the grounds that it can be difficult to control due to its unpredictability (Claes & Vandereycken, 2007; McShane, 2012).

However, the unproblematic and succinct distinction that self-injury is always without suicidal intent is questioned. Babiker and Arnold (1997) state that what may be presented as attempted suicide may not necessarily involve an intention to die; similarly, those who self-injure may also at some other time harm themselves with suicidal intent. Therefore the boundary between self-injury and attempted suicide may not always be clear and straightforward, and it is insufficient to view self-injury, and indeed self-harm too, as only being concerned with coping and survival (Spandler & Batsleer, 2000). The danger of this assumption is a self-injurious act might be viewed as less serious than attempted suicide and not responded to, or alternatively, a life-threatening situation might be overlooked or missed (Babiker & Arnold, 1997; Spandler & Warner, 2007).

2.2.5 Self-harm as a response and communication of deep distress

In their work with young people, Spandler and Warner (2007) recognise the complexity that surrounds self-harm, but they maintain that a distinction between self-harm as a coping strategy and attempted suicide is necessary to minimise ambiguity and confusion. Therefore, as a coping strategy the authors argue that self-harm helps people to survive, as it offers distraction and disassociation from deeply distressing and painful experiences. The complex and multiple functions of self-harm being unique to the individual have also been raised in many survivor accounts, although a shared view within these accounts is that self-harm often provides a way to survive and cope with intolerable distress (Harrison, 1995; Arnold, 1995; Smith & Clarke, 2003; Pembroke, 2006b; Shaw, 2013a).

Shaw (2013a) draws further attention to how seemingly contradictory functions behind self-harm can sit side by side and provide a variety of complex purposes that can vary over time. Self-harm can also offer, Warner (2013) suggests, a way of communicating to the self and/or others the level of pain and distress experienced, particularly when words have failed or are found to be ineffective and unheard. Likewise, Shaw (2013a) asserts that self-harm can also provide a way of making distress into something that is tangible and visible and hence responded to and healed.

2.2.5 Self-harm as defined within this thesis

Clearly there are no straightforward solutions in relation to terms and definitional agreement between the meaning and intent behind acts of self-harm. What is perhaps crucial then is clarity in interpretation to minimise confusion and misunderstandings (Simpson, 2006; Allen, 2007). In view of this, the term self-harm is applied throughout this study, primarily because it was the term the case study group members favoured and applied. Additionally, although the term is fraught with inconsistencies in use I would argue that it is less stigmatising and pathologising, due to its more inclusive positioning.

In relation to definitional interpretation, my understanding of the term is informed and guided by the work of Spandler and Warner (2007) who recognise the complexity that surrounds self-harm, but who favour making a distinction between self-harm as a coping strategy and attempted suicide and who view self-harm as:

> "[T]he expression of, and temporary relief from overwhelming, unbearable and often conflicting emotions, thoughts or memories, through a self-injurious act which they can control and regulate."
>
> (Spandler & Warner, 2007:ix)

The acts of self-harm within this definition are secondary to the meaning and intent behind the act, which are exacted as a way of coping and managing distress. However, for the purpose of clarity such acts would include, for example, skin cutting, burning, hitting, hair pulling and the insertion of objects as a means of causing harm. Less direct and immediate forms of harm, like extreme exercising or smoking are excluded, on the basis that the meaning and function behind the act are not always clear and unequivocal. Likewise, whilst I recognise that a relationship between self-harm and eating disorders is not

uncommon, my interpretation of the term excludes the latter for similar reasons. Finally, my definitional interpretation acknowledges the agency of the person who self-harms and recognises that it is something they own and control and thus in some, but not all, this would exclude acts of self-poisoning.

Having now outlined my definitional interpretation of self-harm I will now turn to examining the contextual background that surrounds this area.

2.3 Prevalence and profiling of self-harm

The range of terms and definitions that abound in relation to describing the act of hurting oneself means definitional ambiguity and inconsistencies are not uncommon. This therefore makes it difficult to generate an accurate and reliable interpretation of rates and prevalence, particularly when this is considered internationally. In view of this, rates and prevalence of self-harm are largely considered only within a UK context.

2.3.1 Rates of self-harm

Accurate identification of the prevalence of self-harm in the general population remains problematic for a number of different but inter-related reasons. As self-harm is mostly undertaken in private and remains largely hidden and unreported, evidence for incidence has mainly come from hospital and school based studies (Babiker & Arnold, 1997). Consequently, deriving incidences and rates from specific populations inevitably affects generalisability. In addition, Sutton (2007) highlights that the wide variety of terms applied to describe the act of hurting oneself and the inconsistent and interchangeable use in meanings applied further complicates the picture and makes establishing any meaningful comparisons between studies difficult.

Despite these challenges there remain a number of prevalent assumptions in relation to rates of self-harm, particularly in a UK context. Firstly, it is often reported that the UK has one of the highest rates of self-harm in Europe, with it affecting 400 people per 100,000 (Royal College of Psychiatrists, 2010; MHF, 2014). Closer examination of the evidence for this raises some doubts about the robustness and reliability of this ratio. The basis for this evidence is taken from a review paper undertaken by Horrocks and House (2002), who reframe the research findings of the study conducted by Hawton and Fagg in 1992 into a

ratio. In the research conducted by Hawton and Fagg (1992), trends in deliberate self-poisoning and self-injury in Oxford from 1976 to 1990 were examined and generalised to England and Wales, but no comparisons were made to Europe. As Horrocks and House (2002) do not provide any further comparative data as to how these rates compare to the rest of Europe during these different time points it raises questions as to how similar or divergent the actual rates in the UK are.

Following on from this, a second commonly held view is that rates of self-harm are exponentially rising in Western societies, and as a result are often reported within both the academic and popular press as being at epidemic levels (Frith, 2004; Brumberg, 2006; Hill, 2006; Miller & Smith, 2008; Dutta, 2015). Such dramatic depictions can distort and sensationalise an area that remains enfolded with shame and stigma. Instead, Barton-Breck and Heyman (2012:448) recommend that caution is taken when interpreting prevalence statistics, because even if there has been an unprecedented increase in self-harm it must be considered an "open question", due to the lack of historical research undertaken and the on-going changes in the definition and recording of events.

Furthermore, an unquestioning acceptance that there is an unprecedented rise in the numbers self-harming fails to consider the impact of greater societal awareness. Since the early 1990s awareness of self-harm has steadily increased, aided by the voicing of personal experience accounts that was heightened further with a number of high-profile figures also sharing their experience of self-harm, such as Diana Princess of Wales, Dame Kelly Holmes and Johnny Depp. Since then there has also been an unparalleled expansion of online self-harm websites and interactive forums for those who self-harm (Adler & Adler, 2011). Therefore, Sutton (2007) suggests that greater awareness might mean people are more willing to speak about their self-harm and seek support than in the past, rather than there simply being greater numbers of people self-harming now.

Although the data and evidence remains inconclusive about rates and prevalence of self-harm there exists a number of prevailing assumptions, which I examine next in closer detail.

2.3.2 Gender and age

One of the most enduring assumptions in the area of self-harm is that it predominately affects young girls. This assumption, Brickman (2004:87) argues, is a result of the "delicate cutter" profile that emerged in the early 1960s and 1970s, when psychiatry first began to take an active interest in self-harm. Invariably the profile consisted of a young, white, middle-class adolescent girl whose physical attractiveness was routinely commented upon. Chandler, Myers and Platt (2011) argue that the restrictive gender constructions of the time, meant that it was more acceptable to view self-harm as a feminine behaviour by reinforcing cultural femininity myths of passivity, than view the act in both genders as aggressive and therefore masculine. Consequently male experiences of self-harm, Brickman (2004) suggests, were largely ignored or they were further marginalised as effeminate men.

This gendered assumptive profile continues to inform and influence current interpretations. For instance, many studies on self-harm are carried out on exclusively female samples (Lindgren et al., 2004; Reece, 2005; McAndrew & Warne, 2005). Additionally, it is not uncommon that the feminine pronoun is adopted for third person references on the basis that self-harm is viewed as an activity primarily undertaken by girls and young women (Smith, Cox & Saradjian, 1998; Strong, 2005; Miller, 2005; Levenkron, 2006). All of which continues to reinforce the assumption, Hogg (2010) argues, that self-harm is overwhelmingly a female activity, and by doing so continues to marginalise and ignore male experiences.

This is not to imply that there are no differences in gender. Indeed, numerous enumerative studies routinely report significantly higher rates in females than males. For instance, in a self-report survey conducted in Scotland and completed by students aged 15 to 16 years, girls were nearly 4 times more likely to report self-harm than boys (O'Connor et al., 2009). Likewise, findings from a service audit undertaken in a random sample of 31 general hospitals in England found that of the 4033 episodes of recorded self-harm in adults, 55% were undertaken by women and 45% by men (Gunnell et al., 2004).

However, alternative explanations of socialisation and normative gender structures have been suggested as a way of accounting for differences in prevalence gender rates. For instance, Sutton (2007) suggests that masculine gender stereotypes, which endorse a

detached, active identity, may make it harder for men to reveal and seek support for their self-harm. As a result they are less likely to appear in prevalence statistics. The method used has also been raised as another explanatory facet to consider. By engaging in more public or violent acts of self-harm, like getting into fights or participating in dangerous sports, it is argued men's experiences of self-harm are much more likely to remain hidden and unknown (Babiker & Arnold, 1997; Taylor, 2003). As such, Inckle (2014) argues that if there are differences regarding male and female self-harm, it is more likely to be about the type and method of the injury and the ways in which they are interpreted than necessarily actual incidence. Hence issues of under-reporting, varying definitions and the impact of stigma may have contributed to a greater proportion of men's self-harm remaining hidden.

Similarly, in relation to age much research indicates that self-harm begins during adolescence (Hawton et al., 2002; Nixon, Cloutier & Jansson, 2008; Favazza, 2011). The onset of puberty and hormonal changes are often presented as probable reasons, which "spontaneously" ends by adulthood (Moran et al., 2011:242). Accordingly the vast majority of research had tended to focus within this age range, and as a result very little remains known about the actual lifecycle of self-harm (Chandler, Myers & Platt, 2011). The assumed rarity of self-harm amongst those above 25 years might be because they have stopped, but alternatively the stigma and shame associated might affect reporting even more so for those in an older age range (Babiker & Arnold, 1997). Such a narrow prevailing profile of the age and gender attributes commonly associated with self-harm limits understanding and potentially ignores those who do not fit this dominant profile. Accordingly Chandler, Myers and Platt (2011) argue that more attention needs to be given to the lifecycle of self-harm in both the general population and beyond adolescence.

2.3.3 Ethnicity

In recent years efforts to identify the risk factors for self-harm has meant the profile of a 'typical' self-harmer has widened to some degree (Gratz, Conrad & Roemer, 2002; McMahon et al., 2010; de Kloet et al., 2011). For instance, Skegg (2005:1474) provides a summary table of the many factors that are considered associated, from demographic profile, social and family environment, psychiatric disorders and situational factors. Consequently those who did not traditionally meet the prevailing profile of a 'typical' self-

harmer have increasingly received greater attention. One such area is in relation to ethnicity.

On the whole, attention has tended to focus on the experiences of South Asian women in the UK, as incidences of self-harm and suicide are frequently reported to be highest in this demographic group than in any other (Bhardwaj, 2001; Husain, Waheed & Husain, 2006). Explanatory reasons however have tended to perpetuate cultural and gender stereotypes and ignored underlying structural inequalities (Marshall & Yazdani, 1999; Chantler, Burman & Batsleer, 2003). Accordingly, Bhardwaj (2001) argues that whilst prevalence studies have highlighted patterns of distribution, there remain fewer meaningful accounts as to why South Asian women in particular self-harm. Furthermore, a recent study by Cooper, Murphy and Webb (2010) raises doubts about the common assumption that self-harm predominately affects South Asian women. As by comparing the ethnic characteristics in three UK cities the authors found rates of self-harm to be highest in young, Black females aged 16-34 years. Clearly risk factors in relation to ethnicity and self-harm remain largely inconclusive and contradictory, which is hampered further, Reece (2005) suggests, by the lack of consideration that is given as to how distress is communicated by different cultural and ethnic groups.

2.3.4 Sexuality

Another area that has gained interest and attention in relation to risk factors associated with self-harm is in the area of sexual orientation. For example, a systematic review of the international literature by King et al. (2008) examined the prevalence of self-harm, along with mental disorder, substance misuses, suicide and suicidal ideation in lesbian, gay and bisexual (LGB) people. The authors conclude that LGB people are at a significantly higher risk of suicidal ideation and self-harm than heterosexual peoples. Tentative explanations of increased stigma and hostility are offered, which is further supported in a small-scale qualitative study undertaken by Alexander and Clare (2004). In this study the subjective experiences of 16 women who self-harmed and identified as lesbian and bisexual were explored. Many of the reasons and motivations were found to be similar, regardless of sexuality, to other women who self-harmed. For instance, experiencing negative and traumatic events in childhood and adulthood. However, the authors found the dimension of feeling different from an early age and not conforming to gendered heterosexual

expectations, was a specific and unique aspect, as many of the 16 women spoke about the disapproval, hostility and bullying they had experienced.

This current emphasis on identifying those at risk of self-harm has widened earlier narrow profiles and indicated that marginalised groups are perhaps most vulnerable. Spandler and Warner (2007) suggest that such a conclusion is not altogether surprising as marginalised groups are more likely to experience oppression, abuse and discrimination, factors that are frequently found to be related to self-harm. In focusing on distinct, marginalised groups there is a concern, the authors continue, that the wider shared factors are ignored or downplayed.

2.4 Myths and assumptions

Self-harm is an area that is surrounded by myths and misconceptions. One of the most commonly assumed reasons is that people self-harm as a way of coping with abuse. This view is supported by the number of studies, both in community and clinical settings, which report an association between self-harm and childhood sexual abuse and neglect. For instance, of the 76 women recruited through community agencies in the study by Arnold (1995), 62% reported having experienced multiple forms of abuse and neglect in childhood. Likewise, Gladstone et al. (2004), who examined the effect of childhood abuse on women diagnosed with depression, found that those who experienced abuse in childhood were significantly more likely to self-harm.

Accordingly, a great deal of the research literature has focused on examining the risk factors between childhood abuse and self-harm (Gratz, 2003). The impact of this pursuit has contributed to an assumptive view that all those who self-harm have experienced abuse. But such a simple causal link is problematic, as not everyone who self-harms has experienced abuse (Smith, Cox & Saradjian, 1998; Gardner, 2002; Pembroke, 2006a; Klonsky & Muehlenkamp, 2007). Instead the reasons why someone self-harms are well documented as being numerous, multi-faceted and individual (Spandler, 1996; Jeffrey & Warm, 2002; Sutton, 2007; Shaw, 2013a). This prevailing assumption however creates the illusion that every person who self-harm fits into one of these existing scenarios (Turp, 2003; Pembroke, 2006a). Consequently Jeffrey and Warm (2002) suggest that it is

important to recognise the reasons and motives as wide-ranging and individualised, but appreciate that common themes do exist.

An additional explanatory assumption that prevails is those who self-harm are manipulative and attention seeking (Pembroke, 1994; Harrison, 1996; Sutton, 2007). These negative perceptions, Jeffrey and Warm (2002) argue, have had an impact in the way those who self-harm are viewed and treated, as it is still not uncommon for treatments and local anaesthetic to be withheld when the stitching of wounds is required (Pembroke, 2006c; Taylor et al., 2009). Negative attitudes expressed by health professionals have also been widely reported, observed and experienced (Pembroke, 1994; Shaw & Shaw, 2007; McAllister et al., 2002; Lindgren et al., 2011). The effect of these negatives attitudes and perceptions on those who self-harm, Warm, Murray and Fox (2002) argue, is that it continues to enhance feelings of shame, guilt and worthlessness in those who self-harm.

Conversely, the research undertaken by Wilstrand et al. (2007) into nurses' experiences of caring for psychiatric patients who self-harm illustrates the conflictual emotions healthcare professionals often face. The authors found that staff often felt 'burdened with feelings' of uncertainty, fear and powerlessness that could consume and weigh them down. These negative feelings were compounded by the challenge of maintaining professional boundaries and their own personal feelings.

2.5 Explaining self-harm

Self-harm is an area of interest to various disciplines, standpoints and interest groups. As a result McAllister (2003) argues there are multiple ways to understand self-harm, which are intrinsically connected to the different ways it is viewed and framed. Rather than discussing these numerous and different positions individually I differentiate between those perspectives that generally locate explanations of function, meaning and treatment within the individual, with positions that emphasise a wider, social-political focus. This separation and distinction is somewhat arbitrary, as there are shared understandings across and within these different frameworks of understanding. Nonetheless this distinction provides a framework of understanding to what remains a complex and contested area.

2.5.1 Individual focus

Self-harm as symptomatic of an underlying disorder

Individual based explanations for self-harm are largely grounded within a psychiatric framework of understanding that tends to view self-harm as a symptom of a diagnosable mental health disorder, as a result of physiological disturbances in the brain (Smith, Cox & Saradjian, 1998). Closely aligned and influenced by the medical model, distress and mental ill health is largely attributed to physical or biological predisposing factors that are viewed as independent to a person's relationship to the world around them and to their relationships with others (Tew, 2005; Loat, 2011). Focusing on the classification and treatment of the disorder or behaviour, the Diagnostic and Statistical Manual of Mental Disorders (DSM) provides the structural tool for diagnosis (Claes & Vandereycken, 2007). In this diagnostic tool, self-injury (the preferred term of choice) is not viewed as an illness or disorder in itself, but rather as a symptom of several other disorders, most commonly those to do with impulse control (McShane, 2012).

In this context, impulsivity is generally characterised negatively as a failure to resist a temptation, urge or impulse that results in harm to the self or others. Chandler, Myers and Platt (2011) argue that such an interpretation fails to consider and recognise the positive features of impulsivity that are necessary, for example when driving or playing sports that require quick reactions and responses. Despite the contested nature that surrounds impulsivity, it is often applied in explanations of self-injury and is also one of the nine diagnostic criteria of borderline personality disorder in the DSM, a diagnosis that is commonly applied, particularly to women, who self-harm (Babiker & Arnold, 1997; Chandler, Myers, & Platt, 2011; McShane, 2012). Klonsky and Muehlenkmap (2007) argue that the link between borderline personality disorder and self-injury is not surprising, as both self-injury and borderline personality disorder are associated with intense and destructive feelings like anger and stress, which are poorly managed or controlled by the individual.

Self-harm as a response to distress

In contrast, from a more psychosocial perspective self-harm is considered more as an expression and way of coping with distress, rather than being distinctly symptomatic of an underlying disorder. Grounded within a functionalist tradition with an emphasis on examining the various functions self-harm serves, Klonsky (2007), in a review of clinical

and psychosocial studies, identified seven distinct functions of self-harm and concluded that affect regulation was the most convincing. In this context self-harm is viewed as a way of alleviating intense and overwhelming negative emotions, like anger, anxiety and frustration, which is then followed by feelings of relief and calm after the act. However, self-harm is largely deemed maladaptive within this framework of understanding, on the grounds, Adler and Adler (2011) argue, that it only offers temporary relief and release of negative emotions and feelings.

Rayner and Warner (2003:307) suggest that a psychosocial perspective of self-harm is often viewed as a response to feelings and thoughts resulting from interpersonal experiences and provides a way of coping by an "internal reaction to external events". This is not to exclude the possibility of an underlying disorder within this perspective, but more a "demotion of the biological rather than a denial" (Ramon & Williams, 2005:2). The importance of social issues and a variety of risk factors are emphasised, as these are considered to affect the onset of self-harm in certain predisposed individuals (McShane, 2012), whilst the root cause of self-harm tends to be located in childhood experiences that take place within the family, especially within the context of the caregiving relationship (Adler & Adler, 2011).

This overview of individualistic focused explanations of self-harm illustrates that in both a psychiatric and psychosocial framework of understanding, self-harm is largely located in the individual who is perhaps struggling with puberty, impulsivity, coming to terms with past abuse or has an underlying organic disorder (Chandler, Myers & Platt, 2011). Such a position continues to be dominant in mental health services, although increasingly wider, social factors are acknowledged. Yet such factors, Loat (2011) argues, are often devalued as of secondary importance to biological factors. In the next section I introduce and discuss those perspectives that emphasise the importance of contextualising self-harm in relation to wider, social-political factors.

2.5.2 Socio-political focus

Positions of understanding within this framework share a similar approach in looking beyond the individual to wider social-political factors and structures as the means to contextualise and understand self-harm. This is not to deny the importance of the individual lived experience, but instead such an emphasis is viewed as providing only a

partial understanding. The three positions discussed here are a feminist understanding, self-harm survivors' movement and a sociological position.

The feminist perspective

A feminist framework for understanding self-harm, McAllister (2003) states, is informed by concepts of power, control and resistance. Focusing predominately on the female lived experience, a feminist understanding emphasises how self-harm transgresses cultural, gendered norms and because of this is less tolerated than other forms of harm (Harrison, 1995; Babiker & Arnold, 1997; Jeffreys, 2005). For instance, beauty practices that involve physical alteration, like cosmetic procedures and surgery, are endorsed, Shaw (2002) argues, as they fulfil the cultural ideals of what women's bodies should look like, whereas acts of self-harm remain intolerable for not reflecting and serving Western aesthetics. By comparing eating disorders with self-harm Shaw (2002) further argues that women are 'forgiven' more if they have an eating disorder, than if they self-harm, as the pursuit of thinness fits within Western cultural beauty ideals.

Therefore, within a feminist understanding of self-harm an awareness of the patriarchal nature of gendered power relationships and hierarchies within society and interpersonal encounters is deemed crucial to understanding the position of women and their expression of distress (Burstow, 1992; Doy, 2003). Self-harm, Shaw (2002) argues, is thus a form of resistance, as it provides a way for women to gain control when they feel they have no control in other realms of their lives. It also offers a way, Babiker and Arnold (1997) suggest, for those who self-harm to speak about the way wider structural factors and conditions, like abuse, oppression and discrimination affect the way they view themselves and their bodies through their acts of self-harm. Therefore, self-harm is not necessarily deemed natural or inevitable within a feminist framework of understanding, but rather is a response to social conditions, constraints and factors (Shaw, 2002; McAllister, 2003).

Feminist activism in self-harm has been key to developing alternative gender specific services, for example with the founding of the Bristol Crisis Service for Women in the late 1980s, which was established to support women who self-harm (Wilton, 1995). A feminist approach to supporting someone who self-harms, McAllister (2003) suggests, involves shifting the attention from the individual towards larger relational factors, which offers opportunities for the person involved to gain control, claim power and use their voice in

less damaging ways. Despite its activist roots, self-harm remains, Kilby (2001) argues, markedly absent from feminist theory, which is evident when compared to the available feminist literature on eating disorders. Moreover, by focusing predominately on the female experience, a feminist socio-political perspective on self-harm continues, Chandler, Myers and Platt (2011) argue, to perpetuate the myth that self-harm is largely a gendered, female act.

Survivors' movement

By the early 1990s Cresswell (2005) suggests that a self-harm survivors' movement had begun to develop in the UK, which was influenced by feminism and the psychiatric survivor movement. Women who had survived abuse and psychiatric treatment began to challenge the myths and misconceptions that surrounded self-harm by organising their own voices (Spandler & Warner, 2007). These accounts highlighted the multiple functions and meanings that are unique to the individual who self-harms (Pembroke, 2006a). With the meanings and functions varying from person to person, and over time, assuming the reasons why someone self-harms, Shaw (2013a) suggests, is a misguided approach. Instead, discarding preconceptions in favour of listening and trusting what those who self-harm identify as the most important features remains a favoured approach from this standpoint (Arnold, 1995).

Survivors, activists and allies aligned with the movement have also raised awareness around the potential restorative features related with acts of self-harm, as survivor accounts have illustrated how self-harm can provide a sense of calm, express distress, release tension, experience comfort and ground a person in reality (Shaw, 2012). This position challenges the view that self-harm is always a maladaptive act, a position largely endorsed within traditional psychiatry. Although self-harm is not advocated as a suitable coping strategy, to deny and ignore these features, it is argued by those with direct experience, disregards the resourcefulness of those who self-harm and their potential for healing and recovery (Harrison, 1995; LeFevre, 1996; Shaw, 2013a).

It was also in these early accounts where the social roots of self-harm were first explicitly stated and recognised (Pembroke, 1994; Harrison, 1995; Arnold, 1995). Survivor accounts revealed that self-harm was often a way of coping and surviving intolerable distress, often caused by abuse, violence, neglect and loss, rather than a symptom of an underlying

disorder (Shaw, 2013b). A common thread within these accounts was the understanding that traditional psychiatry had little to offer people in distress, as it failed to address the real issues in individuals' lives (Warner, 2013). Instead, issues of power and control have been argued as crucial to understanding the reasons why people self-harm. By doing so this moves the focus from the harm people do to themselves to the oppression, abuse or discrimination that underlies it (Martins, 2007). Survivor accounts and personal testimonies have thus been central, Cresswell (2007:12) argues, to establishing a "politics of self-harm", as they illustrated how self-harm was often an act of survival in response to the abuse of power by others, which permitted the violation and silencing of some people.

Additionally as a movement it has raised awareness over the poor care and treatment many have reported receiving in statutory services, along with influencing policy and practice (Spandler & Warner, 2007). With much of the knowledge base, Warner (2013) suggests, around working progressively with people who self-harm having come from those who have direct experience of self-harm. However, as with any social movement, maintaining momentum and representing all experiences equally remains a challenge. Additionally Spandler and Batsleer (2000) suggest that avoiding an 'us and them' division that positions those with direct experience as the only ones who can understand self-harm is an ongoing challenge. The danger of this positioning, the authors suggest, is that it can dissolve support and solidarity, but crucially diminish influence and impact.

Sociological perspective

In recent years a sociological understanding of self-harm has begun to emerge that moves away from the dominant medical and clinical individualistic explanation that tends to detach the person from their socio-cultural context (Chandler, Myers & Platt, 2011). For instance, authors such as Chandler (2012) favour an embodied sociological approach in understanding self-harm. In her research, two in-depth interviews, based around a life story approach, were conducted with 12 people who self-harmed. Participants were mixed in terms of gender and were recruited from a non-clinical setting. Chandler (2012) reports that unlike typical psychiatric interpretations of self-harm, where the practice is often framed as irrational and impulsive, participants portrayed themselves as:

> "[U]ltimately rational, capable actors who were addressing – albeit in an unconventional manner – unwanted, undesirable emotions."
>
> (Chandler, 2012:454)

The author suggests that focusing on self-harm in terms of individual emotional problems could 'silence' attempts to examine wider social processes that might contribute or shape potential responses to such problems. Chandler (2012) proposes that a sociological analysis of self-harm as embodied emotion work potentially offers a more nuanced and practical perspective than current limited clinical understandings and explanations.

In addition, the concept of stigmatization has recently been re-examined from a sociological perspective in the area of self-harm. Drawing upon empirical in-depth interviews with 20 women and five men who self-harmed, McShane (2012) reports that people who self-harm are not only stigmatized by the negative attitudes held by the wider population (including those within the medical profession), but more complexly by their own fear of such treatment. McShane (2012) argues that the dread of negative reaction from others can promote a complex series of stigma management techniques aimed at avoiding and minimising stigma. The author describes techniques that involve re-defining self-harm in order to de-stigmatise it. For instance, by comparing it to other more socially acceptable forms of self-harm like the excessive drinking of alcohol.

Taking a wider, societal view of self-harm and its changing status McShane (2012) proposes that in the past decade self-harm is more highly visible than ever before, aided by the influence of the media and the internet. Consequently those who self-harm today are more likely to have heard or read about it and in many respects are less isolated than in previous decades. McShane (2012) suggests that this awareness means that although the behavior is still highly stigmatised it is becoming less so, a view that is supported by Adler and Adler (2011) who examined the impact of social changes on self-harm, with the rise and expansion of online groups and forums. The authors argue that such a rise has improved awareness and ultimately reduced levels of stigma for those who self-harm.

Chandler, Myers and Platt (2011) argue that the benefits of a sociological framework to understanding self-harm is that it offers a critical eye on accepted explanations, definitions and understandings, and contributes to a more multi-disciplinary informed position.

2.6 Supporting people who self-harm

The multiple ways that exist in framing and understanding self-harm also means there are numerous and varied approaches to supporting people who self-harm. Again, rather than descriptively discuss these multiple and varied approaches I differentiate between those approaches that aim to treat and stop the individual behaviour through control and constraint, from those approaches that aim to facilitate autonomy, resilience and self-help.

2.6.1 Emphasis on control, constraint and cessation

Pharmacological intervention is the common treatment approach when self-harm is attributed to a specific psychiatric illness. But the benefits of this approach are recognised as limited when the self-harming behaviour is not ascribed to a definite disorder (Royal College of Psychiatrists, 2010). Instead, cognitive behavioural therapies (CBT) are often favoured within an individualistic, focused framework of understanding. The aims of CBT are to teach specific skills, such as problem-solving or distress tolerance, to implement cognitive restructuring and by doing so alter the negative way that people think in order to increase self-esteem and reduce self-harm (Rayner & Warner, 2003; Klonsky & Muehlenkamp, 2007). Dialectical behaviour therapy (DBT), a specific form of CBT for females, particularly those with a diagnosis of borderline personality disorder and a history of self-harm, has gained prominence in recent years as a potential effective intervention in the wider management of self-harm.

DBT was developed by Marsha Linehan in the early 1990s as a model of treatment for those specifically diagnosed with borderline personality disorder. As a behavioural-based treatment, DBT attempts to identify the factors that trigger impulses to self-harm and increase capacity to manage emotions and responses more appropriately. Increasingly, there has been an interest in applying this model to those without a diagnosis of borderline personality, but who regularly self-harm, as a number of studies have reported a reduction in the rates of self-harm (Muehlenkamp, 2006; Moro, 2007). However, Feigenbaum (2007) raises concerns about the validity of the evidence available due to the small sample sizes and lack of consideration towards complex confounding factors, and questions whether it is the model itself contributing to the change and improvement, or the regular contact with the therapist that is an underpinning principle of the model.

From the few studies that have explored service users' experiences of behavioural therapies for self-harm, positive views have been reported. For instance, Perseius et al. (2003) found that many women considered the DBT to be a 'life saver', particularly when they compared previous experiences of psychiatric care (often described as poor), before DBT. However, personal testimonies received by Smith, Cox & Saradjian (1998) illustrate the difficulties in distinguishing between the therapy model and level of contact, as many women described how they found the multiple strands of support in a DBT approach to be the most valued features.

Townsend (2014) therefore argues that there remains a limited evidence base on the type of interventions that effectively help those who self-harm, a view that is supported in the National Institute for Health and Care Excellence (NICE) guidelines. For instance, in the 2004 guidelines for the short-term management of self-harm the evidence for the effectiveness of behavioural approaches was reported as inconclusive (NICE, 2004). This conclusion was also reflected in a Cochrane review into the effectiveness of various treatments for self-harm (Hawton, et al., 2009). The guideline development group for the 2004 NICE short-term management of self-harm thus concluded that the evidence base for treatments is limited and that there remains:

> "[I]nsufficient evidence to support any recommendations for interventions specifically designed for people who self-harm."
>
> (NICE, 2004:177)

Similarly, the NICE 2011 guidelines for the longer-term management of self-harm again reported insufficient evidence for the effectiveness of interventions for self-harm and concluded that further research is needed. Despite this, both the 2004 NICE guidelines and 2009 Cochrane Review promote the potentially promising results and further investigation in the use of DBT for those who self-harm, whilst the 2011 NICE guidelines suggest a consideration to offering cognitive-behavioural, psychodynamic or problem-solving interventions.

Criticisms, however, have been raised about the inherent principles embedded within behavioural interventions such as DBT for self-harm. For example, an expectation in receiving DBT is that the individual concedes and accepts their self-harm is a maladaptive

act and that they commit to complete cessation of self-harm from the outset. Babiker and Arnold (1997) argue that such an expectation has the potential to undermine a person's autonomy and jeopardize a therapeutic relationship, and hence are critical of the intrinsic undermining principles embedded within this model of support. Pembroke (2006a) further argues that DBT places those who self-harm in a precarious position, because it has to 'work' if there is no alternative and if it does it is due to the intervention, but if it does not it is the fault of the individual for not being compliant or for being untreatable.

Current individualistic, behaviourist models tend to dominate the treatment and management of self-harm in statutory services, but authors such as Spandler and Warner (2007) argue that these interventions tend to only focus on the 'here-and-now' and disregard the individual's background. Ignoring the often complex and painful life histories of those who self-harm in favour of dealing with here-and-now problems are deemed, McAndrew and Warne (2005) argue, inherently limited and flawed. It is also doubtful, authors such as Pembroke (2006a) and Dargan (2013) have argued, that one type of model is likely to fit all when the reasons why someone self-harms are multiple, complex and individual.

Further criticisms have also focussed on the inherent goal of cessation in behavioural models of support for self-harm. Arnold (1995) argues that such an emphasis fails to consider how other types of harm may take its place if a person stops self-harming before they have developed other coping strategies. Nonetheless these short-term interventions continue to dominate in statutory services. Warner and Spandler (2012) argue that this is partly on the grounds of economics, but also because they fit within the current emphasis for evidence-based treatments. Clear goals on cessation make it easy to measure and 'prove' success and progress by recording levels of occurrence and repetitions.

In both the 2004 and 2011 NICE guidelines for self-harm cessation remains the dominant principle for measuring effectiveness (NICE, 2004; 2011). But such narrow goals fail to acknowledge that cessation is not always the main priority for those who self-harm (Hume & Platt, 2007; Warner, 2013). Models of support that do not impose constraints and controls and which enable the individual to set their own goals and aims are often found to be favoured by those with direct experience of self-harm (Warm, Murray & Fox, 2002; Hume & Platt, 2007; Shaw, 2013b). These values Pembroke (2007) outlines are also more

in keeping with the principles of recovery that can mean learning to live with enduring and complex problems.

2.6.2 Emphasis on autonomy, resilience and self-help

Frustration and dissatisfaction with current service emphasis and provision, by those with direct experience of self-harm, contributed to the development of the two approaches discussed below that promote the agency and strength of the individual.

Harm minimisation

The origins of harm minimisation are in sexual health and drug services where policies based on prevention and abstinence were often found to be ineffective and counterproductive in terms of stopping the behaviour and meeting the health and care needs of the individual (Shaw & Shaw, 2007). In relation to self-harm the widespread enforcement of no self-harm contracts in hospital inpatient settings often leads, Inckle (2010) outlines, to a similar situation, as the self-harm ends up taking on an uncontrolled out of control more damaging manner, because of the methods used and the need for secrecy and urgency. Recognising that an emphasis on cessation is unrealistic and potentially more harmful, survivors within the self-harm survivor movement developed and have advocated a harm minimisation approach, which aims to support those who self-harm to do so in a safer, more controlled way (Shaw & Shaw, 2007).

A common misconception, Inckle (2010) identifies, is that harm minimisation involves giving out clean blades to those who self-harm, thus facilitating an escalation of injuries, as an alternative to providing comprehensive and meaningful support. Instead, Pembroke (2006a) summarises that a harm minimisation approach recommends that staff do not remove or search people's bodies or belongings for implements, but instead provide access to the voluntary handing over of implements without fuss, along with providing information on basic anatomy to limit the damage and provide practical and psychological tools for living with scars.

The grounding principles of harm minimisation involve accepting and respecting a person's autonomy and need to self-harm in order to survive unbearable distress, and by doing so the forbidden nature of self-harm and its accompanying secrecy and urgency is relieved, thereby making the process safer and calmer (Pembroke, 2006a). By allowing and

accepting a person's self-harm as a valid means of coping at that particular place and time facilitates and creates, Inckle (2010) identifies, a context to develop and establish a trusting therapeutic relationship. Harm minimisation is not positioned as an answer for everyone who self-harms. Instead it is intended to offer hope, particularly for those who repetitively self-harm and where cessation might be an immediate unrealistic aim. In such cases Pembroke (2006b) suggests harm minimisation can limit the damage caused by self-harm whilst it continues.

Since the mid-1990s a number of self-help booklets and workbooks have been written by survivors, activists and allies aligned with the self-harm survivor movement to provide guidance and tools for those wanting to better manage and reduce their self-harm (Dace et al., 1998; Pembroke, 2000; Arnold, 2006). These booklets and workbooks are largely experientially based and guided by a harm minimisation approach. For instance, *The Self-Harm Help Book* published by The Basement Project, suggests a range of activities to help an individual identify the reasons why they self-harm, as well as finding other ways to express distressing feelings, emotions and memories (Arnold & Magill, 1998). Such workbooks and booklets are grounded within the principles of self-help and advocate an empowering approach that recognises and promotes autonomy and resilience.

In the NICE 2004 guidelines, harm minimisation was identified as an option to be discussed for those who repeatedly self-harm, which was again recommended in the 2011 guidelines for longer-term management (NICE 2004; 2011). As a result, Shaw (2012) argues that harm minimisation is increasingly gaining recognition and credence in both a clinical and community setting. Indeed, at Selby and York Primary Care Trust harm minimisation was included as a viable option in their handbook on alternatives to self-harm (Pengelly et al., 2008).

Nonetheless, ethical and legal implications have been raised about endorsing a harm minimisation approach, as from a legal perspective, Hewitt (2010) argues, harm minimisation is operating with little or no guidance to protect those who self-harm and those who assist them. Similarly, Gutridge (2010) suggests that health care practitioners who use harm minimisation might be considered to be helping physical injury to occur. However, the author concedes that allowing a degree of self-harm may enable a therapeutic

relationship and in such circumstances allowing injury, with precautions, may not constitute harm "all things considered" (Gutridge, 2010:90).

Self-harm self-help groups

Corcoran, Mewse and Babiker (2007) argue that the majority of people who self-harm do not approach or receive any statutory interventions and for those who do they are generally dissatisfied with current service provision. In contrast, self-help groups are run and led by group members and provide an opportunity for those who self-harm to meet others who share similar experiences for support in a community setting (Parker & Lindsay, 2004). Being able to meet, listen and talk to others who self-harm in a self-help group has been identified as a powerful process that helps to reduce isolation and provide alternative ways of managing and coping (Arnold, 1995; Babiker & Arnold, 1997; Smith & Clarke, 2003; Inckle, 2010; Foster, 2013).

To date, however, there have been few empirical studies that have explored self-help groups in relation to self-harm, with some notable exceptions. Smith and Clarke's (2003) user-led study explored individual experiences of attending self-harm self-help/support groups. Members who had previously attended a group, along with those who currently attended a group completed questionnaires and a smaller number took part in in-depth interviews. Whilst the study did not explore any group as a whole area of study in itself, individual member responses indicated that self-harm self-help groups provided a "much needed resource for many individuals", as members were able to "gain help and support that they were not able to get elsewhere" (Smith & Clarke, 2003:34).

Corcoran, Mewse and Babiker (2007) found similar findings in their study that examined the role of self-injury support groups. Seven semi-structured interviews were undertaken with women who attended three support groups. Although it is unclear how many members came from one group and whether the groups were all member-led and owned the findings indicated that the groups were highly valued by the women that attended them. The authors suggest that meeting others with shared experiences reduced feelings of guilt, shame and isolation and facilitated a process of empowerment that potentially decreased an individual's self-harm. However, in both the studies by Smith and Clarke (2003) and Corcoran, Mewse and Babiker (2007) little or no examination is given to the potential challenges facing these groups and both focus on the individual perspective.

The Bristol Crisis Service for Women, a national voluntary organisation that supports girls and women who self-harm, suggests that many women want and benefit from attending self-harm self-help groups and as a result the organisation maintains an online database of groups across the county. Their publications argue that these groups can provide a space of acceptance where a members' pain is mutually acknowledged (Parker & Lindsay, 2004). The commonality of experience between group members offers a unique source of support that enables members to explore their self-harm with others, and unlike more traditional forms of treatment the focus is not on cessation. Nonetheless, through the sharing of experiences and different ways of coping, self-harm self-help groups, the organisation suggests, can be an effective way of decreasing self-injury (Parker & Lindsay, 2004; Arnold, 2006). Despite these strengths the Bristol Crisis Service for Women concedes that self-harm self-help groups are not considered to be widespread in the UK (Arnold, 2006).

In both a harm minimisation approach and self-harm self-help groups it is frustration and dissatisfaction with current service provision that was often the impetus for those with direct experience to seek and develop alternative forms of support (Shaw & Shaw, 2007; Corcoran, Mewse & Babiker, 2007). Both approaches emphasise the agency and resilience of the individual in controlling and managing their self-harm in collaboration with others. However, unlike harm minimisation, self-harm self-help groups are primarily situated in the community and collaboration is with other peers, whereas a harm minimisation approach is something that is done in collaboration with the person who self-harms and a health professional mostly within a clinical setting. In recent years a harm minimisation approach has gained momentum and attention, whilst self-harm self-help groups remain very much on the periphery despite emerging evidence to suggest they are highly valued by group members.

2.7 Chapter summary

In this chapter I have discussed the definitional difficulties with the use of the term self-harm and outlined my rationale and interpretation of the term that informs this thesis throughout. In this context I distinguish between self-harm as a coping strategy and attempted suicide, but recognise the complexity that surrounds this distinction. In examining the prevalence and rates of self-harm the chapter then provides a contextual, descriptive background and highlights the prevailing assumptions that exist in this area in

relation to demographic profile and explanatory reasons. As self-harm is an area of interest to various disciplines, standpoints and interest groups, I argue that this means there are multiple ways of framing and understanding self-harm. In view of this I consider and differentiate between models of understanding that locate explanations of function, meaning and treatment within the individual, from those perspectives that emphasise a wider, social-political focus to understanding self-harm.

An individualistic, focused explanation of self-harm is considered within a psychiatric and psychosocial framework of understanding. In this framework self-harm is often attributed to the individual who is deemed to be potentially struggling with puberty, past abuse, an underlying organic disorder or impulsivity issues. And it is this individualistic, focused explanation, I argue, that tends to dominant statutory services. In contrast I then discuss how the survivors' movement, feminist and sociological perspectives tend to look beyond the individual to wider social-political factors as the means to contextualize and understand self-harm.

In differentiating between individualistic models of understanding and those that emphasise a wider, social-political focus, distinct differences in the ways of managing and supporting those who self-harm are raised and examined. I argue that behavioural therapies and models tend to dominate the treatment and management of self-harm in statutory services, despite a limited evidence base on the effectiveness of such interventions. Furthermore I highlight how these interventions, with an emphasis on cessation, are often in conflict with the goals and needs of those with direct experience of self-harm. The chapter therefore then examines the alternative models of support that those with direct experience have developed in response to frustration and dissatisfaction with current service emphasis and provision: a harm minimisation approach and self-harm self-help groups. Both these alternative models of support, I argue, place a greater emphasis on improved coping and management, rather than cessation and are undertaken in collaboration with others. In a self-help group this is collectively carried out with peers, whilst a harm minimisation approach is primarily undertaken with health professionals.

In recent years a harm minimisation approach, I conclude, has gained greater attention and credence. In contrast, self-harm self-help groups continue to remain very much on the periphery, despite a small body of research that indicates these groups can provide a

unique and valued source of support for group members. The limited research in this area means that little is known about what takes place in a self-harm self-help group as available research has tended to examine the perspectives of individuals rather than looking at the group as a whole. Furthermore, the tensions and challenges these groups might face have largely been ignored.

In the next chapter the individual and collective features of self-help groups are considered and discussed. This focus further illustrates the challenges stigmatised groups, such as self-harm groups, can encounter in their development and formation.

Chapter Three

The Individual and Collective Features of Self-Help/Mutual Aid Groups

3.1 Introduction

In the previous chapter I discussed and identified how self-harm self-help groups remain very much on the periphery despite a small body of research that suggests they are highly valued by group members. This chapter therefore examines the core characteristics of self-help/mutual aid groups and considers the individual benefits and wider gains often attributed to these groups. The limitations and challenges of self-help/mutual aid groups are then discussed. The chapter concludes by discussing the current gap in knowledge about the role of self-harm self-help/mutual aid groups and provides a rationale for undertaking research in this area.

3.2 Defining a self-help group

3.2.1 Definitional challenges and limitations

Self-help groups are found, Wann (1995) argues, in a wide and varied range of areas that span, for example, physical illness and mental health to carers' and social issues. Located in the voluntary and community sector, self-help groups often develop organically from the grassroots with varied aims and activities (Seebohm, Munn-Giddings & Brewer, 2010). Their diversity in form, focus and function mean they cut across and within different disciplines and are described by Powell and Perron (2010:316) as "heterogeneous entities".

The varied and diverse nature of these groups means an agreed definition remains contested and problematic (Forsberg, Nygren & Fahlgren, 2005). Additionally, Kurtz (1997) argues that definitions of self-help groups are limited in that they often end up defining an 'ideal type', with some groups having all the characteristics defined, whilst other groups might only have some. Further limitations, Schubert and Borkman (1991) have noted, is that many of the features outlined in a given definition can often be related to a large diversity of group types. As well as the challenges related to defining a self-help group the term 'self-help' is one that continues to provoke unease.

3.2.2 'Self-help': a contentious term

At an individual level self-help is often associated, Munn-Giddings et al. (2016) identifies, with the personal use of books and audio recordings that are intended to provide individuals with useful information and suggested coping strategies, such as how to give up smoking, which are generally written or presented by 'experts' rather than peers. The individualised roots of the term means self-help is often considered an activity that is undertaken by individuals to only help themselves or their families and friends (Humphreys & Rappaport, 1994; Burns & Taylor, 1998; King & Moreggi, 2006; Avis et al, 2008). Consequently groups are not always comfortable to adopt the self-help label when naming and describing their groups. Instead, terms that capture the mutual, reciprocal processes of support, like 'peer support' or 'friendship' group are often favoured (ESTEEM, 2011).

A similar unease with the use of the term self-help in a group context exists within the academic literature, particularly in community psychology, as again terms that explicitly emphasise the mutual support process in groups are mostly applied (Loat, 2011). For example, Pistrang, Barker and Humphreys favour the term 'mutual help group', which they define as:

> "[A] group of people sharing a similar problem, who meet regularly to exchange information and give and receive psychological support. Groups are run principally by the members themselves, rather than by professionals, even though professionals may have provided extensive assistance during the groups' founding years."
>
> (Pistrang, Barker & Humphreys, 2008:110).

This definition of a 'mutual help group' emphasises the commonality of experiences between group members, the giving and receiving of support and lack of professional involvement, characteristics that Borkman (1999) argues are synonymous with self-help groups. As a result Borkman (1999) suggests that the various terms that are applied are often expressing the same or related characteristics of a self-help group, but that unease with the use of the term in a group context is linked to a misunderstanding about the individual and reciprocal mutual support processes that occurs.

3.3 Core characteristics of self-help groups

The diversity that typifies self-help groups means that defining these groups remains problematic. Despite these challenges a number of core characteristics are largely agreed upon as features indicative of a self-help group (ESTEEM, 2011). These characteristics are discussed in relation to other types of self-governing groups to illustrate the subtleties and complexities involved in these distinctions. This is then followed by a review of the term and definition that informs this thesis throughout.

3.3.1 Shared experience or condition

In a self-help group members come together in response to a shared condition, situation or problem, and regularly meet, either face-to-face or online (Chaudhary, Avis & Munn-Giddings, 2013). This includes, Wann (1995) identifies, those directly affected by the condition or experience, as well as those indirectly involved, such as family and friends.

The commonality of experience between group members is more than a shared interest that might be found in an activity based group, such as a book club. Instead, in a self-help group, members come together in response to their commonality of experience, with an emphasis on resolving or improving their shared experience or condition (Wilson & Myers, 1998; Borkman et al., 2005). Munn-Giddings (2003:10) argues that the commonality of experience between members means they are often framed as "single issue groups" that span a wide and varied range of areas. Hence it is in those areas where embarrassment, shame and stigma are greatest that participation is often found to be the highest (King & Moreggi, 2006). Indeed Borkman (1999) suggests that stigma is what first instigates any self-help/mutual aid activity and as a result groups are often formed in reaction against the stigma projected by others.

The knowledge base of a self-help group is rooted in the experiential. Borkman (1976) first identified experiential knowledge as that which is learnt from personal, lived experience, rather than that which is studied, observed or provided by others. In a self-help group it is members' shared experience or condition that informs and guides the group's knowledge base and is an integral characteristic that distinguishes these groups from professionally-led support groups (Munn-Giddings & McVicar, 2006; Boyce et al., 2014).

3.3.2 Member-owned or led

A member-owned and led ethos is a defining feature that is often applied to distinguish self-help groups from professionally run support groups. In this latter group the running and organisation predominately lies in the power and control of the professional, who is usually linked to a statutory agency (Kurtz, 1997). In contrast, self-help groups are often described as self-regulating and self-governing, with control of the group ultimately resting with its members (Schubert & Borkman, 1991; Lieberman & Russo, 2001). Yet such a description can give the impression that a member-owned ethos excludes involvement and collaboration with anyone outside the group and with those who do not share the same condition or experience.

To some extent this idea has been supported in the literature, as earlier research highlighted how resistance and reservations largely depicted professional attitudes towards the value and benefit of these groups (Douglas, 1993; Wann, 1995). Indeed, Wilson (1994) concluded that the relationship between professionals and self-help groups was incompatible due to the different worlds they occupied in relation to knowledge bases, leading to misunderstanding on both sides. Similarly, involvement by professionals in self-help groups has also been met with concern and caution, as research has shown that professional involvement, particularly in a leadership role, can threaten the empowering processes within the group and change the power dynamics (Jacobs and Goodman, 1989; Carlsen, 2003). As a result Van Der Avort and Van Harberden, (1985:272) suggested that there were benefits to self-help groups "guarding against professional intervention".

In more recent years the picture has become somewhat less polarized and straightforward, as professionals are frequently involved in initiating such groups, by bringing members together, along with facilitating and organising groups at certain points during their lifecycle (Aglen et al., 2011). For instance, in the research Shepherd et al. (1999) conducted, which examined the level of professional involvement in self-help groups, they found the extent and nature of professional involvement varied. They concluded that self-help groups are often in the middle of the continuum between, at one end, professional-led and facilitated groups, and at the other end those groups that reject any professional involvement. Similar findings were echoed in the ESTEEM study, which worked with 21 self-help groups in England and 26 practitioners who supported self-help groups. The study found that practitioners provided a range of supportive activities to self-help groups,

as some offered more hands off practical support, such as printing group leaflets, whilst others undertook a more hands on facilitative role at certain negotiated times (ESTEEM, 2013).

Increasingly, greater collaboration and involvement is acknowledged between self-help groups and professionals, with recognition and emphasis on the mutual benefits (Ben-Ari, 2002). Additionally, there is greater acceptance that professionals can be sympathetic and committed to promoting a self-help/mutual aid ethos (Borkman, 2006; Oka & Borkman, 2011). Consequently a broader and more nuanced picture is emerging that confronts previously fixed understandings that a member-owned and led ethos is incongruent with professional involvement (Örulv, 2012; ESTEEM, 2013). For instance, in 2004 the Mental Health Foundation (a mental health research, policy and service improvement charity) conducted a mapping exercise to examine the role of mental health self-help groups in the UK. Part of this exercise involved a symposium discussion with a range of self-help groups and organisations that supported self-help initiatives. In this documented symposium discussion the role of facilitation was considered (Wright, 2004). Group members from the Hearing Voices Network, which is a national network that provides peer support groups across the country, disputed claims that their groups were not self-help groups on the basis that professional facilitators might lead some of their groups. Members from the Hearing Voices Network argued that as mutual support remained a foundational feature of all their groups, the facilitators' role was somewhat secondary, as it simply enabled the group to happen (Wright, 2004).

Nonetheless, the tension of facilitation remains a thorny and unresolved one. However, Nelson (2007) suggests that it is the core values and principles of self-help groups that are likely to be more important to group members than professional involvement in the group and whether facilitators are paid or voluntary. Likewise, Shepherd et al. (1999) suggest that the emphasis would be better placed on understanding the degree of autonomy within a self-help group, by examining if group members are controlling and directing the group, or if a professional is leading this. Findings from the ESTEEM (2013) study, however, suggest that autonomy within self-help groups is not a fixed and static feature, as the study found that it varied across and within groups at different times in their lifecycle. The study concluded that a member-owned and led ethos in a self-help group is more than simply who is involved in the running and organisation of the group, but it is also about where the

power, control and ownership are situated.

3.3.3 Voluntary membership

Members of a self-help group attend on a voluntary basis. Wilson and Myers (1998) discuss the different ways members participate in a self-help group, from those who are active, regular attendees to those who attend less frequently, along with those who cannot or do not want to attend group meetings, but still want to be affiliated to the group by being updated about its activities. In the same way, group members' involvement in the running of the group is founded on voluntary principles, with encouragement rather than expectation taking precedent.

Organisationally, self-help groups are often described as informal, anti-bureaucratic, democratic spaces, which a self-help ethos endorses and encourages (Wann, 1995; Kurtz, 1997; Borkman, 1999). Yet structures do vary between groups, as some adopt an informal approach, whereas others apply a more formal style. Affiliation to a wider local or national organisation has been found to influence the formality of organisational approach (Chaudhary, 2013; ESTEEM, 2011). On the whole, self-help groups are usually self-funded with members making small contributions to pay for the hiring of room premises (Wilson & Myers, 1998). Nonetheless it is not uncommon for some groups to apply and be awarded funding grants, which can bring with it distinct challenges around maintaining independence and informality (ESTEEM, 2011).

3.3.4 Mutual support

The three core characteristics that have been discussed so far as indicative of self-help groups, are also synonymous with other types of self-governing community based groups, like user-led and peer support groups. Similarly, the provision of mutual support is a feature that is also common to all these groups (Wallcraft, 2003; Wright, 2004; Faulkner & Kalathil, 2012). This is not altogether surprising as user-led groups, peer support groups and self-help groups are all grounded epistemologically in the personal, lived experience. Nonetheless, subtle but distinct differences can be drawn in a closer consideration of the purpose and orientation of these groups.

By examining groups in the area of mental health Seebohm, Munn-Giddings and Brewer (2010) suggest that user-led groups are rooted in a struggle for rights and improvements in

services, whereas peer support groups draw people together on a more diverse basis than solely a shared diagnosis. The authors highlighted how age, gender, ethnicity, amongst other positions and interests, are important features that unite members of peer support groups. In these groups the emphasis is often on *doing* collective pursuits, like creative activities.

In contrast, although wider interests such as education and campaigning, are often pursued in a self-help group (Adamsen & Rasmussen, 2001), the emphasis tends to be on members resolving or improving their own shared experience or condition through reciprocal peer relationships (Borkman et al., 2005). These reciprocal peer relationships mean it is both desirable and possible for group member to combine the role of giver and receiver within the group and is a central feature that distinguishes self-help groups from other types of community groups (Borkman, 1999; Munn-Giddings & McVicar, 2006). Such a feature has meant that self-help groups are often assumed as having a more inward focus than user-led or peer support groups, which are more likely to be framed as outward orientated through their emphasis on collective and campaigning activities (Munn-Giddings, 2003; Seebohm, Munn-Giddings and Brewer, 2010).

3.3.5 The term and definition that informs this thesis

To highlight the interdependence between self-responsibility and mutuality in a self-help group, a number of academics in this field combine the terms ‘self-help’ and ‘mutual aid’ in their descriptor of these groups (Borkman, 1999; Hatzidimitriadou, 2002; Munn-Giddings, 2003; Munn-Giddings & Borkman, 2005; Seebohm et al., 2013). This semantic distinction is largely ‘academic’, Munn-Giddings and McVicar (2006) argue, as members do not necessarily refer to their groups in these terms. However, misunderstandings about the individual and mutual process within these groups remain. My decision to apply the term self-help/mutual aid to describe the community based groups of interest in this study is informed by this confusion. By combining these two terms it is my intention that the interconnection between the individual and reciprocal mutual processes are equally emphasised and highlighted.

Despite the difficulties inherent with defining a self-help/mutual aid group, due to the diversity that typifies these groups, I am in agreement with Matzat (2002) that an attempt at definition is important, as by doing so it situates and makes clear my interpretative

understanding. Therefore the definition that informs this study is an adaptation of the original by Self Help Connect (formerly Self Help Nottingham) for the purposes of the mapping exercise conducted by the Mental Health Foundation that examined the characteristics of mental health self-help groups, and which defines a self-help group as:

> "[M]ade up of people who have personal experience of a similar issue or life situation, either directly or through their family and friends. Sharing experiences enables them to give each other a unique quality of mutual support and to pool practical information and ways of coping. Groups are usually run by and for their members, although we know that some self-help groups may be facilitated by a paid or un-paid worker who may or may not have the same personal experience".
>
> (Wright, 2004:8)

A wider and more nuanced interpretation of a member-owned and led ethos is recognised and emphasised in this definition. Hence by acknowledging and highlighting the diverse and varied governing features of self-help/mutual aid groups the realities of structures are admitted, rather than a presentation of 'ideal' types.

3.4 Classification of self-help/mutual aid groups: enabling comparisons

The diversity and variance that encapsulates self-help/mutual aid groups has led a number of authors to develop different classifications as a way of conceptualising and understanding this phenomenon. One such approach has been to classify groups according to their different organisational structures. For example, Schubert and Borkman (1991) suggest that there are five types of organisational structure. Those groups nearest the unaffiliated end are classified as having the greatest degree of experiential authority and autonomy, whilst those groups nearest the managed end are described as having less autonomy through their greater reliance on professional involvement or control. Related to organisational structures, Borkman (1999) also classifies groups by their stage of development, from 'fledging' to 'developed' to 'mature', where a group is confident and secure in its experiential position and authority.

Another common approach has been to classify self-help/mutual aid groups by the types of condition or experience they address. In a UK context, Wann (1995) divided self-help

groups into six broad categories: physical illness; disability; mental health; carers' groups; addiction and social issues. Her classification acknowledged the overlaps between categories as, for instance, a self-help group for survivors of sexual abuse might belong in the categories of mental health and/or social issues. Additionally, Wann (1995) argues that although groups might have similar aims and activities in common, they have distinctive characteristics and priorities that are tailored to the particular experience of their members. For instance, she argues that disability groups will tend to look outwards with an interest in changing attitudes, whilst mental health groups that have formed around powerlessness will look to group members regaining control over their lives.

Emphasis on area of focus was the basis for Katz and Bender's early distinction in the mid-1970s between inner-focused and outer-focused self-help groups. Inner-focused groups were classified as those that predominately provided emotional and social support, along with opportunities for personal change, whereas outer-focused groups were depicted as having an emphasis on changing legislation or social policy (Katz & Bender, 1976). Effecting change as a classification theme was further developed by Kurtz (1997) who suggests there are two broad categories of self-help/mutual aid groups. Firstly there are those that are personal-change groups, which primarily focus on individual behavioural changes. And secondly there are those groups that focus more on wider educative and supportive pursuits, with an emphasis on advocacy. In relation to mental health self-help groups, Emerick (1991) reviewed data from 104 mental health self-help groups and divided groups according to their political ideology. Three types of groups were classified as 'radical' groups that focus on transforming mental health services, 'conservative' groups with more of an interest in personal change and 'combined' groups that aim for both social and personal change.

The strength of these different classifications is that they highlight similarities between groups that might otherwise remain hidden if attention is directed only at the commonality of experience or condition. For instance, if both groups' focus was around personal change, applying Wann's (1995) classification of condition or experience with Kurtz's (1997) classification of effecting change would potentially highlight similarities between groups, despite differences in condition or experience. But the difficulties with any classification system are that they can often over-simply phenomena. Furthermore, any classification system is heavily influenced by who is doing the classifying, as for example Wann (1995)

acknowledged that her own system might reflect professionals' attempts to classify self-help groups within their own professional boundaries. Despite these limitations they provide a useful framework to understanding this broad and diverse area of study.

3.5 The expansion of self-help/mutual aid groups

Having discussed the core characteristics and different classifications that are used to conceptualise self-help/mutual aid groups this section examines their historical roots and growth generally and in relation to self-harm and considers the overall position of self-help/mutual aid groups in the social-political landscape.

3.5.1 Historical roots

Self-help and mutual aid are not new ideas. In 1859 Samuel Smiles, the parliamentary reformer, published his book "*Self-Help"*. In this work Smiles promoted individual hard work, thrift and perseverance as the means to self-advancement and self-improvement (Smiles, 2002). Fewer than 50 years later Peter Kropotkin, the Russian geographer, zoologist and philosopher, published his seminal 1903 text *"Mutual Aid: A Factor of Evolution".* In it Kropotkin emphasised collective mutual support, rather than individual effort, as the fundamental and oldest form of help and progress known to humanity, which countered the extreme Darwinist struggle-for-existence positions of the time:

> "In the practice of mutual aid, which we can retrace to the earliest beginnings of evolution, we thus find the positive and undoubted evolution of our ethical conceptions; and we can affirm that in the ethical progress of man, mutual support – not mutual struggle – has had the leading part".
>
> (Kropotkin, 1989:300)

Current interpretations of self-help and mutual aid are informed by their original delineation, as taking action to help oneself typifies modern understandings of self-help, whereas the coming together of individuals to support one another emotionally, socially or materially is associated with mutual aid (Borkman, 1999). Munn-Giddings (2003) and Forsberg, Nygren and Fahlgren (2005) suggest that the friendly societies established in England during the 18th and 19th centuries were the first examples of modern self-help/mutual aid activities, with their emphasis on mutual insurance and other supportive

activities. More commonly, present-day self-help/mutual aid groups are attributed to the founding of Alcoholics Anonymous (AA) in the USA in 1935 (Borkman, 1997).

AA groups were the first to endorse a member-led and owned ethos and emerged as an alternative to the pathologising treatment and perspectives of that time (Borkman, 1997; Adamsen & Rasmussen, 2001). Yet it was some 30 to 40 years later that the growth and expansion of self-help/mutual aid groups took off in the UK and internationally (Chaudhary, Avis & Munn-Giddings, 2010).

3.5.2 The growth of self-help/mutual aid groups

The expansion of self-help/mutual aid groups in the 1960s and 1970s occurred in conjunction with the wider social and political changes that were occurring during this period. This was an era of political unrest and uncertainty. Old systems were being challenged by those whose voices and experiences had traditionally been ignored, with the rise of a number of social movements, like the civil rights and women's movements. The women's consciousness-raising groups that emerged from the women's movement indirectly, Borkman (1999) argues, contributed to the expansion of self-help/mutual aid groups, as many of the women who were involved in consciousness-raising groups founded or participated in self-help/mutual aid groups.

The social theorist Giddens (1991) further attributes the growth of self-help groups to the social and political shifts that began to occur during this time in post-industrial societies. These shifts, Giddens (1991) argues, eroded traditional structures and roles and impacted on the individual self by stimulating a heightened reflexivity about life, meaning and death. Being in a constant state of flux, the self needs to be reflexively explored as a way of structuring and maintaining itself. Twigg (2006) suggests that this restructuring has meant self and identity have become more fluid and more significant in the negotiation of daily life, as it is now something that can be created and constantly revised. As a result, self-help groups have become, Giddens (1994) argues, a distinctive feature of post-industrial societies, as they can provide the means and tools for individuals to realise their self-reflexive project.

Establishing accurate records on the numbers of self-help/mutual aid groups' operating at any one time remains problematic. Firstly, the informal nature of groups means many are

hidden, as meetings may take place in members' homes or other informal settings such as cafes (Wilson & Myers, 1998), and secondly, the continuing disagreement around what constitutes a self-help/mutual aid group has impeded estimation efforts. In the UK, Elsdon, Reynolds and Stewart (2000), estimated that one in 25 adults were likely to belong to a self-help group and approximately more than 23,000 self-help groups are likely to be operating at any one time in the UK. The authors reached this figure by reviewing the database of groups held locally in Nottingham by Self Help Connect, a specialist voluntary organisation that supports self-help groups. As a result, Chaudhary, Avis and Munn-Giddings (2010) suggest that this estimation should be treated with caution, as it is based on records held in one area that may not be representative of the UK as a whole.

Turning more specifically to self-harm groups, the number of such groups that meet on a regular face-to-face basis on the whole are not considered to be widespread in the UK (Arnold, 2006). The reasons as to why this may be so are not entirely clear. One possible explanation is that these groups may not be highly visible. For example, in the research on the lifecycle of self-help groups, Chaudhary, Avis and Munn-Giddings (2010) found that it is not uncommon for some groups to prefer to remain 'hidden' and limit their membership, as shown by their reluctance to publicise themselves. Additionally, the authors found that highly stigmatised groups, like domestic violence, rape and sexual abuse groups were less likely to become established than groups focused on less stigmatised conditions or experiences. Chaudhary, Avis and Munn-Giddings (2010) conclude that there is potentially a negative relationship between social stigma and group survival. Parker and Lindsay (2004) further suggest that some professionals have been reluctant to encourage self-help groups for self-harm on the grounds that it may to lead to an escalation of individuals' self-harm.

This resistance and concern may have had a role to play in the development of self-harm self-help/mutual aid groups, as research indicates that professionals and practitioners can have a pivotal role to play in the support and development of self-help/mutual aid groups (Ben-Ari, 2002; Borkman, 2006; ESTEEM, 2013). Whilst the number of self-harm self-help/mutual aid groups that meet on a regular face-to-face basis are not widespread, in recent years Adler and Adler (2013) argue that there has been an unprecedented rise in the number of online self-harm self-help groups and forums. This rise would thus indicate a desire and need for peer support by those with direct experience.

Determining the number of groups online is fraught, King and Moreggi (2006) identify, with difficulties and inaccuracies, due to the speed to which groups develop and fold. The development and accessibility of new digital technologies, such as interactive forums and message boards, have been successfully utilised by online groups as a meaningful and valued way for members to receive and offer support to each other (Levine, 2005; Boyce et al., 2014). However, opinions on the safety and benefit of online self-harm self-help groups and forums remain divided. The reservation emphasised is that such groups and forums may normalise the act of self-harm and provide new ways for members to harm themselves, echoing similar concerns to those raised about groups that meet face-to-face (Whitlock, Powers & Eckenrode, 2006; Rodham, Gavin & Miles, 2007; Smithson et al., 2011).

The rise in online self-harm groups is indicative of the wider growth overall of self-help groups online, which is estimated to number hundreds of thousands worldwide (King & Moreggi, 2006). On the whole, face-to-face and online self-help groups are largely considered inherently similar in ethos and approach, but distinctly online groups are not restricted by time and distance constraints (Finn, 1999; Lombardo & Skinner, 2003-2004; King & Moreggi, 2006). This does not mean, Madara (1997) argues, that online self-help groups will replace face-to-face groups. Indeed, it is argued that the internet is not as accessible and inclusive as often assumed, owing to ongoing stratified inequalities in relation to age, socio-economic status, gender and ethnicity, which thus continue to inhibit access and participation (Selwyn, 2004; Sourbati, 2012). Furthermore, Boyce et al. (2014) argue that online self-help groups and forums are often used to augment support between face-to-face meetings. Yet in relation to self-harm it remains unclear if the number of groups and forums online is a response to the lack of face-to-face groups or whether online peer support is preferable.

3.5.3 The social-political context

In the UK since the 1980s the involvement of service users, carers and the public in the planning, provision and evaluation of health and social care services has become official policy throughout the health and social care system (Barnes & Cotterell, 2012). Borkman and Munn-Giddings (2008) argue that self-help/mutual aid groups have largely been ignored or forgotten in these UK initiatives and directives, and remain very much on the periphery, a situation that is not reflected in other countries. For example, in Norway and

Germany both countries have explicit policies that underpin and promote self-help/mutual aid groups and activities. In Norway there is a national plan that embeds self-help in health and social care provision and policies, whereas in Germany national self-help clearinghouses network and provide information and developmental support to self-help/mutual aid groups (Munn-Giddings et al., 2016). Consequently, Matzat (2002) argues that self-help groups are an accepted feature in the health and social care system of Germany that is evident in the financial support provided by the state for their development and support.

Munn-Giddings and Stokken (2012) argue that health and social care provision, policies and welfare systems provide a context to shaping and responding to a nation's self-help and mutual aid activities. The lack of explicit recognition and support of such activities at a policy level in the UK means it is not altogether surprising that these groups are often described as being below the radar (McCabe & Phillimore, 2009). Yet in the current climate of public spending cuts and reduction of services, Archer and Vanderhoven (2010:3) suggest that self-help initiatives and groups are more relevant than ever as they have the potential to "empower citizens, build trust and resilience and give communities a sense of influence over local issues".

3.6 Individual benefits of self-help/mutual aid groups

In the self-help/mutual aid literature, attention has largely focused on examining the therapeutic and individual benefits (Kurtz, 2004). This section considers these benefits generally and in relation to self-harm self-help/mutual aid groups more specifically.

3.6.1 Less alone and isolated

Group members express a common motivating reason to joining a self-help/mutual aid group is to minimise feelings of isolation and loneliness and to meet others who share a similar condition or experience (Munn-Giddings & McVicar, 2006; Hatzidimitriadou, 2002). Research shows joining and actively participating in a self-help/mutual aid group helps members feel less alone and isolated through a number of processes.

Universality

The concept of universality was identified by Yalom (2005) as one of the 11 therapeutic

factors that can occur in psychotherapy groups. Feelings of difference, isolation and loneliness are reduced by meeting others who share the same condition or experience, as this makes the condition or experience universalised.

Research into self-help/mutual aid groups has also shown the beneficial importance of universality. For example, in a study by Adamsen (2002) 53 participants from 12 self-help groups took part in qualitative interviews that explored the benefits of self-help groups for people with life-threatening diseases (HIV/AIDS and cancer). The study found that meeting and identifying with others who share and cope with similar problems alleviated group members' isolation and loneliness. Adamsen (2002) concluded participation in the group helped to de-individualise and instead universalise the shared specific problem, resulting in members gaining a sense of 'normalcy'.

Similarly, in the research undertaken by Smith and Clarke (2003) into self-harm self-help groups, they found that meeting others who self-harm aided a shared understanding between group members. This shared understanding meant group members were able to talk openly and honestly about their self-harm, without the fear of judgement or consequences and as a result felt less isolated and alone.

Friendships and networks of support

The development of friendships that often emerge through participation in a self-help/mutual aid group is another process that can alleviate group members' loneliness and isolation. For example, in the study by Corcoran, Mewse and Babiker (2007) into the role of self-harm mutual support groups, they found that caring and supportive friendships often developed in the groups. These friendships were distinctly different to those outside the group, due to the commonality of experience. Additionally, the friendships that developed within the group often extended outside the group and provided a valued network of support.

Munn-Giddings and McVicar (2006) also found that friendships often transcended the group itself. In their research with carers' self-help/mutual aid groups, they found that members gained great comfort and reassurance in knowing that other group members were there for them, in and outside of the group. These networks of support were not always accessed by group members but were pivotal in alleviating feelings of loneliness.

Networks of support in and outside of the group was also found by Wituk et al. (2002) to be a common feature in their random selection of 253 different self-help groups, as 75 per cent were providing support between meetings to group members, most commonly through telephone support.

Connection and belonging

Closely aligned with the process of developing friendships is how participation in a self-help/mutual aid group can enable members to connect with each other and gain a sense of belonging (Kurtz, 1997; Humphreys, 1997). Commonality of experience brings members together and contributes to fostering mutual understanding and empathy. This enables group members, Adamsen (2002:227) argues, to find a "'free space' where they are not expected to explain, defend or excuse their moods". The developing friendships and trust between members that ensues is crucial, the author continues, to establishing this 'free space'.

Gaining a sense of belonging was one of the main positive features reported by group members in the research undertaken by Corcoran, Mewse and Babiker (2007) into self-harm mutual support groups. The shared experience of self-harm created a sense of acceptance and connection between group members. A sense of togetherness was also a key finding in the research undertaken by Avis et al. (2008) that explored the reasons why some Black Asian and minority ethnic groups are less likely to join cancer self-help groups. Overcoming isolation and loneliness was found to be the main reason group members initially joined a self-help group and in doing so many found and valued the connectedness they experienced through being with others who shared a similar condition or experience.

3.6.2 Learning from others

Opportunities for mutual learning are often identified as a distinct and highly valued feature that distinguishes the social relations in these groups from professional services (Borkman, 1999). For example, in the ESTEEM study, which involved working with 21 self-help/mutual groups in two locations in England, the sharing of information was identified as a crucial feature of most groups. This was particularly valued by those groups that shared a health issue as group members were able to share practical and personal information about their condition or treatment, which in some cases helped them to

manage their health or situation better (ESTEEM, 2011).

It is not only practical information, Borkman (1999) argues, that group members gain and learn from one another, but also through sharing experiences and personal narratives group members' experiential knowledge and understanding also develops. Over time an accumulated and shared body of experiential knowledge can develop within a self-help/mutual aid group, which group members learn from and contribute to. Recognising that we do not always become knowledgeable through undergoing an experience, Borkman (1999:16) argues that a reflective process is necessary to convert "raw experiences" into meaningful knowledge, either alone or in conversation with other group members.

In a recent Swedish study undertaken to explore the activities of a self-help group for people with dementia, Örulv (2012) found that the sharing of personal accounts and stories contributed to a more nuanced understanding about dementia for its group members. The different shared stories highlighted the variations in the progress of the disease, along with establishing a common understanding. In addition, from the personal experiences and stories that were shared, group members were able to learn from others' different coping strategies, further contributing to the group's experiential knowledge base (Örulv, 2012).

3.6.3 Effecting personal change

Research has shown that participation in self-help/mutual aid groups can improve, change and transform group members' lives.

Improved coping

Group members often join a self-help/mutual aid group as they are struggling to cope with a particular condition or experience. Through joining these groups improvements in their ability to cope are commonly reported. For example, Medvene (1990) found that carers of spouses with dementia were better able to cope through joining a self-help/mutual aid group. Initially the women were reluctant to disclose and share the difficulties they faced in the group through fears and concerns that they were being disloyal to their partners. Yet over time the women began to talk about their experiences and in doing so established a degree of solidarity with each other as they realised many feelings were common amongst the group shared. In being able to listen and share experiences the women were able to alleviate feelings of guilt and felt better able to cope with the realities of caring for their

partners.

A more nuanced interpretation of coping is raised in the study by Charlton and Barrow (2002) who examined different coping methods for those diagnosed with Parkinson disease. Qualitative interviews were undertaken with eight participants, four of whom were members of a local self-help group. Differences in coping between members and non-members of self-help groups were identified. For non-members, coping mainly focused on maintaining a normal life and denying the condition a central role, but for group members the disease and its likely consequences were accepted and incorporated into day-to-day life. Coping strategies that avoid adaptation are often considered less beneficial than non-avoidance ones, but in some situations avoidance, such as chronic progressive illness, the authors argue, that avoidance may not be harmful. As a result Charlton and Barrow (2002) conclude that the coping methods some people use may not be sustained in the context of a self-help group membership.

Improved well-being

An improvement in individual well-being is an area where participation in self-help/mutual aid groups is routinely reported as effecting positive change. For example, Seebohm et al. (2013) applied the National Mental Health Development Unit (NMHDU) mental well-being checklist to the transcripts drawn from the 21 self-help/mutual aid groups that took part in the ESTEEM study (ESTEEM, 2011). The checklist showed that the participating groups made a strong contribution to mental well-being in all three core categories that included enhancing control, increasing resilience and facilitating participation and inclusion. Group members gained control through the running of their groups and having opportunities to influence and be heard. Resilience was increased through the supportive relationships that developed and opportunities that were available for learning and personal development, whilst gaining a sense of belonging contributed to facilitating participation and inclusion.

In the area of mental health there is an increasing recognition of the value of self-help/mutual aid groups. To ascertain the effectiveness of mutual help groups for people with mental health problems Pistrang, Barker and Humphreys (2008) undertook a review of empirical studies to examine whether or not participation resulted in improved psychological and social functioning. In total 12 studies met the study criteria, which

included only those papers that reported at least one mental health outcome measure, such as rates of hospitalisation. The authors clustered the 12 studies around chronic mental illness, depression/anxiety and bereavement and concluded that from the information available there is limited, but promising evidence, that mutual help groups are beneficial for those with the identified conditions, as seven of the 12 studies reported positive changes in mental health for group members. Pistrang, Barker and Humphreys (2008) speculated that making links and connections with other group members was the process through which members tend to benefit the most.

Identify transformation

Participating in self-help/mutual aid groups has also been found to lead to positive changes in identity transformation. This is of particular importance, Borkman (1999) argues, for those groups of people with conditions or experiences associated with stigma, as it can free them from negative internalised feelings of guilt and shame.

A number of different processes have been identified to facilitate this transformation. For example, the 'helper principle' that was developed by Reissman in 1965 to explain how those involved in a self-help group are themselves helped and enabled while helping others, was found to be relevant in the study by Finn, Bishop and Sparrow (2009). In this study, psychological effects, through participating in mutual help groups, was examined. Qualitative interviews were undertaken with 24 members of mutual help groups, along with observational data. Themes of change were identified from the data in relation to life management skills and self-perception. The authors concluded that the mechanisms facilitating this process of change were attributed to a reciprocal member helping ethos and educative, learning processes.

In the research undertaken by Hatzidimitriadou (2002) into the role of political ideology and individual psychosocial changes in mental health self-help/mutual aid groups found that personal-change, in the formation of a new social identity, occurred in all groups. However the processes of change differed according to the political ideology of the group. Those groups classified as more radical, with an emphasis on making improvements in the delivery of local mental health services, contributed to an enhanced sense of power and consolidated group members' social identity. In contrast, those groups described as more conservative and combined (both conservative and radical ideology) participants described

their groups as having a therapeutic-oriented atmosphere, where sharing of feelings and self-disclosure were emphasised. Being with peers who had similar experiences helped group members to release feelings of oppression and was the process, Hatzidmitriadou (2002) argues, that enabled the formation of a new social identity.

To facilitate the process of identity transformation in a self-help/mutual aid group, Borkman (1999) argues that a liberating meaning perspective needs to occur within the group. In joining a self-help/mutual aid group the author suggests that members are looking to find a less painful and negative way of dealing with their problem, but to do so they need a liberating meaning perspective that will enable a more positive way of viewing themselves in relation to their condition or experience. For this to happen the group has to enter into an open learning stage where the group has a certainty about its core beliefs, but is open to new and peripheral views. Groups, like individuals, Borkman (1999) argues do not always reach this stage, as some might remain in a 'fledging' stage where the group struggles to define the shared problem and how to work as a group.

3.7 Limitations and challenges of self-help/mutual aid groups

Having previously discussed the individual benefits of self-help/mutual aid groups, this section examines the criticisms raised generally and specifically to self-harm self-help/mutual aid groups.

3.7.1 Safety, burdens and demands

Some professionals have expressed reservations and concerns about the safety of self-help/mutual aid groups, particularly in highly sensitive areas such as self-harm. The concern being that they may exacerbate an individual's level of self-harm through the sharing and comparing of techniques (Babiker & Arnold, 1997; Sutton, 2007; Inckle, 2010). From their experience, at an organisational level that supports self-harm self-help groups, Parker and Lindsay (2004) argue that the opposite is true. A self-harm self-help group often provides a space of acceptance where a members' pain is mutually acknowledged due to the commonality of experience. These processes, Parker and Lindsay (2004) argue encourage a deeper understanding and compassion between members, which can facilitate their finding a route to decreasing their self-harm.

More generally, a challenge that is frequently reported in the running of self-help/mutual aid groups is that despite being grounded in the principles of member-led and owned, many groups struggle to fully attain this. For example, in the ESTEEM (2011) study one of the greatest challenges groups faced was encouraging and sustaining collective involvement. Often one or two key members were responsible for maintaining and running the group, which was an ongoing source of frustration. The burdens and demands of running and sustaining a self-help group have wider implications as often, Wilson and Myers (1998) argue, this is the reason why some key members leave the group. Consequently, the departure of a key member from the group often threatens the overall survival of the group, as groups quickly lose their momentum and focus (Nelson, 2007; Chaudhary, Avis & Munn-Giddings, 2010).

Other challenges groups routinely face include attracting and maintaining a consistent membership. This is key, Wituk et al. (2002:113) argue, to sustaining an active and vibrant group, as without it groups are at risk of "becoming stagnant and even disband". As a result, health and social care professionals and practitioners have a pivotal community gatekeeper role for self-help groups, Wituk et al. (2002) suggest, as they are in a position to refer clients and patients. However, many groups struggle to develop this collaborative relationship with professionals and practitioners. For instance, in the ESTEEM (2011) study a number of groups described the lack of respect and recognition they received from statutory services and professionals in the work they were doing that was evident in a resistance to promote and publicise the groups to potential new members. From the limited research undertaken in self-harm self-help/mutual aid groups it is unclear the types of relationships these groups have with external organisations, but it is likely the findings from the ESTEEM (2011) are indicative of these relationships.

3.7.2 Exclusionary structures

Criticisms have been raised about the potential exclusionary structures of self-help/mutual aid groups that tend to favour women and those from the middle classes and under-represent those from ethnic minority groups (Borkman, 1999; Forsberg, Nygren & Fahlgren, 2005; Chaudhary, Avis & Munn-Giddings, 2010). However, there has been limited empirical and theoretical examination of structural and demographic differences on which to base these critiques, with some notable exceptions.

For instance, Avis et al. (2008) examined the possible reasons why some Black Asian and minority ethnic groups have not participated in cancer self-help groups as much as the wider community. Sixty-eight qualitative interviews were undertaken, 49 with people who had been or were a member of a self-help group and 19 with health and social care professionals. Whilst the ethnicity of group members was not entirely clear, the study raises queries around the assumption that trust and mutuality is assured through the commonality of the shared condition or experience, as findings from the study indicated that this was not always enough. Recognition of commonality of experience varied between different members, as although ethnicity was an important influence it did not determine how people reacted and interacted with one another. Instead, other factors such as age and socioeconomic status played an important role for some members, whilst for others having the shared experience of cancer was identified as the unifying feature.

Similarly, in relation to gender, Seymour-Smith (2008) asserts that a range of assumptive claims have been made to explain the gender differences in groups that are not necessarily grounded in empirical research and analysis. One commonly suggested explanation is that women place greater value on sharing and talking, whereas men prefer to take action (Adamsen, Rasmussen & Pedersen, 2001). Whilst not necessarily refuting this claim Seymour-Smith (2008) argues that it fails to capture the complexity of the issue. In her research with cancer self-help groups, she found that stereotypical assumptions of self-help groups being female dominated were an initial barrier to men joining the groups. Male group members feared they would be compared to a feminised stereotype of a typical self-help group member. In the men's accounts, Seymour-Smith (2008) found that their involvement in their group was organised around them offering help, whilst the women's accounts were constructed more around the notion of receiving help. The author concludes that a preference for action is perhaps linked more "to the presentation of a hegemonic masculine identity than to a real preference for action" (Seymour-Smith, 2008:795).

3.7.3 A limited force for social and political change

Some of the fiercest critiques of the value of self-help/mutual aid groups have come from feminist writers. For instance, Rapping (1997) argues that a different kind of self-help model existed in the early 1970s, notably with the feminist consciousness-raising movement and groups. Although the movement focused on personal change, ultimately, Rapping argues, it was concerned with tackling wider social-political issues through

changing institutions and sexist ideologies, which were considered to be directly responsible for many aspects of women's personal difficulties and suffering. Using the AA 12-step philosophy as an illustrative example, Rapping describes how AA groups continue to perpetuate traditional patriarchal structures by defining addiction as a disease that is external to the self and where a 'cure' can only be possible by continuing the programme and "giving one's life up to a Higher Power" (Rapping, 1997:56). For Rapping this rhetoric is illustrative and indicative of a traditional patriarchal Christian God.

Attributing suffering and despair to a "disease" rather than social, economic and political institutions and practices that perpetuate and enforce gendered social injustices prevents, Rapping (2001) argues, the possibility of real social and political change. As a result she argues that the self-help approach is contrary to the principles of feminism, on the grounds that it fails to empower women to make their own changes in their lives by consciously recognising and challenging the material and social conditions that entrap them. Whilst conceding that participating in self-help activities can have a powerful effect through speaking out, Rapping (1997) emphasises the dangers in ignoring the social and political context.

A similar critique has been raised by Spandler and Warner (2007) in relation to self-harm self-help groups on the grounds that the social conditions that make self-harm necessary are largely ignored. The authors acknowledge the importance of how accepting self-harm can be a positive step forward, but they argue that a politics of self-harm needs to move beyond self-help and damage limitation if the social conditions that make self-harm necessary are to be challenged and changed. It is only when the social roots of distress are recognised and a commitment to minimising harm made, Warner (2013) argues, will a movement to a state of hope and recovery occur.

Codd (2002) raises a further feminist dilemma to the value of self-help groups through her study that explored the role of self-help groups in helping women cope with the imprisonment of a male partner. Although the women who attended the groups were found to gain a great deal of support, Codd (2002) questions whether these groups conceal the real issues, of rising rates of incarceration and a lack of support and provision for prisoners' families. On the face of it self-help groups appear an appropriate feminist response to promote, but such a response, Codd argues, continues to perpetuate women's

caring roles and continuing oppressive gendered expectations. Instead, the author suggests self-help groups for women would be more beneficial if they promoted independence and empowerment, not as a means of survival whilst their male partners are in prison, but for their own on-going benefit. Through concentrating on meeting women's own needs rather than prioritising the needs of their male partners, "self-help groups could offer assistance without necessarily reinforcing gendered role expectations that cast women as carergivers" (Codd, 2002:343).

The sociologist Bauman has also raised a similar critique around the limitations of self-help groups in relation to their lack of political focus and force. Bauman (1999) uses the example of a Weight Watchers group to illustrate how personal difficulties continue to remain a private issue, as any change is ultimately individually based. Other group members might advise or provide support, but the only form of togetherness these groups hold, Bauman maintains, is the awareness that other people are like them. Therefore authors like Bauman (1999) and Adamsen and Rasmussen (2001) argue that self-help groups remain a limited force for social and political change as they are more likely to turn the gaze inward, with members focusing on themselves, rather than outward with an examination of the political context towards social problems.

3.8 Wider collective gains: beyond the individual

In the previous section the criticisms that self-help/mutual aid groups remain a limited force for wider collective change were discussed. Attention now turns to examining those perspectives that, conversely, argue for the wider contributions self-help/mutual aid groups can potentially make.

3.8.1 A social movement of resistance

There remains disagreement over whether or not self-help/mutual aid groups qualify as a social movement. Many of the features that traditionally define a social movement, Katz (1981, 1993) argues, are a set of beliefs and values that highlight injustice or strategies that specify goals and processes of social change. On this basis Katz (1981, 1993) concludes that self-help groups cannot be considered a social movement as ultimately they do not constitute a political force for change.

In contrast, Taylor (1996) argues that self-help groups are part of a wider self-help movement that challenges and resists conventional assumptions. Members of self-help groups mobilise around a shared experience or problem, which resonates with group members' sense of 'who they are' and becomes a basis for building solidarity with others. Through an extensive study of postnatal depression self-help groups in the USA, Taylor (1996) argues that these groups offered women an alternative perspective view to the traditional views of mothering and motherhood. The groups provided support, literature and undertook media campaigns to raise public awareness, which gave a voice to women whose feelings defied the expectations of maternal care. Many women spoke out and shared their narratives publicly and debunked the myth that women's self-help is excessively concerned with women's weaknesses, rather than with gender disadvantages, and with women's personal development rather than with political and social transformation. The individual change and activism Taylor (1996) witnessed in these groups is indicative, she argues, of the widespread collective forms of resistance and action that occurs in local self-help groups generally.

Borkman and Munn-Giddings (2008) further argue that self-help groups in the USA and UK challenge the wider, dominant healthcare systems and contribute at a national level to health social movements. The authors outline six ways that health social movements challenge knowledge and authority, which comprise: questioning disease causation; confronting inadequate treatment options; criticising strategies of prevention; challenging research funding priorities; advocacy to participate in policy making; creating non-stigmatising and constructive identities. By re-examining four research self-help group case studies they found that these small local groups were challenging medical authority and contributing to the health social movement. For example, the personality disorder group questioned and criticised diagnosis classification and treatment options. Therefore, Borkman and Munn-Giddings (2008) conclude that self-help groups at a national level contribute to the wider health social movement by challenging the prevailing frameworks of medical discourses both overtly and sometimes more subtly and longer-term through identity transformation.

3.8.2 Enriching and invigorating the local and national landscape

The majority of self-help groups are formed as a result of resistance, Karlsson, Grassman and Hansson (2002) argue, or as a response to professionals' limitations in supporting

members' condition or experience. Yet self-help groups often remain under the radar, the authors continue, when it comes to mapping or discussing a country's voluntary sector, as their informal, local nature makes it hard to identify the scale and breadth of such groups. Munn-Giddings et al. (2016) argue that self-help/mutual aid groups qualify as a form of volunteering amongst peers, as they share common features of other types of volunteering like 'gifting' to each other their time, labour or other skills. Consequently, Humphreys (1997) suggests that self-help groups represent a countervailing trend to the fractured and individualistic features of post-industrial societies, which have seen a decline in voluntary activism and activities. The continuing rise and expansion of self-help groups, with their emphasis on community activities and activism, hence plays a pivotal role in invigorating and enriching the local and national landscape.

Participation in self-help groups, Folgheraiter and Pasini (2009) argue, does not produce individual benefits alone, as active group participation often leads to wider, civic benefits. For instance, Chamberlin, Rogers and Ellison (1996) found that community involvement and activism by members of mental health self-help groups was high amongst group members. The research was unable to determine if it was members of the groups themselves or whether membership in self-help groups raises political conscience. Nonetheless, what this study highlights and questions is the often assumed political inaction attributed to self-help groups. Indeed, Chaudhary, Avis and Munn-Giddings (2013) argue that an aim of many self-help groups is to inform wider society about living, for example, with a specific condition, which can have positive effects on wider society through educating and challenging dominant medical understandings. Additionally, many members of self-help groups are involved in user-involvement activities, such as advisory board membership and consultation processes (ESTEEM, 2011). These activities, Wann (1995) argues, benefit more than just their own group members, as all users of the service can benefit at a local and national level.

The arguments levelled at self-help groups that they are a limited force for wider social-political change (see 3.7.3) have often been informed by the study of a small number of groups on a specific condition or issue. From these narrow examinations, generalisations to all self-help/mutual aid groups have been made that they are incongruous to social-political action or change. Generalising from a few groups ignores that self-help/mutual aid groups are typified more by their diversity and variety than their homogeneity. Additionally, little

or no consideration is made to the stages of the development that can take place in groups over time. A group captured at an inward stage in their development does not necessarily mean this will reflect their future position. Borkman (1999) suggests that in adopting a voluntary action or social movement perspective towards self-help groups, an expanded understanding to the typical examination from a therapeutic and individualistic perspective is achieved. In doing so, features of wider benefits beyond the individual of collective resistance and change are highlighted.

3.9 Chapter summary

This chapter has examined the definitional challenges that remain in defining a self-help group due to the varied and diverse nature these groups can take. It highlights how the term 'self-help' remains problematic with group members and within the academic literature. I suggest that this unease is linked to the individualised roots of the term that appear to ignore the mutual, reciprocal processes of support that often occur in these groups. To highlight the interdependence between self-responsibility and mutuality in a self-help group I discuss my reasons for combining the terms self-help and mutual aid to describe the groups of interest in this study. Next I consider my motivations in adopting a wider and more nuanced definition of a self-help/mutual aid group in this thesis on the basis that the realities of structures are acknowledged, rather than a presentation of ideal types.

The core characteristics that are largely agreed upon as features indicative of self-help/mutual aid groups are then considered. These include: shared experience or condition; member-owned or led; voluntary membership and mutual support. The chapter moves on to discuss how these characteristics are also shared with other types of self-governing community based groups, noting, however, that the characteristic of mutual support is a foundational feature of self-help/mutual aid groups.

The chapter next considers the rise and expansion of self-help/mutual aid groups since the 1970s and links this with the wider social and political changes that were occurring during this period. However, I argue that this rise has not been equal in all areas, as groups focusing on conditions or experiences that are highly stigmatised are less likely to become established, potentially due to a negative relationship between social stigma and group survival. Equally, concerns and reservations on the part of some professionals about the

value of self-harm self-help/mutual aid groups may have also had a role to play in the development of these groups, as research indicates that professionals and practitioners can have a pivotal role to play in the support and development of self-help/mutual aid groups. The limited development of self-harm self-help/mutual aid groups that meet on a face-to-face basis is conspicuous, I argue, when the numbers are compared with groups and interactive member-led forums online. The expansive number of online self-harm forums and groups thus indicates a desire and need for peer support by those with direct experience. The chapter therefore acknowledges that questions remain about whether the number of groups and forums online is a response to a lack of available face-to-face groups, or whether online peer support is perceived to be preferable.

I then turn to look at the social-political context of self-help/mutual aid groups generally and argue that despite their expansion these groups have largely been ignored within a policy context despite the growing evidence base that indicates a wide range of individual benefits. Feeling less alone and isolated, along with providing opportunities to learn from others and effecting personal change are individual benefits often reported in self-help/mutual aid groups. However, an emphasis on individual gains means these groups are often overlooked as a source of wider political resistance, action and change, and are often criticised for their potential exclusionary structures. Finally I demonstrate that a consideration of the wider community activities and actions many self-help/mutual aid groups and their members are involved in illustrates that these groups often occupy a more complex position where the benefits can go beyond individual ones.

3.10 Gap in knowledge

In Chapter Two the dominant ways of framing and understanding self-harm as being located within the individual were discussed. This framework of understanding was contrasted with a wider social-political focus that looks beyond the individual to frame and understand self-harm. Within this framework of understanding, approaches of support that emphasise autonomy, resilience and self-help were considered. A review of these approaches illustrated that whilst a harm minimisation approach and self-harm self-help groups developed as a response to dissatisfaction with current provision, they have not attained the same levels of attention and prominence. As a peer-based source of support within the community self-harm self-help/mutual aid groups remain very much on the

periphery despite a small body of research that suggests they are highly valued by group members.

In Chapter Three I argued that the expansion of self-help/mutual aid groups has not occurred equally in all areas, particularly for those that are stigmatised like self-harm, which has seen greater expansion online. Concerns and reservations about the potential negative effects have been raised about the value of self-harm self-help/mutual aid groups. Similarly, these groups, and self-help/mutual aid groups generally, have faced criticisms about their tendency to look inward, rather than outward. However, very little is known about self-harm self-help/mutual aid groups, particularly at a group level, as research has tended to focus on individual experiences and has largely ignored the wider issues facing the running and development of these groups.

Therefore the aim of this research is to examine the role of self-harm self-help/mutual aid groups from the perspective of group members and those who support these groups. In doing so it is intended that a more informed and comprehensive understanding of self-harm self-help/mutual aid groups will be attained. Furthermore, it is anticipated that potential insights might be gained in terms of the type of support group members are looking for, thus highlighting what may be missing in service provision that is currently framed by an individualistic focus and understanding. Additionally an in-depth exploration of the role of self-harm self-help/mutual aid groups will further contribute to the wider self-help literature in potentially highlighting the unique benefits and challenges that face stigmatised groups. Finally, in examining the role of self-harm self-help/mutual aid groups from both the perspective of group members and those who support these groups, it is envisaged that insights will be gained into the features and processes that can help to support and sustain the development of such groups.

In the next chapter I discuss how my methodological approach to the research was informed and guided by this context and emphasis.

Chapter Four
Methodology

4.1 Introduction

In this chapter the philosophical underpinnings of the study are presented and discussed in relation to the interpretivist paradigm of inquiry that frames this study, which aims to explore the role of self-harm self-help/mutual aid groups from the perspective of group members and those who support such groups. After detailing the philosophical underpinnings of the study I discuss how the research was undertaken and guided through a qualitative case study approach. In this section a consideration of power and the importance of reflexivity in the research process is discussed, which then leads into a consideration of the process taken in relation to sampling, recruitment and data collection methods. Key decisions made in the data analysis process and the trustworthiness of the findings are then presented. The chapter concludes with a consideration of the ethical issues and dilemmas raised during the research process.

4.2 Paradigm of inquiry

This section begins by describing the philosophical underpinnings of research paradigms. These underpinnings are then explored in relation to an interpretivist paradigm which informs and guides this study. The section ends with a consideration of the assumptions and dilemmas embedded within this framework of understanding.

4.2.1 Defining a research paradigm

A research paradigm provides philosophical and theoretical traditions through which attempts to understand the social world are conducted (Blaikie, 2007). In this sense a research paradigm provides the philosophical underpinnings of the study in how it connects with the research question, approach and outcomes. There is a range of different paradigms that specify different relations between knowledge, experience and reality (Ramazanoglu & Holland, 2002). These various paradigms have a profound effect on how the research might be undertaken, presented and the conclusions drawn (Crotty, 1998). The importance of paradigms, Maynard (1994) argues, cannot be ignored, as they provide the

social researcher with the philosophical grounding to determine what kinds of knowledge are possible, legitimate and adequate.

Denzin and Lincoln (2013:26) suggest that the research paradigm can be seen as the "net" that contains the researcher's epistemological, ontological and methodological premises. In this sense paradigms of inquiry provide clear indications of the researcher's stance on the nature of social reality (ontology), how social reality can be known (epistemology) and how such knowledge may be generated and justified (methodology) (Howell, 2013). These philosophical underpinnings will be explored next in relation to the interpretive paradigm that frames and informs this research.

4.2.2 Interpretivism

Interpretivism, Blaikie (2007) argues, is often framed in opposition to the classical research paradigm positivism. A central tenet of the positivist tradition is that the existence of an objective, universal reality or truth can be known and discovered through neutral instruments of observation and measurement (Brooks & Hesse-Biber, 2007). Prediction and explanation of phenomena typifies this paradigm of inquiry, applied by the objective, value-free researcher, who remains detached from the topic under investigation (May, 2011). In contrast, rather than applying these methods of the natural sciences to the social sciences, an interpretivist position rejects such an application on the grounds that people and their institutions are fundamentally different from the focus of the natural sciences (Bryman, 2012). Instead, Blaikie (2007) suggests that the study of social phenomena, from an interpretivist position, requires an understanding of the social world that people have constructed and which they reproduce through their continuing activities.

As a research paradigm, the roots of interpretivism are grounded within hermeneutics and phenomenology (Blaikie, 2007). Originally concerned with the translation and interpretation of classic texts, like the Bible, hermeneutics is closely aligned to Max Weber's notion of *Verstehen*, meaning understanding (Bryman, 2012). Writing in the early twentieth century, Weber emphasised that human culture and behaviour was a necessary aspect of the research process, but that explanation and understanding needs to take place within an historical context (Howell, 2013). Since then, Robson (2011) suggests that hermeneutics offers a framework for the analysis of text and human action, recognising the

importance of language in achieving that understanding and of the context in which it occurs.

The intellectual philosophy of phenomenology has also heavily influenced and informed interpretivism, particularly in its concern with the question of how individuals make sense of the world around them and how the philosopher might 'bracket' out preconceptions in their grasp of that world (Bryman, 2012:30). In a research context, Robson (2011) describes how phenomenology is concerned with understanding how humans view themselves and the world around them. The researcher is not considered separate from this process, hence rather than bracketing and setting aside these biases, an attempt is made to explain them and to integrate them into the research findings (Robson, 2011).

Phenomenological ideas within the social sciences are attributed to the work of Alfred Schutz, who asserted that there is a fundamental difference between the subject matter of the natural and social sciences (Blaikie, 2007). The fundamental difference, which Bryman (2012) draws from Schutz's arguments, is that as social reality has a meaning for human beings, human action is therefore meaningful. The role of the social scientist, the author continues, is to gain "access to people's 'common-sense thinking' and hence to interpret their actions and their social world from their point of view" (Bryman, 2012:30). A central tenet of an interpretivist position is that social phenomena are thus studied from the 'inside', as opposed to the outside, as in the natural sciences (Blaikie, 2007).

The primary aim of this exploratory study was to develop an in-depth understanding of the role of self-harm self-help/mutual aid groups from the perspective of group members and those who support such groups, an area that remains largely underexplored. Therefore an interpretative paradigm suited the aims of this study, as the importance of subjective experiences, actions and interpretations are emphasised which I considered crucial to gaining an in-depth understanding of this social phenomenon. Additionally, Dadich (2003-2004) argues that such a framework lends itself to research being undertaken sensitively and respectfully, aspects that I was committed to endorsing throughout. Furthermore, an interpretivist approach also matched my own ontological and epistemological positioning, with its emphasis on the importance of understanding social phenomena in context and recognition that the knowledge generated is also informed by the researcher's own beliefs

and setting. In the following discussion the dilemmas and assumptions in framing the study within an interpretivist paradigm are considered in greater detail.

4.2.3 Dilemmas and assumptions

In the previous section the foundations of interpretivism were discussed and I considered how this paradigm of inquiry was appropriate for this study. My attention now turns to considering the kinds of knowledge that are generated and possible within this paradigm of inquiry and the ontological and epistemological assumptions this raises.

A fundamental methodological problem that faces social researchers is what kinds of connections are possible between ideas, social experience and social reality (Ramazanoglu & Holland, 2002). In an interpretivist paradigm of inquiry, Bryman (2012) argues that an abductive approach to the relationship between theory and research is closely aligned. An abductive approach aims to discover how those under investigation construct their reality and give meaning to their social world. Blaikie (2007) claims that it is the everyday language, meanings and accounts social actors ascribe to making sense of their lives that offers the social researcher the basis of understanding and explanation. Unlike an inductive or deductive approach, the author continues, the meanings, interpretations, motives and intentions that people use in their everyday lives are elevated to a central place. Consequently the social world is the world perceived and experienced by its members from the 'inside' and the social researcher's role is to explore and describe this 'insider' view and not to impose an outsider's view on it (Blaikie, 2007).

The dilemmas related to abductive reasoning revolve around the challenge of retaining the integrity of the phenomenon and whether it is appropriate to interpret the accounts of others in relation to wider theories and concepts, as to do so risks privileging expert knowledge over experiential knowledge (May, 2011). There are no straightforward answers to these embedded dilemmas, but Bryman (2012) claims that transparency throughout the research process offers the means by which others can judge the quality of the work. Taking this idea further, I would argue that transparency, particularly in the analytical process, can provide the means for judging how far the findings presented remain grounded in people's everyday understandings and experiences. Consequently a reflexive, transparent approach is a position I have attempted to adopt throughout this

research process as a way of working with and through these embedded assumptions and dilemmas.

A major criticism of the knowledge that is generated through an interpretative paradigm of inquiry is that it largely fails to consider the impact of wider structural constraints and conflicts. Social actors, Blaikie (2007) argues, are not always aware of the role of institutional structures and relations of power, hence by focusing predominately on the subjective there is the risk these structures and constraints can go unidentified and unexplored. Whilst I recognise and accede to the value of these criticisms I would argue that the exploratory nature of this study lends itself to an interpretative approach as the subjective experiences of those who attend, run, and support self-harm self-help/mutual aid groups remains a largely underexplored area. In addition, although the emphasis of the study is on the subjective experience, the findings generated will be located and discussed in relation to the broader literature on self-harm and self-help/mutual aid groups, thus providing opportunities to engage with wider social-political factors.

Having considered and described the philosophical underpinnings of the study, the next section reiterates the research question and aims. This then leads into a discussion on how the research was undertaken.

4.3 Research question and aims

My initial intention in this thesis was to examine the role self-help groups might play in the development of members' strategies to manage their self-harm. However, upon my first meetings with the groups I quickly realised that such an emphasis did not match the aims of the groups involved. So, rather than ascribing my own predefined assumptions as the basis for investigation, it was agreed a more exploratory approach was needed, as this would be more insightful and appropriate. The limited empirical research that has been undertaken in this area has tended to focus on individual experiences and largely ignored the group perspective. Therefore by examining the role of these groups from the wider group perspective I considered that a more faithful understanding of the groups could be attained, as pertinent issues and insights would have the opportunity to emerge, rather than being predefined. A broader and more exploratory question thus guided the research,

focused on looking at the role of self-harm self-help/mutual aid groups from the perspectives of group members and those that support such groups, and thus framed as:

> What is the role of self-harm self-help/mutual aid groups from the perspective of group members and those who support such groups?

In examining the role of such groups from the perspective of individual group members, along with the wider views and experiences of those who support these groups, I considered that a more comprehensive understanding of the groups could be attained. To achieve this, my objectives were therefore to:

- Explore the benefits of self-harm self-help groups from the perspective of group members and those who support such groups.

- Examine the wider context of the issues facing the running and development of self-harm self-help groups from the perspective of group members and those who support such groups.

4.4 Research design

In this section the reasons for adopting a qualitative case study approach to the design of the study are presented. This then leads to a consideration of power and the importance of reflexivity in the research process. An examination of the process taken in relation to sampling and recruitment of the research participants follows. Finally, the strengths and limitations of the data collection methods applied are discussed.

4.4.1 Qualitative case study approach

The research design was guided and informed by a qualitative case study approach. Thomas (2011) argues that a case study approach is not a method in itself, but instead provides a focus on one thing looked at in depth and from many angles. A case can be individuals, small groups, organisations and partnerships; Yin (2014) suggests less concrete cases would include communities, relationships, decisions and project. The primary purpose of a case study approach is to generate an in-depth understanding of a

specific topic by examining multiple perspectives of the complexity and uniqueness of a particular case (Simons, 2009). The exploratory focus of this study thus lends itself to a case study approach as it can provide in-depth insights into under-researched areas, such as self-harm self-help/mutual aid groups.

The in-depth nature of a case study approach means that generalisations are hard to make. But, as Thomas (2011) states, generalisation is not always what is needed from the inquiry process, instead gaining a 'rich' picture and analytical insights may be what is required. Cases can be single or multiple and can incorporate multi-methods that include both quantitative and qualitative approaches (May, 2011). Darke, Shanks and Broadbent (1998) argue that there is no ideal number of cases that can be adopted for exploratory research. In contrast, Yin (2014) suggests that there are analytical benefits from having two or more cases, as multiple cases often provide broader insights, thus strengthening the overall findings. Therefore from the outset I planned to work with more than one self-harm self-help/mutual aid group to gain a wider understanding of the area by exploring similarities and differences within and between cases (Baxter & Jack, 2008). A multiple case study approach was thus adopted as the study involved working with two self-harm self-help/mutual aid groups. The groups differed in their development, structures, finances, links and geographical locations, which offered a useful comparative contrast (Yin, 2014).

A common pitfall, Baxter and Jack (2008) suggest, associated with a case study approach is that the research question is too broad or it has too many aims for one study. To avoid this, the authors recommend that boundaries are placed around a case in relation to definition and context. Therefore, whilst I investigated what was within the boundaries of the case study groups the context outside the groups was also relevant and of interest. Hence individuals external to the cases and supportive of self-harm self-help/mutual aid groups were recruited into the study to provide access to a wider, contextual understanding of the issues facing the running and development of such groups. In addition, whilst a case study approach can apply both quantitative and qualitative approaches (Scholz & Tietje, 2002), only qualitative methods were used in this study. This approach was informed by the philosophical underpinnings of the study that was concerned with the subjective and interpersonal.

Qualitative research, Denzin and Lincoln (2013) argue, is a nebulous entity to define, as it does not belong to a single discipline, nor does it have a distinct set of methods or practices that are entirely its own. Nonetheless, the authors offer guiding principles that situate qualitative research as an activity that locates the observer in the world and which consists of a range of interpretive practices that make the world visible. Undertaking qualitative research therefore means studying phenomena in their natural setting and involves attempting to make sense of, or interpret such phenomena in terms of the meanings people bring to them (Denzin & Lincoln, 2013). Consequently I considered that a qualitative case study approach suited the aims and theoretical underpinnings of this study, as the emphasis with this approach, as Stake (2005:450) argues, is on thick description, context and subjective experience.

4.4.2 Power and reflexivity

Power differentials have been raised by feminists as embedded in traditional research practices that have tended to serve the purposes of the researcher, and which were often carried out in a way that objectified participants (Letherby, 2003). Feminists, amongst others, have thus sought to find and foster less exploitative relationships in the research process (Ramazanoglu & Holland, 2002). However, accurately representing and not misrepresenting those in less powerful positions remains an unresolved tension (Letherby, 2003). There are those who suggest being attentive and open about the power differentials goes some way to minimising the imbalances between the researcher and 'subject' (Ramazanoglu & Holland, 2002). Whereas Macguire (2001) argues that it is only through participants' active involvement in the research process that power differentials can be meaningfully diminished. In contrast, Bhopal (2010) argues that it is too simplistic to assume actively involving participants in the research process is ultimately empowering for participants, as power is a multi-layered, dynamic and fluid process.

Clearly there are no straightforward solutions to these dilemmas. However, I considered that adopting a reflexive, transparent approach throughout the research process offered a way to engage with these dilemmas and ultimately undertake research of a respectful and sensitive nature. Whilst a reflexive approach is agreed on – and particularly encouraged in feminist inquiry – as a good principle to adopt throughout the research process, defining what this means and how it might be achieved remains problematic (Letherby, 2003). For example, Ramazanoglu & Holland (2002:118) suggest that reflexivity generally means

"attempting to make explicit the power relations and the exercise of power in the research process". Conversely, Burns and Chantler (2011:72) argue reflexivity is "about challenging the notion of objective, neutral and value-free research, focusing instead on accounting for subjectivity". Despite the differing interpretations on what constitutes reflexivity, as a principle it is valued for providing the means for critical reflection during the entire research process. Therefore it is not simply about the researcher expressing their feelings and emotions during the research process, the limitations of which Burns and Chantler (2011) highlight:

> [F]irstly, the focus becomes the researcher, rather than the research topic or the relationship between the researcher and researched; secondly, a personalized reflexivity serves to strengthen the researcher's position, rather than attending to the power relations inherent within researcher-researched relationships.
>
> (Burns and Chantler, 2011:72)

Reflexivity thus attempts to unpack what knowledge is contingent upon, how the researcher is socially situated and how the research focus and process has been undertaken (Ramazanoglu & Holland, 2002). To facilitate a reflexive, transparent approach within this study I used the practical research tool of a research diary as a way of critically reflecting upon my reactions, responses and interpretations that I made during the research process. I would also think through emerging and developing ideas and theories through the course of undertaking the research. Additionally, I endeavoured to adopt a transparent approach in undertaking the research, by being open and honest about the purpose of the research and its progress with participants and in the presentation of the study's process and findings.

4.4.3 Sampling and recruitment

There were two phases of research to this study. The first phase involved working with the case study groups and their members and the second phase involved undertaking research with those who support such groups. For the purpose of clarity the research undertaken with the case study groups is referred to as phase one, whilst the research undertaken with participants supportive of self-harm self-help/mutual aid groups is referred to as phase two.

Phase one: identifying and gaining access to the case study groups

A purposive sampling strategy was applied to select the potential case study groups, as this permits the selection of groups or categories that are meaningful theoretically and empirically to the research question (Mason, 2002). The main criterion in identifying potential groups was that the group was run for and by its members with direct experience of self-harm. Whilst no definitive source for identifying potential groups existed at the time, the Bristol Crisis Services for Women (a national voluntary organisation that supports girls and women who self-harm) compiles a national list of self-harm support groups that is accessible on their website. However this is not an exhaustive list and comprises both member-led and professionally facilitated groups. Therefore to gain a reasonable understanding and overview of the range of self-harm self-help/mutual aid groups in existence at the time I also undertook my own searches. My search began at the start of 2009 and was multi-faceted. The first step consisted of undertaking an internet mapping exercise that involved applying a variety of terms in the search engine Google to identify relevant organisations that might host or publicise self-harm self-help/mutual aid groups. Table 1 below outlines the range of terms that were applied to identify thirteen relevant organisations.

Table 1 Range of terms applied to identify relevant organisations

Terms	**Hits**	**Name of Organisation**
Self-harm charities Self-injury charities Self-harm organisations Self-injury organisations	8	The National Self Harm Network Voices of Self Harm (previously LifeSigns) Self-Injury and Related Issues (SIARI) FirstSigns Sirius Project (self-help for self-harm) HarmLess Equilibrium RecoverYourLife
Self-injury groups Self-harm groups	2	Bristol Crisis Service for Women WISH
Self-injury support groups Self-harm self help groups	1	UK Self Help Groups (which lists LifeSigns, SIARI, NSHN)
Self-help networks Self-help services	2	Self Help Nottingham Self Help Services

During this process links to resources on self-harm from national mental health charities were returned. The main four charities were: SANE; Mind; Mental Health Foundation; Rethink. Therefore, the next part of the search involved examining the thirteen organisations individually and the four mental health charities to ascertain if they hosted or publicised details of local self-harm self-help groups that met the study criteria of being member led by those with direct experience of self-harm. This identified potentially 21 groups, most of which were advertised on The National Self Harm Network and Bristol Crisis Service for Women websites. Of the national mental health charities only Mind had relevant information, although it was necessary to search on an individual locality to see if that local Mind office supported a self-harm self-help/mutual aid group.

I was aware that my mapping of groups was only identifying those that were already in the public domain, which was problematic as many self-help/mutual aid groups are not always highly visible or linked with other organisations (Wilson & Myers, 1998, ESTEEM, 2011). In view of this, and in an attempt to identify those groups that did not necessarily have a public profile, I made use of my own existing links and networks. Through contacting representatives from a number of mental health user-led organisations, one contact identified a small local mental health user-led organisation that supported a self-harm group in a London borough. Identification of this group increased the number of potential groups to 22.

Initially I had intended to keep some geographical boundaries to the research, as at the time I was working full-time and undertaking the study part-time. Therefore I planned to recruit groups located near to where I was living, so my search focused on London and the South East. However, of the 22 groups identified only five were within this area and further investigation into these five groups revealed two were no longer in existence, one was professionally facilitated and the contact details for the other group were no longer working. The only group remaining was the London group that had been identified by my contact, so it was clear that I would have to widen my selection outside London and the South East. Therefore a somewhat pragmatic, flexible approach was taken to selecting the next group as I considered travel costs and distance. This led me to identifying a Midlands groups to contact, in addition to the London group.

Before contacting the groups I drafted an invitation letter and information sheet that provided background information about the study, along with an introduction about me. Some members of SE-SURG, the South Essex Service User Research Group, which is a group of current or former mental health service users, reviewed these documents. Hosted at Anglia Ruskin University, SE-SURG undertakes research and consultancy for commissioners and providers of mental health services. I was keen to seek their views on the tone, language and clarity of these documents, as they have experience of undertaking similar research in sensitive areas. Minor amendments were suggested and incorporated into the final versions (see appendix I and II). These documents were then posted to the London and Midlands groups in spring 2009.

The next step was to follow this up with a phone call or email, depending upon which option the group had access to, a couple of weeks later. However, it took much longer than this before I managed to make direct contact with the groups, as initial follow up emails or phone calls went unreturned. I assumed perhaps this was due to a lack of interest in the study, but during the course of the study this pace of response often typified our communication. Therefore, it was some four to six weeks later that I successfully made contact with each group and I found myself in the fortunate position where both agreed in principle to participate and were happy for me to meet with them and other members of their groups to discuss the project further. I was surprised to find myself in the position that both groups agreed in principle to participate. I had anticipated that it would take numerous attempts and some time before I would gain access to such groups, primarily because of the sensitivity involved and the likely disruptive effect an outsider entering the group would have on its members. After travelling and meeting with the two groups a couple of times, both confirmed they were keen to be involved, facilitated by similar motivations to explore and promote the value of self-harm self-help/mutual aid groups.

Phase two: identifying and selecting participants

In the first phase of the research the focus was on developing an in-depth understanding of self-harm self-help/mutual aid groups, by working with the groups and their members directly. The focus of the second phase of the study was to explore the perspectives of those who are external to and supportive of such groups as a way of gaining broader insights into the running and development of these groups.

To guide me in identifying a relevant sample for the second phase of the research, I identified a number of features that I considered would be important to try and capture. These were:

- Individual and organisational experience of supporting self-harm self-help/mutual aid groups without direct experience self-harm.
- Individual and organisational experience of supporting such groups with direct experience.
- Individual and organisational experience of member and professionally instigated groups.

I considered that inclusion of these features would offer a broad range of perspectives and provide wider insights into the role of self-harm self-help/mutual aid groups. I purposively aimed to only invite individuals from organisations who had experience of working with self-harm self-help/mutual aid groups, as I judged the views and opinions shared would be informed by 'insider' knowledge. This did not necessarily exclude the possibility of criticisms, but I felt reassured that any criticisms levelled at such groups would be fair and grounded in direct experience.

With my developing links and growing awareness of key organisations and individuals in this area I was able to apply these sampling features and identify a potential sample of four participants from three different organisations. Information sheets were sent (see appendix III) and again I found myself in the fortunate position where all agreed to participate in the study, thus the final sample at an organisational level comprised:

- Two representatives from a specialist self-harm charity that actively promotes self-harm self-help groups.
- One representative from a mental health user-led organisation that hosted a facilitated peer support group for women who self-harm.
- One participant who had instigated and ran a self-harm self-help group and at the time was the director of a user-led organisation that provided awareness training and consultancy in self-harm.

At an individual level these four participants had experience of the key sampling features identified above, which is presented in Table 2 below and further discussed in 5.1.3.

Table 2 Number of participants' individual experience of key sampling features

Supporting with direct experience	Supporting without direct experience	Experience of member instigated group	Experience of professionally instigated group
2	2	1	1

4.4.4. Data collection methods

The chosen data collection methods for both phases of the research are outlined and discussed in turn below.

Phase One: the case study groups

Semi-structured interviews were the main method of inquiry in this phase of the research. The basis for suggesting the use of semi-structured interviews to the participating groups was informed by the aims of the study and its epistemological underpinnings. The primary aim of the study was to develop an in-depth understanding of self-harm self-help/mutual aid groups. Hence qualitative semi-structured interviews lend themselves to the aims of the study as they can generate rich data grounded in the lived experience (Robson, 2011). Directed by an interview guide, such interviews remain topic focused, thus reflecting the clear, defined boundaries of the study. As a method, semi-structured interviews remain flexible and responsive to exchanges between the interview and participant, as questions that are not included in the guide might be asked (Hennink, Hutter & Bailey, 2011; May, 2011). Such a feature is relevant to exploratory studies, like this research, as it offers the opportunity to examine potentially unforeseen areas and issues of importance. In addition, Bryman (2012) argues that semi-structured interviews are particularly suited to a multiple case study design as they provide the option of cross-case comparability at the analytical stage.

Recognising my own positioning in relation to the production of knowledge being situated and contextual, I also considered asking questions and gaining access to individual accounts through a semi-structured interview to be a meaningful way of generating data. In

keeping with my efforts to be as transparent throughout the research process all members of the participating groups were provided with a copy of the interview guide to comment upon, which explored individual motivations, expectations and experiences of attending a self-harm self-help/mutual aid group. This provided a means of ensuring group members were comfortable with the questions I was proposing to ask with the possibility to be able to add or delete those questions they were uncomfortable with. In neither group were changes to the draft interview guide made so my drafted version became the finalised version (see Appendix IV).

All core regularly attending members from both groups were interviewed, which was four per group. With written consent and anonymity assured, group members agreed to the interviews being recorded. I transcribed the interviews verbatim and provided all participants with a typed up transcript of the interview in which they could amend, qualify or withdraw any or all of their comments. All participants agreed the transcript was a fair representation of the interview, the only comments raised were concerns that their accounts appeared lengthy and inconsistent at times.

Through the course of undertaking these interviews it became clear that the interview guide was failing to capture the history and development of the groups. This seemed important data to capture to inform understanding as to how these groups develop and the challenges they might have faced along the way. The decision was therefore taken to undertake an additional interview to capture this data with a key member from both groups. Again the same process was followed where I drafted the interview guide, which was then made available to the key members for comment. Once more, no changes were suggested and each interview lasted around 60 minutes. The history and development interview guide is shown as Appendix V.

All the interviews were undertaken on the premises where the groups met. Interviews ranged in time from 60 minutes to 180 minutes, meaning that a number of interviews had to be undertaken over a few meetings. Specific challenges occurred in arranging and completing these interviews. Numerous times I would turn up to the group's meeting venue to undertake an interview to find out that the participant was no longer able to attend, or if they were they could only meet for a short period of time. This was not so

problematic with the group that I lived near to, but it was frustrating when this happened with the Midlands group that took me a couple of hours to travel to.

In the end it took nearly 18 months to complete the ten semi-structured phase one interviews, from beginning the process of identifying the groups in January 2009 to gaining access, maintaining access and completing the interviews with group members. At the start of undertaking the research I did not envisage it would take quite so long to complete this phase. But gaining access and building trust with groups that remain marginalised takes time and I found it was something that I could not rush. Nonetheless, at times I found this to be a source of frustration and concern, as notes from my research diary illustrate:

> *I'm starting to feel things are starting to 'slide' a bit with the fieldwork, it's all a bit chaotic to organise. I have mentioned it a number of times, but sustaining momentum is a source of frustration for me. Progress feels so slow at times!*
>
> [Research Diary, January, 2010]

Additional unplanned data sources

During the process of undertaking the empirical fieldwork with the case study groups, opportunities arose where I could use additional unplanned data sources to gain an in-depth understanding of the groups. For instance, I was invited by the London group to attend a management meeting. This meeting lasted about 60 minutes and it was agreed I could record the discussion. The time of the meeting coincided with the group's end of year funding grant and a frank discussion took place about how the group had not spent all its awarded funding, an admission that had not been raised in the semi-structured interviews. As the Midlands groups did not hold management meetings I could not attend such meetings there.

In addition, as previously mentioned, it was not uncommon for an arranged interview not to go ahead when I arrived at the group. Since all the interviews were arranged during the group meeting times I often found myself in the situation where I was present during these meetings, when I would be asked to stay for a cup of tea or some food. At first I was uncomfortable with intruding at these meetings when members had not been previously informed that I would be there and hence I would often decline the invitation. However,

after this had occurred a few times it felt impolite to leave so hurriedly and instead I decided to take up these opportunities to informally attend a few group meetings and relied on my judgement as to when it perhaps felt inappropriate to stay.

Bryman (2012) suggest that participant observation has the potential to come closer to a naturalistic emphasis, as the researcher encounters members of the social setting in their natural setting, but that there remain a number of ethical issues in applying this method, particularly around intrusion and disruption. Hence, I considered that as an outsider to formally observe the group and its members was not an appropriate method to use in what is a sensitive and stigmatised area. However, my informal attendance at a number of group meetings and the descriptive notes I wrote up after each meeting meant I gained further insights into the running of the groups. For instance, through a process of attending a few group meetings and having the opportunity to follow up points raised in the individual interviews I came to realise the importance the sharing of food together had for the London group, which initially I had struggled to appreciate:

> *I do wonder if the meetings are always this informal and unstructured. It felt more like a social event with the eating together, rather than an actual self-help group!*
>
> [Group meeting notes, October, 2009]

As presented in section 5.5.3, the cooking and eating together was not just about providing a social space, but had an important role in facilitating group discussions. Being able to informally attend a number of group meetings assisted me in gaining an in-depth understanding of the group, which informed the descriptive overview of the group and its members, as presented in 5.1.1.

Lastly, throughout my time with the groups references were made to a number of group documents the group held, such as their aims, objective, ground rules, promotional material. I considered it was important to gather this range of documents, as a way of contributing to building a thorough and comprehensive understanding of the mechanics and functions of the groups.

Phase two participants

Semi-structured interviews were also undertaken with the phase two participants. The interview guide was informed by the data generated from phase one, for instance distinct challenges and benefits raised in the groups were examined. The interview guide was slightly adapted each time to make it relevant to the participant's role and position (see Appendix VI). This was sent to the participants before the interview for comment and agreement. Four participants were interviewed in total, with two from the same organisation. The interviews lasted around 90 minutes and were either undertaken at the person's place of work or at a quiet café. All interviews were recorded and fully transcribed and all participants were provided with a copy of the transcripts for them to add, delete or amend their accounts. As with phase one, no changes were made.

4.5 Data Analysis and trustworthiness

4.5.1 Analytical process

A thematic approach to data analysis was applied to both phases of the research. A thematic approach involves working with the raw qualitative data to identify and interpret key ideas or themes (Matthews & Ross, 2010). Unlike other analytical approaches, such as grounded theory, a thematic approach is not linked to any particular theoretical perspective (Bryman, 2012). Therefore, flexibility, Robson (2011) argues, typifies this approach as it can be used with virtually all types of qualitative data, descriptive and/or exploratory, and provides a means of summarising key features of large amounts of qualitative data using a systematic and methodical approach. For these reasons I considered that a thematic approach was a suitable way to analyse and interpret the large volume of data amassed, whilst providing a rich exploratory, description of the entire dataset, rather than a detailed account of one particular aspect. The approach taken was from the "ground up", as this ensures that the analytical interpretations made are grounded in the data gathered, rather than a top down approach where theoretical propositions inform and guide the analysis (Yin, 2014: 136). I considered such an approach to reflect the philosophical underpinnings of the study.

Bryman (2012) notes that analysing qualitative data can be an overwhelming and confusing process at times, due to the vast amounts of unstructured textual material generated. As such it is important that an analytical strategy is followed to ensure that the

analysis is credible and transparent to others (Matthews & Ross, 2010). In view of this I followed Braun and Clarke's (2006) six phases of thematic analysis. Taking each of these phases I will discuss how this related to the process in this study. But before doing so it is important to emphasise that this analytical approach was not undertaken in a straightforward, linear process. Instead, I found myself moving forward and back between the different phases a number of times. However, having a clear and systematic analytical approach helped to guide me through the process.

Step one: Familiarizing myself with the data

The first analytical step involved becoming familiar with the depth and breadth of the content of the data. Initially this began with the verbatim transcription of the interviews, which, whilst a lengthy and time consuming process, helped to make early connections and initiate ideas (Fielding & Thomas, 2008).

Braun and Clarke (2006) suggest repeated active reading of the various data sources to aid familiarisation by searching for meanings and patterns. Before I began the repeated reading of the various data sources I took the time to listen again to all the recorded interviews. My reasons for doing this were twofold. Firstly, I recognised that a transcript is always partial, judgements have to be made about which verbal utterances turn into text, as for some verbal utterances there are simply no written translations (Mason, 2002). Secondly, as there had been a lapse of time between fieldwork and analysis, due to my taking a year's maternity leave, this re-listening enabled me to reconnect with the data on a number of different sensory levels. During both processes of listening and re-reading of the various data sources I began to make notes on impressions, thoughts and ideas for coding to be considered in the next step.

Step two: Generating initial codes

Although Braun and Clarke (2006) do not necessarily promote the use of qualitative computer software analysis packages I used NVivo 10 to aid the organisation and retrieval of data. Concerns have been raised that computer-assisted qualitative data analysis packages can fragment text due to the ease with which it can be coded and retrieved (Bryman, 2012). Bearing these concerns in mind I considered that using NVivo would help me to manage a large dataset by making the coding and retrieval process faster and more efficient. Therefore all recorded and transcribed textual documents were transferred into

NVivo in two files under one project. These related to the phase one and phase two interviews. This meant the codes created would be distinct to the individual files, but they could be quickly cross-referenced to the other coded data sources.

Once all the data sources were transferred into NVivo I began by methodically coding the entire dataset. All parts of the dataset were initially coded as Braun and Clarke (2006) suggest that this ensures potential developing themes and ideas are not lost. In view of concerns raised about computer software analysis packages potentially fragmentising text I coded extracts of the surrounding data as a way to minimise this. Also I was sensitive to retaining inconsistencies and differences within the different data sources in what initially appeared as the dominant narrative, as this can offer rich insights that can be reviewed and refined later on in the process (Braun & Clarke, 2006).

Coding all parts of the various data sources meant a large number of codes were initially generated. However, I gained reassurance from Braun and Clarke (2006) that this was an inevitable but a necessary outcome and hence I did not feel too overwhelmed. In addition, I was aware that the next step would start to involve the refining and reduction of these codes.

Step three: Searching for themes

When all the data has been coded Braun and Clarke (2006) suggest that the next step is to refine the number of codes by combining some to form an overarching theme or sub-theme. I started off attempting to do this in NVivo, however I found this to be a disconnected way of working. Therefore I printed off a list of all the different codes for the various data sources, along with the text attributed to these different codes. Whilst this was a large, bulky document I found having a paper copy of all the coded data easier to read and consistently follow. My next step was to look at the various code lists and check for any multiplicity of codes that could be framed under the same named code across these lists. I saw this step as more of an administrative process, but it helped to generate some consistency across the different data files and in the process reduced the number of codes. Once completed, I started to search for themes by interpreting the data.

Clearly, ideas for emerging themes had already started to form prior to this step, as throughout the research process I had been recording my developing thoughts and ideas.

Similarly, whilst coding the data I made notes about areas of interests, impressions and queries within the data. At this point it is perhaps beneficial to clarify my understanding of what constitutes a theme. This is informed by Bryman (2012:580) who suggests that a theme builds on the coded data that provides the researcher with the "basis for a theoretical understanding of his or her data that can make a theoretical contribution to the literature relating to the research focus". Therefore, by reflecting back on my notes throughout the research process and during the coding phase, I began to search and identify emerging themes within the data by examining the different codes to see how they might be combined to form an overarching theme or sub-theme.

Whilst the process of refinement was initiated by reading through a paper copy of all the coded data, I returned to NVivo to make changes to the codes and structuring of the themes, as it provided a consistent and reliable way of keeping on top of the analytical process. I found the 'memo' function in NVivo to be particularly helpful as it meant I could provide a description of the developing themes that could be stored and easily retrieved. This step was a particularly slow and time consuming process, but developing themes slowly began to emerge. There remained some codes however that did not seem to belong anywhere, and in these instances I found Braun and Clarke's (2006) suggestion of creating a 'miscellaneous' theme helpful as it meant as I was able to move forward into the next step feeling reassured that nothing at this stage had been discarded or ignored.

Step four: Reviewing themes

To review the preliminary themes generated through the previous step I began by reviewing all the collated extracts for each theme and considered whether or not they formed a coherent pattern. To do this I again printed off the data attributed to each theme and read through these documents. If the extracts did not appear to fit within this theme I reviewed whether the theme itself needed refining or whether the extract was better suited in a different or new theme. Braun and Clarke (2006) suggest that once all themes have been refined, it is beneficial at this point to re-read the entire dataset to ascertain whether the themes generated work in relation to the dataset, and to identify any potential data that has been missed in earlier stages. In addition, I found the re-reading of the entire dataset a good way of helping me to reconnect with the data at an individual and wider contextual level. It also helped me to make sense of the extracts that had been themed as

'miscellaneous', as it became clearer where some of these extracts fitted within the preliminary themes.

Step Five: Defining and naming themes

The next step involved defining and refining the themes generated at this point, by identifying the 'essence' of what each theme was about (Braun & Clarke, 2006). Hence for each theme I documented what each was attempting to capture, by considering how it fitted into the broader overall research question and aims. Through this process a number of additional sub-themes were generated so as to avoid the theme being too diverse and complex. Once these steps were completed I was then able to describe the scope and content of each theme in a couple of sentences, which was invaluable when it came to the final step of producing the final report.

Step Six: Producing the report

Braun and Clarke (2006) suggest that the final step of the analytical process is the writing up of the findings into a concise, coherent story of the data with the overall intention of convincing the reader of the merit and validity of the analysis. Whilst I agree with these sentiments I found that the authors glossed over the realities of producing a findings report by ignoring how the production is often an iterative process that can generate further analytical insights. For instance, although I felt confident that I had identified the essence of each theme it was still down to me to create a coherent story where the various themes linked together. This was not a straightforward process as the report went through numerous revisions and processes of refinement.

At first I began by writing up the findings for the case study groups separately from the phase two participants. At the time I felt that this was the most thorough and straightforward approach to guarantee that all the data was included. Once completed, my attention then turned to writing up, again separately, the findings for the phase two participants. At the end of this process I had what felt like two discrete findings reports. But reading these separate documents it was clear that there were a number of areas where the different phases of the research illuminated each other and generated similar interpretations, which were being lost in keeping the findings separate. Therefore, in discussions with my supervisors the decision was taken to combine these two reports.

Combing these two reports however required a great deal of reworking, as it did not simply involve adding the findings from one report to another, mainly as the two reports were not framed and structured entirely the same. My approach involved slowly and sensitively entwining the two reports with the emphasis placed on applying the findings from the phase two participants to illuminate similarities and differences in experiences and opinions with the case study groups and their members. Whilst the production of the final findings report was an extensive and lengthy process, I believe that the process I followed was an appropriate approach to take as it meant that the data has been comprehensively analysed from within and then across the different phases. Ultimately, such an approach has also contributed to the overall credibility and trustworthiness of the research itself, key concepts that are discussed in greater detail in the next section.

4.5.2 The trustworthiness of the findings

Standard measures of assessing the reliability, validity and generalizability of quantitative studies are not necessarily transferable to flexible, qualitative studies (Robson, 2011), primarily as such criteria are grounded in a paradigm that privileges universal truths that can be deducted through objective, value-free measurement (Crotty, 1998). Lincoln and Guba (2007) are critical of the notion that a single absolute account of social reality is feasible in qualitative research and instead they argue that there can be more than one account. Consequently, the authors recommend that qualitative research should be judged by different criteria from those used to evaluate quantitative research. Drawing upon the work of Lincoln and Guba I consider the trustworthiness of this study's findings in relation to their criteria for credibility, transferability, dependability and confirmability.

Lincoln and Guba (2007) suggest the credibility of the research is increased when time spent in the field is prolonged utilising the means of 'persistent observation' and the cross-checking of data. Working with the case study groups in phase one of the study was a time consuming process, which took approximately 18 months to complete, with another six months to complete phase two of the study. 'Persistent observation' involves an in-depth pursuit of the features found to be especially important through prolonged engagement. Working with the groups over a sustained period of time meant I was able to comprehensively identify and explore, with group members, implicit and explicit salient features of the role of self-harm self-help/mutual aid groups. The cross-checking of the

data was gained through sharing and discussing my interpretations with the case study group members and phase two participants.

The transferability of the findings can be realised, Lincoln and Guba (2007) suggest, by the use of thick descriptive data as it allows the reader to make judgments about the degree of fit or similarity that may be made by others who wish to apply the findings elsewhere. My use of purposive sampling enhances transferability as it ensures the unit of study is meaningful and relevant to the research question. Furthermore, applying Braun and Clarke's (2006) systematic approach to analysis contributes further to the criterion of transferability as it provides a methodical and transparent way of identifying, analysing and reporting patterns and themes across a large data set.

Lincoln and Guba (2007) suggest that the use of an external audit to examine the process results in a dependability judgment and that confirmability is attained by an external audit of the data. These criteria have been met as throughout the research process I have been transparent about the decisions made and provide a clear audit trail through my supervisory log notes and research diary that have been examined by my supervisors.

4.6 Ethical considerations

Formal ethical approval was obtained for the different phases of the study from the Faculty's Research Ethics Panel. For phase one approval was granted in June 2009. Ethical approval for undertaking semi-structured interviews with the phase two participants was granted in December 2011. Please see Appendix VII and VIII for approval letters.

Due to the sensitivity of the area of study, confidentiality and anonymity were of particular relevance to this research. In collaboration with the case study groups and phase two participants, the decision was made, not to name the groups and organisations involved. Following standard good practices, personal references were removed from the transcripts. In addition, personal data such as names and contact details were kept securely and separately from the research data on computer password protected files to which only I had access.

Ethical concerns arise at all stages of the research process, from conceptualisation and design to data gathering and analysis (Birch et al., 2012). Given the sensitivity of the area of study I considered a feminist ethics of care was appropriate to this study as this approach emphasises care and responsibility, where the dilemmas are rooted in specific relationships that involve emotions, and which require care for their ethical conduct (Edwards & Mauthner, 2012). Rather than establishing moral principles that stand above power and context, a feminist ethics of care works with dilemmas of conflict, disagreement and ambivalence. Such an approach I found guided me through the many ethical dilemmas that were raised during the course of this research, most of which related to phase one participants, but others related equally to participants in both phases and that is noted where relevant below.

The sensitivity that surrounds my chosen field of study meant from the outset I was keen that I would be transparent and clear in my motivations for undertaking this research. In view of this in the information sheets that I sent to the case study groups I provided some information about myself and the reasons why I was interested in self-harm self-help/mutual aid groups to the case study groups (see Appendix II). I considered that such information might help to inform group members about my intentions and bridge formal divides between researcher and researched. This helped to initially establish some trust with the Midlands group and aid their decision for me to meet with them to discuss participation, as the key member of the group explained she was familiar and valued the work of an organisation to which I made reference.

Once the groups had agreed to participate in the study, I found gaining informed consent needed to be an ongoing and re-negotiated process, due to the length of time that I was involved with the groups. Written consent was obtained initially at all interviews, but as many interviews were conducted over a series of meetings, I would verbally introduce the purpose of the study again and re-emphasise that participation was voluntary and that the participant could withdraw at any time without a reason. Similarly, whilst I informally attended some group meetings I would remind group members the reason why I was there and provide updates on how the research was going. However, despite my best efforts my role within the London group began to blur mid-way through the fieldwork. Upon reflection I believe that this had to do with the regularity of visits that I made to the group over the course of a few weeks, as notes from my research diary below illustrate:

> *Sometimes I forget that I am there to do 'fieldwork' and although I know that I am not part of the group it has become quite comfortable being there. I do worry as I would have been there four weeks on the go and I wonder how much of an invasion I am making.*
>
> [Research Diary, December, 2009]

In the above extract I had attended the group four weeks in succession as I had been asked to come back this number of times to complete an individual interview. Each time I would then be asked to stay for the evening meal. After this I found myself being invited to a number of events in and outside the group, which I did not always feel entirely comfortable with, as the below extract illustrates:

> *Being included in all these events, although very nice, illustrates the blurring of my boundaries with the group. To be honest I am finding it very difficult to manage and deal with.*
>
> [Research Diary, January, 2010]

At the forefront of my mind was an awareness that at some point my involvement with the group would end. Hence I did not want the group to become too reliant or familiar with my being there, but at the same time I was keen to continue building and developing a trusting, mutually supportive relationship. Therefore balancing these competing demands was a challenge at times. After expressing these concerns with my supervisors, the suggestion was made to break up the frequency of visits and to accommodate my emotional needs as well as those of group members. This advice I found helped to re-establish and better manage my role within this group throughout the remainder of the fieldwork.

Whilst the focus of the research was not about examining an individual's self-harm per se, I was mindful that group members, and indeed the phase two participants, might share their own experiences to contextualise the wider benefits and challenges of self-harm self-help/mutual aid groups. As a way to manage this I acknowledged the importance of participants choosing to talk to me at a time and place that they felt most comfortable with and encouraged breaks to be taken when needed. In some instances this meant an individual interview was undertaken in the group meeting space with other group members nearby. At first I struggled with this as I was concerned that the group member might feel

uncomfortable at having other members nearby who might hear what they had to say. Moreover, from a research perspective the noise in the room could be quite loud at times, so it was not always easy to hear what was being said. However, ultimately I realised that my notion of a 'safe' space with an emphasis on privacy and seclusion differed to that of those group members who wanted the interview to take place in an informal, familiar setting. Hence if I was genuinely concerned with endorsing group members' comfort and trust it was important that I recognised and appreciated these different ways of working.

In addition, to the possible emotional risks for group members and participants during the course of the research the emotional burdens on myself, as the researcher, became pronounced at times. Regular supervision of both a formal and informal nature was established throughout, and was increased following the suicide attempt of one member from the London group. This was a distressing time for the group and myself, as at this point I had been working with the group for quite some time and, indeed, the key member from the group informed me, via a text, over the weekend when she had found out. At the time I felt a mixture of difficult emotions in not being able to identify that such an event might occur, particularly as I had only seen the individual concerned a couple of days before the suicide attempt. The supervisory support offered to me during this time was critical in working through some of these difficult emotions and, on a practical level, planning how to continue my future involvement with the group.

Finally, the power differentials that were raised during the research process were another area of complexity. At times, working with the case study groups I felt the research process was very often directed and controlled by the groups, as the group and its members would allow me to meet with them when it was suitable and convenient to them, a principle that I strongly endorsed and supported. However, at times I felt I had very little control in this process, which was intensified by my own internal perceived concerns about the slow pace in the progression of the fieldwork. There is an assumption that the researcher is always in control of the research process, but, as Bhopal (2010) suggests, the power relations are often more nuanced and complicated than this implies. Whilst the researcher may have the objective balance of power throughout the research process, power is not simply a binary have/have not aspect of a relationship. Instead, Bhopal (2010) claims that the subjective experience of power is often ambivalent for both the researcher and participant. Certainly Bhopal's interpretation of power matched my own ethical dilemmas, but ultimately I am in

agreement with Cotterill (1992:604) that the final shift of power between researcher and participants is balanced in favour of the researcher for eventually they “walk away” and “leave the field”.

4.7 Chapter summary

In summary, an interpretivist approach frames this exploratory study with the aim of generating a rich, detailed understanding of the role of self-harm self-help/mutual aid groups. A qualitative case study research design supported the exploratory nature of the study and offered the opportunity to gain an in-depth understanding of self-harm self-help/mutual aid groups from the perspective of those who attend and support these groups.

There were two phases of research in this study. The first phase involved working with two self-harm self-help/mutual aid groups and their members to gain a detailed understanding of the groups. The second phase explored the perspectives of those who support self-harm self-help/mutual aid groups to gain broader insights into the running and development of these groups. A thematic approach to the data analysis was applied to both phases of the research. This chapter concludes with a consideration of the ethical dilemmas I encountered during the process of undertaking this research.

The next chapter presents the findings that were generated through the adoption of this methodological approach.

Chapter Five
Findings

This chapter presents and describes the findings of the study that explored the role of self-harm self-help/mutual aid groups, from the perspective of group members and those that support these groups. It is organised in three parts to aid clarity, with an introduction and summary before and after each part to link the sections. Part One provides a descriptive background of the groups, its members and their experiences prior to joining their groups. In Part Two the findings are framed around the contribution of self-harm self-help/mutual aid groups, and lastly in Part Three the findings are examined in relation to the challenges facing the groups. The themes presented integrate the findings from both phases of the research, with the identifiers 'A' and 'B' referring to case study group one and two respectively. Data from the phase two participants is denoted with the identifier 'C' and is used to provide additional illustration of the themes in relation to the case study groups.

Part One: Descriptive Background

As noted above, Part One begins with a descriptive background to the case study groups, their members and the phase two participants. It concludes by providing a contextual background to the case study group members' experiences of self-harm that was typified by isolation, shame and guilt before finding and entering their groups.

5.1. Descriptive background: The groups, group members and phase two participants

5.1.1 The two case study groups

Group A

Group A was a small sized group with four regularly attending members based in the Midlands. The group was member instigated by the founding member 12 years ago in response to a lack of support, particularly of a peer support nature at the time in the local area. The group was only open to women with direct experience of self-harm who were 18 years or older. At the time the group was self-funded by its members, although in the past the group had been awarded small amounts of intermittent funding from local and national voluntary organisations.

The group met once a week for around 90 minutes. A typical meeting involved the four members meeting in the city centre. From there they would then take the short walk to a room in a local housing project, which one of the group members had secured at a reduced rate through being a tenant of the scheme. The room was divided into two halves, with one side consisting of a small kitchen area, whilst on the other side there was a comfy seating area that was arranged in a circle with a coffee table in the middle. The windows looked outside of the building, which meant no-one from the housing project could see in except by a small glass panel in the entrance door, which the key holder always covered up with a note saying "Meeting in Progress".

Once the group members were in the room hot drinks would be made. This activity was taken in turn with no one having sole responsibility for it. Likewise, the group members took it in turns to buy the cakes and biscuits that always accompanied the hot drinks. Once the drinks were made these would then be taken over to the comfy seating area where members would sit to begin the meeting. The meeting started with one member asking another how their week had been, again this varied in who took the lead in asking this starter question. Each member would then have an opportunity to talk about how their week had been, discuss things that were causing them difficulty or distress, and share wider areas of their lives. After each member had spoken the meeting would come to a natural close. Usually the key holder would stay behind to tidy up once the other members had left.

Group B

Based in an inner-city London borough, group B was established eight years ago by a clinical psychologist who brought a number of his clients who self-harmed together in a group for mutual support. Within a year the group had evolved into a member-led group, owing to the departure of the clinical psychologist from the borough. The group began to flounder in its second year until one of the original members returned to the group and took the lead in its running. Upon her return she was appointed facilitator of the group and has remained in this role since.

This was also a small sized group with four regularly attending members, referred to as the 'core membership'. Unlike group A, group B had a small number of additional members who did not attend the weekly meetings, but who instead accessed the group's funded

crisis support line, which was predominately managed by the facilitator of the group. Twice weekly meetings were hosted that were open to both men and women with a minimum age restriction of 18 years. Nearing the end of my time with this group a third meeting was established mid-week for women only.

Unlike group A, this group had been awarded, on a regular basis, the maximum annual amount of £5,000 from a local service user involvement project, funded by the local Adult and Health Wellbeing and Primary Care Trust at the time. The original terms of the grant were to help initiate local peer-led groups to provide support outside normal working hours to mental health service users. In response, group B provided a 24-hour crisis support line, hosted groups after 5pm and held a number of social activities at the weekend throughout the year.

Group meetings were held at the premises of a local mental health user-led organisation, of which the facilitator of the group was a Trustee. The group had an agreement to pay the organisation ten per cent of its awarded funding for room hire. The Friday night meeting involved the facilitator of the group cooking a meal for everyone. Group members would meet in the lounge room, where there was a sofa and a number of comfy seats, along with a pool table, TV, Hi-Fi system and a large dining table and chairs. A kitchen area was attached to this room and group members were free to help themselves to hot and cold drinks. All cutlery, including knives, was locked in drawers, which only the facilitator and employees of the organisation had a key to access. The first 45 minutes involved group members exchanging pleasantries, after which they would then be in and out of the lounge room. The facilitator would be in the kitchen cooking and other group members would be making drinks or going outside for a cigarette. By 5.45pm the dinner was usually served and everyone would sit round the table to eat. It was at this point the group came together as members would each take their turn to talk about their week and share their plans for the weekend. Informality characterised this discussion with members talking freely and over each other. By 6.30pm the plates would be cleared away and washed up by the male member of the group, whilst the remaining members usually went outside for a cigarette. Just before 7pm everyone would leave together once the building had been closed and locked up by the facilitator.

In contrast, the meeting at the beginning of the week was more formal and task orientated and was led by the facilitator of the group. For instance, preparation for any events the group might be involved with would be organised and discussed at this meeting. Usually only a couple of members would attend this meeting and the group always met in a smaller room, which had a computer and a couple of comfy chairs.

Table 3 below provides an outline of both case study groups' organisational features, as described earlier.

Table 3 Overview of case study groups' organisational features

	No. years running	**Location**	**Member / professionally instigated**	**No. weekly meetings**	**Inclusion criteria**	**Funding**
Group A	12	Midlands	Member	1	Women only 18years +	Intermittent small amounts
Group B	8	London	Professional	2 (increased to 3)	Mixed 18years +	Regular annual award £5K

5.1.2 The group members

The regularly attending members from both case study groups were all female except for one male member (B1) from group B. The mean average age was 46 years and the ethnic background was white British for all group members. The majority of group members were unemployed and in receipt of benefits, except participant A1 who worked part-time. Two group members had adult children (A3 and B4), and group member A1 had young children living at home. All were single apart from A3 who was married and B4 who was in a relationship.

On the whole, group members had been self-harming since childhood or early adolescence except for two participants, who identified their self-harming as starting in their late 20s/early 30s:

> I started when my middle child, [name], he must have been about two or three and he's thirteen now, so it's ten years. (A1)

> I think in some ways I'm one of the less common cases in that I didn't start until I was in my 30s, no, probably late 20s actually, because most people start as a child. (A2)

Group B members all made references to having been an inpatient, at some point, for their mental health problems, with the term "hearing voices" applied by two members from this group (B2 and B3). The remaining two members used less specific terms, although both identified as being in recovery from alcohol and drug dependency. In group A one member (A2) said they all suffered from depression in the group, although participants A3 and A4 never explicitly stated this.

Group involvement and attendance on the whole was consistent from when a group member first started attending the group, which ranged from 3 to 12 years.

5.1.3 The phase two participants

Participants C1 and C2

Both participants C1 and C2 were employed members of staff from the same national charitable organisation that supported women in emotional distress, with a particular emphasis on helping those who self-harm. Since the organisation's establishment in 1986 it has compiled a national list of self-harm support groups, and produced a range of resources detailing how to set up and be involved in self-harm self-help groups. C1 was the director of the organisation and had experience of facilitating a local self-harm self-help group for a number of years. C2 was the organisation's project worker whose role involved managing the organisation's various projects, along with maintaining the national list of support groups.

Participant C3

Participant C3 was an employed crisis support worker within a user-led organisation based in the North of England that offered a person-centred approach to people experiencing mental health crisis. In 2012 the organisation was awarded funding from a local NHS Trust to host a facilitated self-harm peer support group for young women. The aims of the group were to reduce group members' visits to A&E, reduce their self-harm or severity, reduce loneliness and isolation and increase confidence in their ability to manage crisis and awareness of alternative coping strategies. Having direct experience of self-harm,

participant C3 co-facilitated the weekly group sessions with another worker from a local women's health charity that had experience in facilitating women's groups in the community.

Participant C4

As the founding member of a self-harm self-help group that ran for five years, participant C4 described herself as a survivor-activist in this area. The group disbanded in 2001 and during that time more than 100 women passed through the group. In 2006 she co-founded a not-for-profit user-led organisation that provided awareness training and consultancy in self-harm. As the director and lead trainer of the organisation up until 2013, she now works as an independent freelance self-harm trainer and consultant.

5.2 Descriptive background: Context of life prior to joining the group

With the average age of the case study group members around the mid-40s, many started self-harming at a time when awareness and understanding of the meanings behind self-harm were limited. Judgemental attitudes and a lack of wider societal understanding meant most group members, over the years, had tried to keep their self-harm hidden from others:

> There's a lot of people tend to keep it to themselves. Cover themselves up. Don't let it be known you know. It took me years to come out you know, because I wouldn't tell anybody…You had to keep yourself quiet, especially, you know, with self-harming, suicide, hearing voices you know. All them three. You had to sort of be quiet about it because in them days it was thought "Oh nutter", "mad". And nobody understood what you were going through, you know, or they didn't want to know what you were going through they just didn't want you near them. (B2)

> I'd been doing it for a long while before, but not told anybody, but then I did it quite bad and tried to cut my wrists, so she [mum] found out…my mum didn't know that I'd done it all those years before. (A1)

The hiddenness, secrecy and lack of understanding that surrounds the area of self-harm meant for a long time one group member was even unaware that the harm she did to herself had a name:

> I didn't know what I was doing. It didn't have a name. (A2)

In keeping their self-harm hidden, many group members spoke about how they had felt very isolated and alone with it, which was compounded by a lack of available support at the time:

> I think you feel very alone with it and particularly when you started in childhood, self-harming for whatever reason you just don't know where to go…You don't know who to talk to and it is something that most people including myself kept very close to your chest for obvious reasons. (A4)

> There was nobody to talk to. (B3)

> There was nothing and you just had to suffer in silence and get on with it. (B4)

Although most group members felt that there was now greater awareness of self-harm, stigma, shame and guilt continued to be powerful inhibitors to group members admitting and seeking support from those close to them:

> It's more widely spoken about in this day and age and you see articles in magazines which you would never have seen when I was growing up…When I told my friend…when I said I'd actually gone to hospital I felt I had to make an excuse and say I'd fallen over and I'd had to have stitches in my leg, and then some time later it did come out, and she said, "If it ever happens again you must phone me" and she said, "It wouldn't matter what time of the night it was, we would have taken you to hospital"…And I said, "I couldn't in all honesty have phoned you because I self-harmed", I said, "I inflicted it on myself", I said, "Obviously if I'd had an accident I would have felt I could turn to you, but because I'd done it myself there's no way I'd phone you up at that time of night". (A4)

These attending feelings of shame, guilt and embarrassment are effective, participant C4 identified, in continuing to keep those who self-harm silent and hidden:

> I think that living with a secret is for anybody is always painful and destructive and there is some issue regardless of the fact that there's slightly more awareness around it there's always going to be difficulties around talking about it in a personal sense…taboos and stigma and just sheer embarrassment are really, really effective silencers you know. (C4)

Even when others close to the case study group members became aware of the self-harm, some found friends and family often struggled to accept and understand it, which often ended up re-emphasising negative feelings of difference, shame and isolation:

> There is nothing worse than, when I've self-harmed and my mum, you know I've told my mum, my mum seen me wearing long sleeves and you get that horrified look and then it kind of reinforces to me that I'm weird and you know I'm not normal and I do something that other people don't do and I think all of that's really unhelpful and I sort of wish my mum could say or I wish my mum could see "Okay [name] was really upset and distressed". (B3)

Insecurities and doubts around the legitimacy of the level and extent of their own individual self-harm meant two group members questioned whether or not they would have a place in a self-harm self-help/mutual aid group:

> At the point I first joined I didn't really felt I fitted in, I don't know whether I thought I fitted the criteria or whatever, but I didn't feel comfortable. So I sort of went away and then came back…It was a few years later, there were different people in, we were meeting somewhere different. (A4)

> I wanted to know if I actually…"Do I like qualify being in a self-harm group?", because I was cutting with glass but I mean I'd never, I'd never been to hospital or needed stitches so in my head it was like, "Well am I" "Aren't I?" and so [B4] said "Yeah, like you don't need to", but I sort of thought cause it wasn't stitches, even though I was cutting from head to toe, but because it wasn't stitches I kind of thought "Well does that qualify?"…I didn't feel considering that I'd seen people and, you know, from being in and out of hospital I'd seen people you know stitch

> their own wounds up and been really you know cut through arteries. In my head it was like "Oh am I going to be a minor", if you like. (B3)

Such doubts and insecurities are not uncommon, participant C4 reported, as in the group she established many women also compared their self-harm to others, with the assumption that those who required medical attention met the criteria of a 'self-harmer' more than those who did not. That assumption is re-enforced, participant C4 argued, by health services, as medically severe injuries mostly gain greater attention, of both a positive and negative nature:

> There was a natural tendency for women to compare their experiences with other people. Well, mine wasn't so bad, you know, hers was worse and I think women did that around their self-harm and I think people were given really strong messages from services as well…and there was sometimes within the group some assumptions about the people who were kind of ending up needing medical attention regularly, they had a stronger claim or a stronger position within the group… I would always challenge that assumption, but I think I would have to say that sometimes there's some insecurities about levels of self-harm. (C4)

5.3 Summary of Part One: the descriptive background

The descriptive background to the case study groups illustrates that whilst the groups were similar in size and member demographics, they differed in development, with group A being member instigated and group B originally being initiated by a professional. Additionally, group B for the past few years had been awarded a regular funding grant, whilst group A had for some time been member funded. Similarities however were shared across the two groups in relation to members' personal experiences of self-harm. Lack of awareness and judgemental attitudes of the time meant most group members had tried to keep their self-harm hidden throughout the years. In doing so, loneliness and isolation often typified group members' personal experiences, which was enhanced by feelings of shame and guilt. In part two of the findings, which examines the contribution of self-harm self-help/mutual aid groups, these negative feelings will be explored further.

Part Two: The Contribution of Self-Harm Self-Help/Mutual Aid Groups

> *For this group being here and for the confidentiality and the safe space, for me it gives you that place to talk and discuss it and I think that's really important, or otherwise you do feel isolated and on your own…but when you hear other people and they do it, it kind of gives you that bit of self-worth and "Oh I'm not a complete weirdo"*. (B3)

In Part Two the findings are framed around the perceived benefits and strengths of self-harm self-help/mutual aid groups at an individual and wider collective level. Under this overarching category there are four substantive themes and a number of sub-themes within each of these main themes. The first theme relates to the groups being identified, as the above quote illustrates, as a *safe space*. In entering into a safe space members were offered *a different approach* to that experienced in statutory services and this is the focus of the second theme. In finding a safe space, *alleviation of isolation* and *personal development* were fostered, and constitute the last two main themes in this part of the findings chapter.

5.4 Contribution of the groups: A "safe space"

Case study group members identified and referred to their groups as a "*safe space*", which provided members with a space where they could listen and talk to others about their self-harm. The practical features and emotional space fostered within the case study groups were key to establishing and maintaining the group's safe space and are discussed below.

5.4.1 Practical features

The physical space where the case study groups met played an important role in creating and maintaining a safe space for group members. Over the years, group A had struggled to find suitable, affordable meeting venues, which at times had inhibited members' sense of safety and impacted upon group discussions:

> We met in the cafe for quite a long time, but you can't talk so openly, you can't just be however you want to be. You can't sit there and cry if you need to. (A2)

> The other place we met up was probably more personal, you know, it was smaller, it wasn't brilliant by any means, but it was more intimate and I think people felt safe, safer. (A4)

Due to the shame and stigma that continues to surround the area of self-harm, the importance of building and maintaining trust between members was central to creating a space where case study group members felt sufficiently safe and secure to discuss their self-harm:

> Because we're confidential and because it doesn't go elsewhere, people put more of themselves on the line really, take more risks, and I suppose the group appreciates that and values that, what sort of people are doing, you know. And feels honoured really that just a person would trust other members of the group, because they probably haven't been able to trust and tell professionals these things, they aren't going to panic if they say things. (A3)

To maintain the group and members' safety, confidentiality was important in both case study groups and was emphasised to reassure new members entering the group as well as the established membership:

> Confidentiality, what goes on in the room stays in the room, about safety, so group members feel safe. (A3)

> I suppose we take it for granted that so and so isn't going to go outside and tell the world what you've been saying in here but I think for new members it kind of, it reassures the old members that the new members aren't going to go and do that so I think it works for both sides. (B3)

The breaching of trust was therefore taken particularly seriously in both case study groups on the grounds that it threatened the safety of the group. For example, the facilitator of group B took decisive action and suspended a member from the group when another member's confidentiality had been breached outside the group. Though the suspended member was offered the opportunity to discuss their temporary suspension, they did not turn up to a planned meeting and never returned to the group:

> It goes against the whole aim of the group if someone was that's sort of why I think [name of facilitator] decided that the person should be suspended…because the member that had sort of become a victim to the rumours you know didn't feel comfortable coming into the group and talking. I think the rest of the group sort of sympathized with [name of member] and thought, "Yes we all agree we'll go in that direction"...we invited the person to come in and have a meeting and sit down and discuss sort of you know why we had suspended them if they wanted it clarified but they didn't turn up. (B3)

Maintaining a safe space also meant rules played an important role in both case study groups. All new members entering the case study groups were provided with the group rules, which were open to revision and expansion. Similarly, collectively agreed rules also played an important role in the group participant C4 founded:

> We were very, very, very emphatic about ground rules…we constantly revisited the ground rules and added new ones so we ended up with quite a long list but because things would happen. (C4)

5.4.2 Emotional space

In the early days of instigation the case study groups had faced resistance and concerns from mental health professionals about the value and safety of their groups. There was an embedded assumption and fear that through meeting others who self-harm, an individual's own self-harm would be escalated:

> There was difficulty in health people trusting us, I guess, that we weren't going to be a cutting party sort of thing, so that was difficult to start with. (A3)

> There was some sort of disagreement when the hierarchy within the medical profession and particularly the psychiatric system, because they thought, put a load of self-harmers together in one room and all you'll get is us teaching each other how to self-harm, and it will be a never ending spiral out of control. (B4)

Group members were not impervious to these concerns. For instance, one of the case study group members shared doubts about the safety of the group before joining it, as he was

concerned that he would learn more damaging ways to self-harm, which echoed the reservations expressed by some members in the group participant C3 co-facilitated:

> I would only say what's going through my mind when I first started, when I first heard about it, is like, well are they teaching you a better way to self-harm and that…do more damage than good… you know, because it's like a group run by self-harmers is unheard of, you know. (B1)

> Some people were worried about if people talked graphically about what they actually did to themselves that that might give them ideas, people did actually say that as a kind of worry of the group. (C3)

Upon entering into the case study groups these fears and concerns were found to be unfounded, as the main activities within both groups involved members talking and listening to one another, with the emphasis on the feelings behind self-harm and different ways of coping, rather than the mechanics:

> We don't talk about the mechanics, but the different ways that we've tried to cope with self-harm and yes, just mutual support. (B4)

> So we meet and make drinks and then talk about just general things really, how the people are feeling, what's happened in the last week, any key things that have happened to them, how they're feeling, we talk about whether people have self-harmed if that's what they want to talk about and talk about their experiences around that. We're just there to listen to each other, really. (A3)

Entering the group for the first time, case study group members were often silent and did not talk, preferring instead to listen to other group members discuss their self-harm. For many it was the first time they had heard anyone else talk so openly and honestly about their self-harm. After attending a few meetings, group members began to feel reassured that they were in a safe, non-judgemental space with others who shared similar experiences. It was at this point group members felt confident and secure enough to discuss their self-harm free from judgement and dismay:

> It was like…either I can keep silent or I can say something, and I think it was after around about the third week I started talking and that, because I felt I thought I was somewhere safe and I wouldn't be judged. (B1)

> I think I just felt more secure as I got to know them. I could open up a bit more. I knew whatever I said, they weren't going to think I was awful…I've never heard people just say, "Yes, I've cut myself this week", just openly without everybody gasping, because that's sort of the response you've had before. So it was nice to be able to admit to something and not be frowned upon. (A1)

Having the opportunity to meet, listen and talk with others who shared a common experience of self-harm in a safe, non-judgemental space facilitated an implicit understanding and acceptance between group members that was deemed difficult for family and friends without direct experience to attain due to competing concerns and fears:

> It's a safe space. I think I could say pretty much say anything here…without the fear of being judged, where I suppose if I said it to a family member you'd get the more horrified look, where here you wouldn't…The people in the group understand about the pressure building up and well you can't have that conversation with and I know my mum obviously worries and my boyfriend and he sort of worries…my boyfriend likes to go out and have a drink and trying to explain it in those terms when you're really stressed you have a drink and when I'm really stressed I cut myself…I don't think you can't have the same I suppose it's their fear and that they love you, and but they can't speak about it on the same level as the people here that can. (B3)

The commonality of experience between group members offered them an emotionally safe space where their individual distress was acknowledged by others within and outside group meetings as something real and painful. In turn, members felt listened to, understood and accepted:

> It's good to have someone else's you know, someone to say that's sounds really tough for you, it's about being understood, that that was a really distressing moment in time for you and you're not ringing someone up to give you an answer

> or take it away or make the pain go away, but just to be sort of be heard and acknowledged that that was, whatever that situation was led you to feel rough and then you done that. (B3)

Finding shared experiential understanding in the group also meant the support offered was considered to be more heartfelt and genuine. Group members were able to empathise and offer a more compassionate response, which reaffirmed the group as being an emotionally safe, accepting space:

> People are talking from personal experience so they can have a deeper understanding of services or where they've been treated. People really understand the feelings behind self-harm…So if I talk about how I got on at A & E, other people will have had similar experiences and they can empathise with me in what that was like…I guess that is more valuable when somebody from the group says "Yes, I understand that", or "That's really hard, isn't it", or "Oh my God that must have hurt", you know. If people have been stitched without anaesthetic people can support each other in that sort of way, in a deeper level…I know they really understand. (A3)

5.5 Contribution of the groups: A different approach

The safe space found within the case study groups offered its members a different approach to that experienced in statutory services, as the case study groups emphasised individual strength, value and harm minimisation, rather than powerlessness and a focus on cessation from self-harm.

5.5.1 Previous experiences of services and available support

Most case study group members only come into contact with statutory services in relation to their self-harm at times of crisis. It was not uncommon for many to experience a lack of kindness, care and indifferent attitudes when entering into services. For example, the deliberate self-harm team had left one group member feeling further judged and guilty, whilst another group member spoke about the lack of compassion her GP expressed when she confided in him about her self-harm:

> The sort of groups you get from services and the support you get isn't very good at all and the deliberate self-harm team don't really support you, they offer six-week cognitive behavioural therapy but they often seem harsh and judgemental. (A3)

> Other doctors have been less than useless, like one of them said, 'What do you want me to do about it?". I showed one of the doctors my scars and I said, "I've been self-harming", and he said, "So?". I was like, "Hello, I'm here, I've got a problem, I've just admitted it to you". It was like he didn't care. (A2)

The lack of understanding displayed by some staff was another source of frustration identified by case study group members who had entered into secondary mental health services. Requests on mental health inpatient wards to sign no self-harm contracts were viewed by one group member as failing to grasp the realities of self-harm, as her acts were often unplanned and beyond her control at times:

> I had the occasion when a guy came up with a form for me to sign and that was to not to do self-harm and I thought these people really don't understand…you don't know, the minute you're going to self-harm you know I couldn't say to you, you know "I'm going tomorrow to self-harm." That is idiotic because you don't think that way, you don't even think about it because it's when you're in a really, really poor state like I was the other week that it's just impulse, straight away, spur of the moment you know, and it's not as if though it's been planned. You don't plan it. (B2)

Very few case study group members received direct support in relation to managing their self-harm from statutory services, as the emphasis was usually on treating the diagnosed "*whole mental health*" (B1). Hence most group members felt there was an absence of support within statutory services for those who self-harm, and as a result many had looked outside this medical model:

> There was no support for people who self-harm in the area…service user support, there was none of that in the area…I learnt about the National Self Harm Network at just about the same time as I set the group up and so I was learning more about self-harm which was amazing to me at the time to think that other people actually

> felt like I felt and had got similar experiences and different motivations for self-harming, and actually it relieves things and it helps them to deal with life. (A3)

Recognising their own individual need to meet others who self-harmed, two case study group members' contacted local voluntary organisations to help them identify resources where they could meet peers, as a way of reducing their isolation and potentially gain support:

> I did wonder whether there was. I suppose I wondered whether there was anybody else out there with the same problems…so yes, I wanted the support and wanted to know whether there were other people out there with the same problems. (A4)

> When I was 17/18 I found the Hearing Voices group and I just thought it was amazing how you just learnt things off other people, sit there and "Oh someone else hears that kind of voice" and it makes you feel that you're not on your own anymore and I think when you just know you're not out there on your own isolated, it's kind of learning from each other…I thought, well, there's got to be something out there for self-harmers that would work the same… I really had nothing to lose by doing it if it had all gone, you know, no this weren't for me, I would have been sort of no further forward than what I was in the first place. (B3)

As a regular member of a Hearing Voices group, the learning and peer support participant B3 above had gained encouraged her to contact the case study group; at the very least she considered that she would be no worse off. Similarly, having had a positive experience in a mental health user-led group meant case study group member A2 was open to the possibility that a self-harm self-help/mutual aid group might be "*helpful and beneficial*".

5.5.2 Taking back control and setting own rules

The founding member's motivation to establish case study group A was informed by poor experiences in statutory services. In establishing the group she hoped to offer a space that rejected stigmatising labels and judgemental assumptions and instead promoted the principles of collective equality and individual self-worth:

> I think we wanted it so it wasn't a them and us, that we were all equals, because in the services it's very much them and us, we're the baddies, they're the goodies and we didn't want it to be like that…We treat each other better, we're not treated as though we're manipulative, we don't give people labels here…we can talk about things that have hurt us as people being labelled and stigmatised, we can talk about it in the group and that helps you to feel more normal and not such a bad person after all. (A3)

Similarly, the group participant C4 founded developed as a form of resistance to the poor care received in statutory services. Participant C4 was motivated to take back control by instigating a self-harm self-help/mutual aid group that was grounded in individual power, control and self-reliance rather than powerlessness and helplessness. The self-harm survivors' movement that emerged in the mid-1990s also played a key role in informing participant C4 of a different and less stigmatizing way to understanding self-harm:

> I think I was prompted by reading stuff like Bristol Crisis Services, Lou Pembroke realising that there might be a different way of doing things…Having been in hospital where it was kind of just being utterly powerless, very unsafe and feeling very misunderstood and wrongly labelled…I wanted a different way that was my motivation…that was about us and our needs and a kind of different model of support…that was not about powerlessness and helplessness, that was about us having an active role within our own support networks. (C4)

Being regularly funded by an external statutory source meant case study group B had a number of formal obligations to meet as part of its funding agreement, particularly in relation to monitoring outcomes. Nonetheless, this was something the facilitator of the group resisted completing on the grounds that these measures did not truly reflect the group's work:

> I still won't fill out part of their monitoring form, they keep asking me how many members, like I will tell them overall how many members use the service, but I won't tell them on a daily basis what members are using [name of group], because, I mean my members don't, a) they don't want to do that and b) it would not be a true representation of what we do. (B4)

Case study group A's lack of external funding meant to some degree it was positioned further outside mainstream services, as its ways of working were not fixed, but instead could be negotiated and revised, as seen in the response by the group in relation to their "*no self-harm on the premises*" rule. Initially, to prove its value and credibility to outsiders, a rule of no self-harming during group meetings was established. Over time this rule was revised as group members wanted to distance themselves from a reductionist and cessation emphasis typically taken within statutory services to a more accepting, harm minimisation stance:

> I guess we always felt that we have to prove ourselves, so we had a rule, like no self-harm on the premises when we first set up. Then we decided that wasn't good to have that rule, so then we said that if people self-harmed then they should look after themselves or seek help from somebody…we were being like the hospitals, we were being like the establishments: how they would have this no self-harm policy and we're looking at trying to help each other and make it less bad and we had some steri-strips and cloth, things like that, if people needed them. And nobody did harm, nobody came and wanted the steri-strips. (A3)

The boundaries of responsibility being placed on the group rather than one member alone, was a unique feature the founding member from group A valued in distinguishing it from the ways of working in statutory services. Participant C4 also identified this as a unique but challenging feature at times:

> You don't have to do risk assessments though, so you're more free and easy with what you can say or you're more daring in what you say or how you deal with something than services that will be held to account for decisions that are made, and how the person is, is more down to them and they have to say why they do certain things. In a group we don't have to do that, we don't have to cover our own backs…We don't have to do anything if people are talking about feeling really desperate. We don't have the duty to do anything about that, we can just support them and be more human in our response, because we don't have to be accountable to anybody. (A3)

> I'd say the main challenges were about sharing the power and responsibilities or the not sharing and the kind of about the boundaries, boundary keeping you know. But then that's kind of the flip coin of the major benefits of the group as well the boundaries were open, the boundaries were flexible, they were open to our kind of setting, they weren't being set for us, and around the power and responsibilities most of us had been in situations where we were totally stripped of it in care, prison or hospital so learning to take some of that on to some degree was hugely important, but it was really difficult. (C4)

5.5.3 Emphasis on harm minimisation not cessation

In neither case study group was the emphasis on cessation of self-harm, instead it was more on members helping each other to "*manage a bit better*" (B3) and "*supporting as we are now*" (A1). Whilst neither group explicitly stated that their groups were informed by a harm minimisation approach, acceptance and understanding of an individual's need to self-harm at times of distress underpinned the ethos of both groups. In case study group B, however, a more preventative approach was endorsed, as the facilitator of the group encouraged group members to ring her or someone else in the group in times of distress to potentially minimise the risk of an act of self-harm from taking place:

> It doesn't make me feel so bad, it doesn't make me feel so guilty when I've done it, you don't beat yourself up about it so much, and when you have, you get support and you're told not to feel so bad about it. (A1)

> Not particularly to stop, we never actually say to anyone, you've joined [name of group] and you're going to stop because it doesn't work like that…All we do is ask people to phone us before they self-harm so that we've got a chance to do something about the situation rather than what a lot of people do, and I must admit I've been guilty of it myself, doing the self-harm and then phoning somebody and saying, "Oh dear, look what I've done!". By that time nobody can stop it, you've done it. All they can do is say, "Look stop, don't make yourself feel too guilty about it, you know, we can work through this". (B4)

This responsive approach was not something the facilitator and other members of the group always found easy to adhere to, but having a network of support inside and outside of the group meetings sometimes prevented individual acts of self-harm from occurring:

> If I've had a big row with my mum and I've gone home, sometimes I've self-harmed and then phoned [B4] the next day and discussed what was going on at that time and other times I've phoned [B4] straight after the argument and spoke to her and not self-harmed. It doesn't always work that, but it does sometimes. (B3)

Additionally, an emphasis on cessation was not a focus for the group participant C4 founded or for the group participant C1 had facilitated in the past. Indeed, by taking away an emphasis on stopping, participant C1 had found that the support offered within the group was better received by group members:

> It's just about being there for them and supporting them, that's it and it comes up very regularly that when people know they don't have to stop it makes so much difference to how that support is received. (C1)

In contrast, a reduction in self-harm and visits to A&E for young women aged between 16 and 25 years was an outcome goal set by the local NHS trust that funded the peer-led group participant C3 co-facilitated. This directive goal differed to her own position as instead she favoured a less direct approach with an emphasis on mutual support and reciprocity:

> My hope was for people to feel like they genuinely had a space to talk through their feelings with other people and kind of get support from each other. That was my hope rather than people would stop and it would all be fine. I just don't think that that's realistic. (C3)

A reductionist and cessation emphasis was considered by participant C4 as failing to recognise the social roots of distress. Until these issues are addressed, participant C4 argued, a reduction or cessation of self-harm was unlikely to occur:

> I would say that self-harm, if you like, is a symptom of distress so the focus of support groups around self-harm or about dealing and living with distress that needs to be the focus, not the cessation of self-harm. If that's the outcome hurrah, if it's not then the focus is on people addressing the issues that are causing their distress…if the focus is on stopping self-harm, people won't come. (C4)

Moving away from an emphasis on cessation in both case study groups meant a more holistic approach was taken in relation to how members engaged with each other, as wider areas and interest of group members' lives would be shared in the recognition that their self-harm was only one aspect of who they were and what united group members:

> We're not just self-harmers, no, we're mums or we're sisters and we've got this hobby and that hobby, probably similar to what some of the other group members have got, you know, we like watching different films or the same films and there's all this world, that's our world, and self-harm is one part of it, you know. (A3)

This holistic and wider approach meant the style of both group meetings were of an informal and relaxed nature, with laughter, food and drink occupying an important place in facilitating group discussions:

> We have a meal together and just have a chat and a laugh and a giggle…it's just part of sharing, it's another part of sharing really…I just thought it was a sociable thing to do and something that you would do if you had a crowd of friends in your own home…And it's part of leading up to the weekend as well to have that giggle, to start the weekend off on a good foot…during all that laughing and joking there is that element of what have you done during the week, what are you planning at the weekend, what are you getting up to and sharing, so it's like a positive thing to sort of carry you through the weekend if weekends are tough for you. (B4)

Likewise, in the group participant C4 founded self-harm was the commonality of experience that initially brought group members together, but over time discussions within the group broadened beyond self-harm itself to encompass the wider realities and relationships of the women's lives:

> It was never a focus of what we talked about in [name of group] we talked about what happens on a day-by-day, week-by-week basis, women talked about how they felt, what was going on in their lives, because that was the real issue the self-harm was just kind of the shared understanding that was sort of the base layer of understanding when women first started to come to the group they tended to want to talk about it quite a lot and then they'd move into just how things were and you know what was going on with their partner or their family or the things that were bothering them that were current in their lives that were causing them difficulties. (C4)

5.6 Contribution of the groups: Alleviation of isolation

In finding a safe space to meet, listen and talk to others who self-harmed, case study group members no longer felt so isolated and alone with their self-harm. This was enhanced by the safe space being a consistent source of support.

5.6.1 No longer alone

In case study group B the members spoke about the close bonds of friendship that had developed between group members, "*I don't know how we've managed it, but we've actually become friends rather than just a group of strangers*" (B4). The close bonds of friendship that had developed in the group meant members were often in contact with each other, through text and phone calls, outside scheduled meeting times, providing each other with a network of emotional and practical support that was open and transparent to other members:

> We're there for each other, we're always on the phone to each other, that's it really. (B1)

> I think it's unique because you do feel kind of like that you are sort of friends and I don't really know how that comes around, but yes, because you're all maybe experiencing all the same things and you know if one of us is in hospital we will go out and visit… you know I think we are all welcome to ring each other if we've got an issue and if one of us could help we would go to the extra bit of trouble of maybe ringing another person and saying "Oh I've just given this bit of advice do

> you think that's the right bit of advice?", you kind of feel everything is kind of double checked and you do it's not sort of you know if I phoned [B2] it wouldn't be kept a secret it would be quite open and maybe [B2] would ring [B4] and say "I've just said this to [B3] do you think that's advisable?"...it's a bit of a network. (B3)

The bonds of friendship in group A had changed from close relationships to "*loose friendships*" (A2), due to the quick departure of a number of key members from the group in recent years. Despite this, members from group A felt reassured that in times of distress they could contact other members of the group, usually in the form of a text message. These acts of support might appear quite small, but the impact for the individual in knowing that somebody was there for them and was listening to their pain and distress was highly regarded and valued:

> I won't say who it was, but one member of the group text me very late one night to say that she'd cut herself quite badly, she was waiting for an ambulance, and I was able to be there for her, we kept texting each other, and when she hadn't text me for a while I was making sure I text her to see that she was OK… just knowing that somebody's there when you text is really important, even if you don't say much, just send them like a hug over the phone and that means a lot. (A2)

Having a safe space where case study group members could go to meet and talk to others who self-harmed helped to alleviate feelings of isolation and meant most members no longer felt so alone with their self-harm:

> Because we're all in the same boat and we all know where each other's coming from…I can turn around and say "Guess what I did today", and not feel embarrassed about it. (B4)

> Coming to the group it makes you realise that you're not on your own that you're not going mad and that there are people that understand. (A1)

5.6.2 Consistent source of support

The regularity of weekly group meetings offered members a sense of reassurance and

comfort in knowing there was something and someone there for them:

> I think just the fact that we meet regularly and knowing that I have got that support there on a regular basis…it's like a safety net. (A2)

Regular group meetings also offered one group member respite from a stressful home life and were a motivating factor to continue attending the group:

> It gets you out of the house. You can sit at home and feel so depressed and going on the internet doesn't make you feel any better because you're still sat at home in those four walls, especially with me having kids at home driving me absolutely mad, it's nice to be able to get out of the house. (A1)

In times of distress disconnection from the group and its members might occur, but one member from group B spoke about how the facilitator helped her to reconnect to the group and brought her back "*to the fold*" (B2). Consistency of group meetings also helped those group members who struggled in social situations, providing a space where they could work on this:

> It gives routine coming…I do think it's helped me to socialise I do find socialising a bit of a killer and I think the more you socialise the easier it gets and yeah keeping sort of keeping in the circle of things. I think sometimes on a Tuesday and a Friday you might feel a bit crappy and not want to go out but it is only a couple of hours and from coming you get a load of sort of gossip from other people. (B3)

In addition, a small, consistent group membership contributed to the case study groups being considered a place of safety. Regularly meeting the same group members built close connections between members and facilitated a sense of security and trust where group members felt safe enough to share and confide:

> I think when the group is safe and it's the same people and there's a bond there, and people risk talking about more deep things. (A3)

5.7 Contribution of the groups: Personal development

Case study group members individually benefited through active participation in their groups. These benefits relate to self-awareness and understanding of self, social roles, managing/lessening acts of self-harm, and transformative effects at an individual and collective level.

5.7.1 Self-awareness and understanding of self

Some group members spoke about how, before joining the case study groups, they did not fully understand the reasons why they self-harmed: "*I didn't understand why I did it. I didn't understand why it felt good, nothing like that, I just did it*" (A2). Entering into a safe space where group members could talk and learn from other members helped to facilitate a sense of individual understanding and self-awareness:

> I understand why I do it and why other people do it...just when you hear other people talk about why they do it and how they feel after and you think, "Yes that's the same for me really". (A1)

> It's hard to say how it has, but I think hearing people say why they do it has made me realise, well actually that's probably why I do it…It's like someone's turned a light switch on. (A2)

Learning from others did not only occur passively through listening to other group members, as offering advice also benefitted the individual giving the advice, in that it helped to re-emphasise potential scenarios and triggers that could facilitate acts of self-harm occurring:

> I think listening to other people's experiences, and you know sometimes you hear a story and you think, "Oh god you've gone wrong all of a sudden because you've already said you've agreed to do something that you didn't wholeheartedly want to do" and yeah you do sort of see people's mistakes…so you sort of learn from experience and you can say to other people in the group "Do you know when I've done that and agreed to all of that and it really don't make you feel good"…I do think that's quite good and even if it doesn't benefit the person who you're saying

> it to "Actually you could try and do it different" it kind of mirror images to yourself actually I know from my own mistakes I would definitely do that different. (B3)

Becoming aware of the triggers, meanings and motivations behind their own individual self-harm meant for the first time many group members did not feel that they had to continue hiding or denying their self-harm. Group members felt able to admit they self-harmed to themselves and others within and outside the group:

> I'm more open about, if somebody asks me something about self-harm I'm very open with it and that's it. Although I don't go around and tell people about it, within the group situation I am very open about it and that's it, because I accept it within myself now. (A4)

5.7.2 Social roles

Whilst a formal leadership role was rejected in group A, most members had specific responsibilities within the group, including key holder (A2), treasurer (A4) and group mobile holder and point of contact (A3). Similarly, to aid member involvement and group ownership, the facilitator of group B had assigned formal roles, with distinct responsibilities, to all core members of the group, consisting of a chair (B2), liaison officer (B1) and secretary (B3). These formal roles provided some group members with a sense of purpose, achievement and identity beyond a 'self-harmer':

> It picks you up out of your little world for those few hours, throws you into something different whether it's typing a piece of paper up or so it does it and I suppose keeping commitments and turning up on the right times kind of gives you a routine. (B3)

Reciprocal relations between case study group members played an important role in both groups. Group members would reciprocally listen, learn from each other and offer mutual support and advice when it felt appropriate to do so:

> We all listen to each other, obviously, and then I suppose we kind of give some input, share what we think about it and if there's anything we can suggest to help

> that person…if someone's just having a bad time you don't know what to say but you just listen, sometimes you can perhaps offer a bit of advice or support. (A2)

The reciprocal support gained meant some case study group members felt their role within the group had widened to one where they wanted to transfer and pass on the support they had received over the years to new members entering into the group:

> I feel really quite responsible for the group in a way because I've been involved for so many years…I'd like to see new members come into it and be able to support them and give the support that I've received over the years. (A4)

> My reason now is to actually help other people, help other people and to sort of send the message out. (B1)

Active participation in the group also resulted in a number of unofficial, less formal roles in group B, with some group members taking on an educative, informative role in and outside of the group:

> I do a lot of public speaking…and even that's been built up from absolutely being terrified to sort of really being able to put down a set of notes and saying, this is it…If you saw me talk to people in the early days, particularly in front of a crowd, I was terrible. If I didn't have everything written down in front of me, I totally lost confidence and couldn't do a bloody thing…I was standing up in front of about 30 people just talking about self-harm, but pretty much still reading it so I didn't lose my place and I didn't panic. Then all of a sudden, for no apparent reason whatsoever I thought, I don't need that, and I threw it down and I actually spoke to them. And that got a much better response. (B4)

Additionally, in case study group B quasi-parental social roles were adopted by the facilitator and male member of the group, which brought with it distinct tensions that are discussed in the next section:

> I suppose as a sort of parental figure, although I don't want to be their parents, believe me, you tend to want to protect, you tend to want them not to see

> sometimes, you know, want to sometimes put them in cotton wool, that's what I used to do, I don't do that as much now because they've got to face life, I can't be that cotton wool around them all the time. (B4)

> It's really strange, it's like really being the father of the group. (B1)

5.7.3 Managing and lessening individual acts of self-harm

As discussed (see 5.5.3) neither of the case study groups' emphasis was on cessation of self-harm, yet the facilitator of group B reported that participation in the group had indirectly reduced group members' hospital admissions and rates of self-harm:

> We've actually reduced even myself hospital admissions and the need for psychiatric interventions for quite a few members…one of our members nearly went a whole year without self-harming, stayed out of hospital at a certain time during that year that they usually spent in hospital on a regular basis. (B4)

Whilst neither case study group emphasised cessation from self-harm, having the opportunity to talk to others with shared experiences, in a non-judgemental, safe space that provided a network of emotional support in and outside of the group, enabled most members within the group to lessen and better manage their self-harm:

> Not particularly to manage it, although that has happened. It just really helps being with people that understand why you do it and things like that really…It's more getting the chance to talk about it, because in everyday life you don't. But actually being able to talk openly about it makes a lot of difference because you're not going to get judged. (A2)

> It's not necessarily what the group's about but I have been able to manage my self-harm because I can talk to group members outside the group on a one to one basis who give me support like that, but it's not set up to do that, it just happens. (A3)

Being able to talk and listen to others with an intrinsic, direct experiential understanding of self-harm was identified by one case study group member as being the main contributing factor to her being able to control and manage her self-harm. In contrast, another group

member initially reflected a degree of ambivalence about the value of being able to talk to other group members, but upon reflection acknowledged that it was an important contributory factor in lessening her self-harm:

> It definitely supports me because I mean I haven't self-harmed for a long while so it has helped me tremendously, because I know there's support out there for me and that the group will help me…I think the management of it comes through us talking and if you feel, you know, by the time we go away from here we feel less bad, you know…I've been more in control of myself actually, because the group itself does that to you. (B2)

> I don't think it's made any difference to whether I self-harm or not, but it's helped me. I mean it doesn't make you do it more…I suppose probably in a way it perhaps does help, because if things are bothering me…I can talk to them here about it and perhaps that relieves some of it, so I'm not going to go home and self-harm, so I suppose maybe in a way it does…so yes, it can help to lessen it. (A1)

The lessening and management of some group members' self-harm was also attributed to the roles of responsibility that they occupied within the group. Being the 'facilitator' of the group and adopting a maternal, quasi-parental social role within the group meant participant B4 felt she had a degree of responsibility to other group members to present herself as a positive role model through managing and controlling her self-harm. Similarly, the male member of the same group, who had informally adopted a father figure role within the group, felt a degree of responsibility in displaying control and management of his self-harm, through fear of losing the respect of other group members:

> It's helped me extremely with my self-harm, because I can't be seen to self-harm if I'm looking after other self-harmers…So it's helped me to control it, not stop it, but it's helped me to control it enough to be able to function like a normal human being, unless at certain times when I go down the pan, which has happened, but thankfully is getting fewer and fewer as time goes on. (B4)

> It's like people are looking up at you and they're saying, "Well he's stopped self-harming", so you know I must say, if I kept self-harming you know in my eyes

> people of the group wouldn't listen to my suggestions, and actually now the suggestions I come up with, people are valuing them. There are times when I have wanted to self-harm, but the only thing that has stopped me is actually fear. It's a fear if I start self-harming I wouldn't stop and I'd do so much damage to myself and it's just like, I'd rather if I feel like I want to self-harm and that, I've got two options. I can phone another member or I can go down to the hospital to see the on duty psychiatric team. (B1)

The fragility of adopting a role where a group member feels a sense of responsibility to present themselves as controlling and managing their self-harm was unfortunately highlighted by a suicide attempt undertaken by the male member of group B (B1) nearing the end of my time with this group. His quasi-parental, paternal role within the group and fear of the damage he might do if he self-harmed were not secure coping strategies. Fear of potential negative medical consequences was also described by group member A4 as a preventative motivation stopping her from self-harming. This was also not a dependable coping strategy as the group member was hospitalised after an act of self-harm due to an underlying health condition:

> I think I'm touch wood going through quite a good period again anyway, I wouldn't say I never think about it but I'm in a different situation in my personal life and also that when I do harm myself badly I don't heal very well, so that is another criteria for me to consider. I have to think twice before I do it, because when I do it, I do it badly, and then unfortunately people have to know about it. So that's a bit frightening to me. (A4)

5.7.4 Individual and collective transformative effects

Participation and involvement in the case study groups had positive effects for some members that were transformative at an individual level. Over time, regularly attending and being actively involved in the group had gradually increased group member's B3 self-belief and confidence to such an extent that she had recently enrolled on an NVQ course and was undertaking a voluntary placement in her chosen area of study, which she stated: "*I couldn't have done that years ago that would have killed me the thought of it*". Likewise, attending the group, building friendships and finding a role within the group had

improved group member B1's confidence and self-esteem so that he was able to take these improvements outside the group and into other areas of his life:

> I can really say that the actual thing is, it's changed my life. It's made me more talkative to strangers, making friends and that…It's made me get involved with things and be able to build up my confidence…It has been quite a leap. It does happen very slowly, because when, to be honest, when I came into the group I didn't have any confidence, I felt lousy about myself, I felt, I can really say I felt like scum, you know. I only had a few friends who would accept me and I didn't have any acceptance, and by coming to [group] little by little things did change…it's just changed so much of my life. (B1)

In recent years a number of key members of case study group A have moved on from the group into work or study. The individual effects for current members were more subtle, but no less transformative, particularly in relation to acceptance. Finding a space where group members felt valued in a place where their own self-harm was accepted facilitated group members' own acceptance and sense of self-worth:

> Coming to terms with self-harm and actually finding people to accept you as you are is quite important, because even people that you think would accept you and accept the fact that you self-harm, a lot of people can't accept it at all, so it can be difficult. I mean obviously you don't want to force it in their face and say, well look, I self-harm, but just to sort of have somewhere you can come and be accepted. (A4)

Gaining a sense of self-acceptance meant for one group member that she felt confident in her own position to challenge stigmatising attitudes outside the group:

> It has been a great help for me because I can now talk openly to other people where before I didn't. So say, for instance, somebody outside mentioned, you know, "Oh she's just cut herself up", or something like that, I can approach them and say, "What is wrong with that?", you know, and then they can get more knowledge from me going through the experience. (B2)

Such transformative effects were not always intended and are often unforeseen, as participant C3 illustrated when she described how encouraging group members to consider different ways of framing and understanding self-harm had prompted one group member to question the diagnosis she had been given with her key worker. Participant C3 however struggled with the implications of this potential 'radicalisation':

> The first time I met her [group member] she came with a worker and didn't really say much, the worker kind of spoke on her behalf and by the end she said, "I'm actually sort of challenging the diagnosis that I've been given", and I was thinking, "Oh I hope it didn't come across like we were just, you know". We had a lot of conversations about different approaches and how some of them aren't very kind of supportive, and I definitely think that's important. I hoped that we hadn't by the end just kind of radicalised people against the medical model or anything like that. But maybe we did in a way I don't know. (C3)

Similarly, individual and wider collective transformative effects were an unintended but greatly valued outcome for the group participant C4 instigated. Being involved in raising awareness about self-harm locally meant individual members undertook a wide range of activities from which they were able to gain new skills. Adopting a feminist approach to understanding self-harm also meant the group had a political edge, which upon reflection participant C4 argued benefited the individual, group and wider community:

> Speaking from my own experience, I got skills and abilities and awareness from that that I would never have had. It opened my life up in some completely unexpected directions…just finding out what you're capable of, writing a funding bid, having meetings with directors of mental health trusts and, you know, stuff that I just wouldn't have done otherwise…I think they're not small changes, they can be across the whole of somebody's life, the change that brings about…being part of something bigger and knowing other women who self-harmed and their stories and commonalities and differences and recognising self-harm as a political issue as well, I think that was really important hugely important to me…that it wasn't just a space that wasn't just about coming and getting support that it was actually about understanding self-harm as part of a larger framework and we were really overtly

> feminist in some ways and I'm really happy about that. Looking back, I think it was really important for the group. (C4)

5.8 Summary of Part Two: Contribution of the groups

A number of individual and wider collective benefits associated with attending a self-harm self-help/mutual aid group have been identified. Fundamentally, the groups offered their members a safe space where they could meet, listen and talk to others who shared similar experiences. Finding a safe emotional space meant group members were able to learn from others and better understand the meanings and motivations behind their own self-harm. Regularly meeting and building trusting reciprocal relationships with other group members who shared similar experiences aided a sense of individual acceptance and belonging that meant group members no longer felt so alone and isolated with their self-harm.

The groups offered their members a unique form of support which was unavailable in other sources of formal and informal support, like statutory services and friends/family. Neither case study group emphasised cessation from self-harm, but finding a safe, non-judgemental space that provided a network of support in and outside of the group enabled most members to lessen and better manage their self-harm. Building friendships, feeling valued and finding a role within the group were crucial features that increased group members' confidence, self-worth and self-esteem, which were then taken outside the group and into other areas of their lives.

In part three of the findings the benefits of these groups are balanced with an examination of the identified challenges, tensions and dilemmas facing self-harm self-help/mutual aid groups.

Part Three: The challenges facing the groups

> *I think that being able to be part of a group is a really, really important choice and I think that it's important that people have that choice open to them and that they're aware what groups can offer them, but that they're also honest about the fact that it can be a difficult experience at times and why that might be, and I just don't think there is that honesty at the moment about the benefits and the difficulties…I think they're really, really important I think they're a really important option. I don't think they're perfect and I don't think they're suitable for everybody at every stage in their journey. (C4)*

The findings in Part Three are presented under the category of the challenges facing the groups that relate partly to the nature of their self-harm focus, which as the quote above illustrates have largely been ignored or under-explored, and partly to broader issues that relate to other self-help/mutual aid groups. Overall, there are six substantive themes within this category. Two of these themes represent external challenges and relate to *fostering links and networks* and *funding issues*. The remaining four themes are linked to group processes and dynamics and involve *group life cycle and focus, tensions and dilemmas of safe space, issues relating to harm minimisation*, and *leadership and responsibility*. To begin with, the external challenges will be presented.

5.9 Challenges: external to the group

There were two discrete areas of external challenges facing the groups, first, in relation to fostering links and networks, and second regarding funding issues. In some instances these challenges were shared by both case study groups, but in others they were particular to the individual groups.

5.9.1 Fostering links and networks

As previously discussed (see 5.4.2), the case study groups had faced resistance and concerns from mental health professionals about their value and safety in their early days of instigation. Despite these concerns and reservations some mental health professionals had played an important role in raising and endorsing the value of peer support for self-harm for group B members. For instance, the establishment of group B by a clinical

psychologist informed group members B2 and B4 about the notion of peer support, and the mental health counsellor who assented to the value of joining a self-harm self-help/mutual aid group provided B1 with the confidence to contact the group:

> I first heard about us through a flyer in [name] hospital…I spoke to my counsellor about it and he said it was a good idea me joining them…I contacted the group a couple of days after. (B1)

Differences between the two case study groups were found in the links and relationships they fostered with mental health services. For example, in group B a more outward looking approach to engaging and building relationships with statutory services was adopted through the group's outreach activities and initiatives to raise the group's profile by inviting mental health professionals into group events:

> We get them, we do get some of them come along, we get quite a few professionals come along. On the psychiatric side…not the psychiatrists, people like that, you know, OTs, yes, people like that will come along, anybody that's really concerned like nurses. (B2)

Through these active efforts case study group B was beginning to gain interest from some mental health practitioners in referring their clients to the group:

> We're actually getting more and more referrals in…for instance I had the CMHT phone me up yesterday about a guy…I sort of gave her a run-down of how we meet, what we do and stuff like that and she was quite happy with that and she said "Well what do I do next?" I said "Just give him the number if he's a self-harmer I'm available 24/7". I said "Just let him make contact and if he wants to meet somebody outside to come in that's fine". (B4)

In contrast, limited contact and involvement characterised the relationship case study group A now had with mental health services. The founding member suggested that recently the group had not been as active in its efforts to raise and maintain its profile within statutory services, to the potential detriment to the group's position and sustainability:

> We don't get many people come from hospital…maybe it's our fault we haven't got enough leaflets there, maybe we need to go and talk to them, show them the video again and try and say we're still here and we're still awake and open…I think our group has missed the boat in lots of ways, because when the National Institute of Clinical Excellence brought out their findings for the short term, looking after people who self-harm, they wanted service users to go into hospital, A&E department, and talk about self-harm, what's helpful, what's not helpful, you know, blah di blah di blah, and we haven't picked that up as a group. We should have done that, we should have been more proactive in doing things like that, but instead we've been very insular and just supported each other, whereas we should have been stronger and we should have been out there getting more known about. (A3)

Neither of the case study groups, however, was well-linked or networked with any of the national self-harm voluntary organisations and both were largely unaware of current debates and approaches, like those around harm minimisation. Instead, both groups had fostered links with local community organisations. For instance, group A identified a local voluntary organisation that supports and promotes self-help groups as an invaluable source of support and advice, from managing group dynamics and encouraging collective involvement to applying for funding:

> We had one person in the group who was being really disruptive and we didn't know what to do and so I went to see [name] at [organisation], who is used to supporting groups and she gave us some ideas of how we might cope with that…and just suggestions, things like everybody taking a turn in making a drink and about people putting 50p in to pay for the tea and coffee when we have to buy it, so only one person was responsible for buying it and it was a group thing, everybody put money into it, so it's group owned rather than it being one person's group…They help any self-help group that gets in touch with them, they will help them set up, help them to get funding if they can…they've helped us print out our aims, because if you're applying for funding you have to have a group constitution…the lady we see most is [name], she's very good, she actually helps us word things correctly and get them down on paper correctly, which is quite a big thing really. (A4)

Having an outlet where tensions and challenges could be raised and shared was identified by the founding member of case study group A as an important feature of the group's survival and development over the years, which was further enhanced by the point of contact being consistent:

> Importantly there's somebody there if you've got problems in the group that you can't resolve. There's somebody there you can talk to about it and they'll maybe get somebody from another self-help group to help you or they'll say what other groups have done and what's worked really…we are always aware that they're there and we can go if we have a problem, because we have had group problems, we have gone there and it's helped…we really couldn't do without [name] at [organisation], she's always been there, so it's been great having the same person, that consistency, yes, she's lovely, she's amazing…she'll help as much as she can. (A3)

Being located in a local mental health user-led organisation meant group B also had access to an external source for practical advice, although the level of involvement was not as great as for group A. Case study group B was also part of a local network of peer-led groups that were all funded through the same grant scheme, although the value of this was deemed limited by the facilitator of the group, hampered further by a poor relationship with the network's development officer:

> We just can't breathe the same air, it's just one of those things. (B4)

5.9.2 Funding issues

Lack of funds within case study group A was a source of worry and concern that threatened the sustainability of the group, particularly in relation to finding affordable, suitable meeting venues. Being member-funded, the group had limited resources to advertise and promote itself, which impeded its efforts in attracting new members and undertaking its awareness raising activities. Fundamentally, relying on group members to self-fund the group was counter to the vision of equality the founding member envisaged for the group:

> Often people who come to the group have got low incomes, so they can't afford to be paying for photocopying, leaflets and stamps and the mobile phone, all this, they can't afford that, and it's not about money, we want people to be equal. So I think it's really important that there is some money there…It will help us to be able to send our information out to more organisations and it will help pay bus fare for people to go say to the [hospital], or the different health centres to give talks or do whatever, help us get photocopying and stuff so that we can give out leaflets to people. (A3)

A lack of funds also meant case study group A could no longer offer social events outside group meetings. This was a source of frustration and disappointment as both case study groups had found activities outside the group sustained connections between current members, as well as establishing trust and confidence in new members:

> Because we talk about such deep issues within the group, maybe a new member wouldn't feel safe to open up to the group until they've seen us outside the group and got to know us that way, and then they feel more able to talk about things in the group. So I think you need that, to be able to go bowling or just whatever. And it's quite expensive to go bowling. I think it's important that the group is able to offer things like that. (A3)

> I think that's what has helped to bond us, is having that social side…Not sort of being all besty mates, because it doesn't work out like that, but just do something every now and again, even if it's once a quarter or whatever, just do something together as a group. Go out, have a bloody good laugh, we do. But it helps bond, it helps the bond, I don't know, people trust you more with all their little hidden secrets. People will tell you all the big stuff…She opened up in a way that she hasn't done before. I know for instance, I mean I knew she was a self-harmer, but I know now where she cuts and I know when it started, and now I've got something to work with. (B4)

Reflecting upon their own organisation and service provision, participants C1 and C2 reported that securing any funding for self-harm services remains difficult, primarily because it remains a stigmatised area that is associated with blame and accountability:

> There's quite a lot of blame in terms of funding culture, I think that's where self-injury struggles because it's seen as self-inflicted and the kind of sympathy and for people putting their hands in their pockets kind of diminishes slightly because of that reason even though we know that those reasons why people self-injure are very very difficult. (C2)

> It's seen as unattractive to fund you can't you don't know how anyone can it's not straightforward the kind of getting better or whatever it is. I just think all that is tied in with it somewhere, whereas something like cancer is almost like something that is awful that descends on somebody, nobody's fault and, I don't know, it just feels like we've got different attitudes to different things that have happened to people. (C1)

Specifically in relation to self-harm self-help/mutual aid groups, where the emphasis tends to be on members talking and listening to each other, participants C1 and C2 suggested that these groups struggle to secure funding as this emphasis does not fit with funders' ideals of task-oriented and time-limited groups:

> It does feel like group support is perhaps, I don't know, not so approved of or not so popular as it used to be. (C1)

> The perception that they should be doing X Y and Z instead, rather than getting together and sitting about and talking about self-injury. (C2)

Indeed, the funding secured for the group participant C3 co-facilitated meant the group and its members were expected to produce some sort of material object that could be used to educate and inform A&E staff about self-harm. Participant C3 felt that the basis for this was to prevent the group from developing into solely a talking group with no assumed focus or value, an opinion reflected, she reported, in the concerns of some mental health workers about safety:

> Part of the proposal and the kind of funding was there was £500 to create some sort of project that would…feedback to NHS staff how people wanted to be treated…I think as well the idea was in the proposal…to stop the group just becoming like a

> discussion without any focus, the project would provide a focus…my kind of take on it, that really people don't want to do that, they do just want to talk…Some people said that they felt their workers had discouraged them from talking about self-harm because they didn't want to feel like they were in like there was in fact a bit of a perception in some services and somebody actually said they'd been encouraged not to come to the group because their worker felt that talking about it would encourage them to do it more, so that was an interesting sort of attitude that I'd not really thought about, not really thought that people would think that. (C3)

In recent years, however, participants C1 and C2 reported that they had found it easier to secure funding for services with an upper age limit of 25 years. This meant women who had previously accessed their services were now no longer able to do so if they were older than 25 years:

> We've got the [name] service which was always set up for young people and we didn't really enforce the age angle at first but as it's getting more and more popular we're having to be a bit more stricter about or making sure people know that it's for 25 upper age limit so we have to be a bit cautious of our publicity in case we are inundated…It does feel like it's easier to get money for young people's stuff these days which is fantastic but at the same time we just had some feedback from somebody that had tried to use the [name] service but is aged 50 who kind of used the service and then realised that she's too old and is a bit like "Why isn't there anything, why there's a 25 age limit?" (C1)

Whilst case study group B was in the fortunate position of receiving a regular funding amount, at times the group had struggled to spend all its grant money. For instance, when I attended an end of year group finance management meeting the facilitator highlighted that they had not spent nearly 25% of their funding grant. This meant when they applied for the full amount of £5,000 for the next financial year the group was awarded what they had spent the previous year, which was 25% less than the amount requested. The facilitator of the group conceded that the largest overhead for the group was venue costs, which was 10% of their grant monies, but the remaining overheads, such as publicity materials, food and refreshments and the group's mobile phone were relatively "*small amounts*". Despite

this, completing the end-of-year financial accounts was identified by the facilitator of the group as an overwhelming source of stress and tension at times:

> Just keeping up with the paperwork sometimes is a nightmare, particularly the finance, because when I came into this job, although I'm not thick and could add up and take away, doing the finance to begin with was an out and out nightmare. Every quarter I just went into one of my nervy bees, purely and simply because you know, what am I supposed to do with this? Especially if something didn't add up right and you think, "Oh God, this is all my responsibility". (B4)

Additionally, the facilitator of case study group B felt that the current monitoring forms that she was expected to complete were not adequately capturing all the work the group was doing and hence was another source of frustration and stress:

> We're monitored as well, quarterly. We have to give out financial monitoring forms and like the quality and what we're doing, what the group's up to, how many members we have, has there been an increase, where they're coming from, what's their nationality, have they got any disabilities…some of our work's done over the internet through the website through outside people contacting us that they don't even know we're doing because it's not part of their monitoring forms. And then I just won't fill it in. I can say "Oh, there's three people turned up at group today", but then have 30 phone me up at some point or contact me during the day, so they can see three and think, "Oh, it's not really worth putting that on. But you look at the overall picture, it's very different. (B4)

Recognising that the current monitoring forms were not capturing all the group's activities, the facilitator of the group was considering seeking external support and advice on revising the forms so that they were more relevant and meaningful:

> It's quite difficult to monitor and I think maybe it's something we need to discuss with the development officer here, what's the best way for us to think about monitoring that sort of thing so that we've got basically proof in writing again, "Look we've done this service and this is actually what we're achieving". (B4)

Similarly, the monitoring outcomes set by the funder for the group participant C3 co-facilitated were also found to be inadequate and limited, as very few group members met the required age profile or consistently attended the group to complete the three stages of outcome monitoring required:

> We didn't have that many people coming forward that were in that age group of 16 – 25 years…and we only really had three people that were able to answer it from the beginning, middle and end perspective so the information wasn't that useful like the statistical sort of monitoring, but the anecdotal feedback is much more useful... like the quotes from people will be more useful than any kind of like graphs about how people felt at the beginning and end. (C3)

In addition, participant C3 also found the criteria set by the funder in relation to group size difficult to meet. As previously discussed, a small, consistent group membership was a key feature that contributed to the case study groups being considered a place of safety (see 5.6.2). Likewise, participant C3 reported that a small, discrete group was also favoured by the members of her group. However, this did not match the funder's requirements, as they wanted the group to consist of 12 regularly attending members, but despite participant C3's best efforts this number was never attained:

> The funders were like you must have 12 people, and like 12 people in this room plus two like facilitators is a lot of people, like it's not the biggest room, and also people like the first question that most people ask is, "How many people are in a group?", "I don't want to meet, I don't want to walk into a room full of people"…knowing that they weren't going to come to a room full of people they had never met was like quite important to a lot of people…I think in the first session there were five people, then there were four and then there were kind of two that would come, like it was two people but different combinations of two people for like quite a long time. (C3)

5.10 Challenges: group processes and dynamics

The internal challenges across and within the case study groups are thematically framed in relation to the group life cycle, tensions and dilemmas to do with the group being a safe

space, issues around harm minimisation and finally, leadership and responsibility challenges.

5.10.1 Group life cycle

In recent years a number of key members from case study group A had moved on from the group into work or study. The founding member felt these individual positive developments had had a negative impact on the group, suggesting that the group had become too complacent as a result of its reduced size. The founding member believed the group had lost its original reciprocal supportive focus and now provided an outlet solely for members to offload, which meant members gained and gave very little else:

> We've got stuck in a rut as a group because there's only four of us meet regularly now…Well, the group isn't very healthy now, I know it's not healthy, we need more people…Because the group's got no order to it now, we just say, "Oh how are you doing this week?", and people will talk, but I guess they won't talk in detail about being depressed or about having cut, although people do say if they've cut actually. But I don't feel like I am being, or the group is being very supportive to each other…just for the last year or so I think. We've got complacent…It's been just jangling, the group, four people meet but... I don't know if we support each other as well as could, we just tend to have a moan really I think that's what we do more. We say what's going on for ourselves but we just tend to have a moan about things I think. (A3)

Attracting new members was therefore the main pressing issue for the founding member of group A, who believed new members would help to renew the group by making current members revisit the group's grounding principles. New members would also bring different experiences to the group, which would stimulate discussions and encourage other members to talk on a deeper level than was currently happening:

> I think because we've got to know each other so much that we don't talk about self-harm…I think we need to do the ground rules again. I think it would be really good if we got two or three new people in and just went through the ground rules right from the start, what they wanted from the group and how it could be made safe for them to get these things. And it would be really, really good, set us back on track

> more…And to bring new perspectives to the group, each person brings their own unique perspectives of life and things. And I suppose it stops you getting complacent if new people come to the group or there's more people in the group, because you could become lazy and not talk about how you're really feeling, whereas in a group the more people are doing that, the onus is on you to do that too. (A3)

One member from case study group B also identified the value in new members entering the group, as way of reviving the group:

> I think it's kind of quite exciting, like "Oh there's someone new coming to join". (B3)

A sense of duty to attend group meetings was keenly felt in case study group A, hence the group was also keen to attract more members to guarantee the regularity of group meetings and to reduce a sense of obligation to attend:

> I think if, if there's four members, if one doesn't come then they're noticed more than if there were six people and then one doesn't come, so it can feel like a duty rather than something you actually really want to do…if we had more members then people wouldn't feel they had to come to the group if they didn't want to come to the group or they were having a hard time themselves and they felt the group wouldn't help them. (A3)

> I think as well you feel a bit guilty if you miss a week when there's only four of you, so you do tend to try and make sure that you do come, where some weeks perhaps you might not feel like it, but you feel, oh God, I've got to make the effort. (A4)

Similarly, in group B a small, core group membership meant at times it was vulnerable to meetings being cancelled at short notice, which was a source of frustration and disappointment:

> I had a horrible time on Monday, I really felt stressed out…and I thought, I'm at [group] tomorrow…but it didn't happen because nobody was there…I got a text saying [group] isn't happening tomorrow. (B2)

The founding member of case study group A's motivation to increase the group's membership was also connected to her desire to move away from the group by having a less central role within it. Currently there was no-one within the group who was stepping forward to take this role owing to time constraints or lack of interest. The dilemma facing the founding member was that if she ended her involvement with the group, there was the risk that the group would close:

> I just wish I could take more of a back seat now, I wish I could, yes, just be a group member instead of trying to get funding or trying to get more members or trying to do more advertising…I don't think the group would run if I didn't carry on coming and I think that's a real shame because it had got to a stage when we were saying to people at the group that if I didn't come to the group it would still continue, but I don't think it would now, although I think there's so few of us that maybe two of the group members would meet up weekly or something like that would carry on…that's a shame, because we've weathered the storm a lot, we've got through quite a lot together and it would be a shame…But maybe it is time, maybe the group's lasted as long as it should last, maybe the group should close. I don't know (A3)

Despite the founding member of case study group A feeling frustrated and fatigued with her continuing involvement, her attachment to the group meant it was hard for her to let go and hence she was willing to have one more attempt at renewing the group:

> The group was my baby then, it's still my baby…we've got to have one more big oomph and a push and get our leaflets out there, go and talk to people, get more visible and see if people come to the group, if we can get younger people. Or maybe if we could have another group for new people and then introduce them to this group, just look at different ways, we need to talk about it as a group, as a whole, and look at, what are we going to do and are we happy with just being four people. (A3)

The dilemma that faced the founding member of group A in relation to maintaining the group or letting it come to a natural close echoed concerns expressed by participant C1 in relation to ongoing self-help/mutual aid groups generally, the main concern being that such groups are in danger of becoming too inward-looking and potentially stagnant over time:

> I suppose my ideal is that there would be lots of different sorts of provision available but a group where people could feel safe to talk about whatever they wanted to talk about, but to have an idea of moving on or including other sorts of support at some point not just, you know, you just sit in this group for kind of the rest of your life and it could be seen a bit insular, couldn't it? (C1)

However, both participant C1 and participant C2 recognised that such a judgement was problematic as it is based on external outcomes and measures of value that may not reflect and match the individual's own, such as those around consistency, constancy and need:

> It's really hard not to make judgements about whether this is helpful or not and whether it would be healthier if you were doing something else…but who decides what is of value, isn't it what is useful to somebody else. (C1)

> But then is there value in there being one final kind of thing that doesn't change its regular it's always there…And if that is years in years out and the actual support quality may feel diminished the fact that it's still there is still a really vital support for some…It's so complex, people's needs are different and if that's what people need that's what they need and it's as simple as that…and if that is what is effective and that's how they feel supported themselves that's the only measure for me. (C2)

Indeed, as one participant from case study group A pointed out, whilst group members may become familiar with each other's difficulties and struggles over time, support can still be offered, so ongoing groups can remain a valuable and beneficial source of support:

> You can't say, "Well we've heard all your problems so we're going to close the group, can you really?"...you like to think, well, you could carry on for years supporting each other, you might have heard all what's happened with them in the past, but you're still going through problems, aren't you. (A1)

5.10.2 Tensions and dilemmas of safe space

Whilst a safe space was a feature highly valued by group members, it also raised a number of dilemmas and challenges in relation to exclusions, differing needs of group members and intimacy in face-to-face groups versus benefits of the anonymity and control afforded online.

Exclusions

In order to facilitate a sense of safety within the group, case study group A in particular was closed to those who did not have direct experience of self-harm. This meant that professionals, friends and family members were not allowed to enter into the group during meeting times. Whilst this rule had protected the safe space and differentiated it from statutory services, at times it had closed it to potential new members joining the group:

> It's very rare that we let anybody come into the group, it's really, really rare, because we've always, like I said, only people who self-harm can come into the group…we've had things like nurses and also people like relatives of people who self-harm who want to come into the group, or like when one woman came from our Medium Secure Unit, her nurse who accompanied her wanted to come in the group, and we've had to be quite strict about that, that no, she's not allowed, even though that has meant that on one occasion an Asian woman couldn't come to the group because we wouldn't let her mother come to the group, which is really harsh, but the group wouldn't have felt safe if she had come. (A3)

Over the years the boundaries around group A were re-negotiated to also exclude new members in acute distress. This judgement had been informed by a number of challenging incidents where the group had tried and struggled to accommodate those in crisis with the resulting effect of the group feeling unsafe. One of the most challenging incidents identified by the founding member was when a group member came to the group in a suicidal state. Group members felt ill-equipped to deal with this level of distress and the founding member felt to some degree annoyed and disappointed that the member had breached the group's and its members' limits of support:

> The worst thing that happened is somebody came to the group and said they were going to kill themselves after the group, and that was really, really terrible…I was

> very angry about it, I thought it was really, really bad that this person had done that…if somebody says, I am going to go and jump off [name] Bridge, what can you do?...If they're adamant they're going to do that, how does it make the group feel? Terrible, failures, inadequate, scared, all sorts of things it made us feel…I was quite firm with the person and the other group members thought that was wrong, that I shouldn't have been so firm. (A3)

After this incident the group amended its leaflets and flyers and clearly stated that the group was not about crisis support for those in acute distress. To offer this was recognised by the founding member of the group as being beyond the skills and abilities of its members and potentially risked individual group members' safety by making them feel responsible for another person's distress:

> That's something we've had to learn because we wanted to support people who had been in acute distress but it just hasn't worked, it's made the group unsafe and made the group so people don't come because they can't cope with things like that, because they become distressed by somebody else's distress. It affects them acutely and they might feel responsible for supporting the person or meeting the person outside the group and offering one-to-one support, but then they're not being supported properly. (A3)

However, despite the group's best efforts in clarifying who the group was for, this had not filtered through to some referral sources:

> I went out to meet a prospective new member of the group and it was very obvious to me that this person was totally, totally not looking for the sort of support we offered, she was actually the sort of person that was actually self-harming in the street and was in deep crisis herself and you have to sort of say to somebody like that, "I'm sorry, but we can't offer you a place at the group", and that sounds awful…it was like the Mental Health Team had pushed her towards this group thinking it was the answer to all her problems, which obviously it wasn't and that weekend I got a very nasty phone call from her mental health worker telling me off for turning her away from the group. (A4)

Although an open policy to those who self-harmed was endorsed by the group participant C4 instigated and founded, this meant at times women would turn up to the group in high levels of distress and need. On reflection, participant C4 also felt this had sometimes made the group an emotionally unsafe space for members:

> It was a space of unusual safety where you could talk about issues that just didn't feel kind of possible to talk about in that way in other company, so the overriding experience was feeling really safe, but absolutely women were coming to the group and it was an open group so anybody could come at any point in any level of distress with any number of issues of course there were times when it didn't feel emotionally safe, although I never felt that physical safety was an issue. (C4)

Case study group B, in contrast, did not have any exclusion criteria, except a minimum age restriction of 18 years, with those in deep crisis tending to use the crisis telephone for one-to-one support, rather than the group. However, a more subtle, if temporary, form of exclusion in both case study groups stemmed from their consistent, small membership. Whilst facilitating a safe space, this could make the group vulnerable to the development of cliques so that new members felt excluded, something one member of group A had experienced, and that the facilitator of group B was particularly sensitive to:

> Those three knew each other very well, so it took me quite a few weeks to sort of feel part of it. (A1)

> I had somebody on a Friday and they had a problem, it was talking about alcoholism and the fact that they're self-harm was bad when they were drinking. I said that I'd been to AA, I knew that route I had a good chat with them in a group setting, there were quite a few of us there that day. But one member came to me afterwards, because this member that was talking about the alcoholism was quite a new member, he came up to me and he said, "I don't like him". So I said, "Well why not?" He said I spent too much time talking about alcoholism. I said yes, I agree, but it was important at that time that we gave him all the answers and our points of view about how he could control his drinking and stop maybe to get his life together, he needed our help at that time….I said that's what we are about.

> We're not just…the select few and nobody else is allowed in…be careful not to lose members because your other members have actually shut them out. (B4)

Differing needs of group members

In both case study groups the average age of group members was the mid-40s, but in group B, the age range was wider and throughout my time with this group references would be made to younger members dropping in and out of the group and accessing its telephone support line. In group A, however, the clustering of members around the 40s and 50s, was felt to explain why the group had struggled to attract and sustain younger women:

> I think because we're all at a certain age…if you get somebody a lot younger wanting to join a group I think that can put them off that we're all a certain age range, but there's nothing we can really do about that. (A4)

Likewise in the group participant C4 founded a predominantly younger membership appeared to close the group to older women:

> Our youngest member was 15 we had a cluster of women round about 18 slightly younger than 18 the bulk of us were in our early 20s there were a couple of women who came who were significantly older but they didn't really tend to come back. (C4)

Varying needs in different age ranges were highlighted by participant C2, who felt that the life experiences of a young person between the ages of 12 to 18 years are often different to those of someone between 18 to 25 years old:

> I think also there's needs within different age groups as well…Even in a young people's group because the needs say from a 12 to an 18 year old are vastly different to the needs of an 18 to 25 year old, which you can kind of understand you know with life experiences going on for those different groups. (C2)

Tensions were at times keenly felt in the group participant C3 co-facilitated between younger and older group members. For instance, participant C3 reported that younger

women found it difficult to hear older group members talk about the realities and continuation of their self-harm, particularly in a life-threatening manner:

> I remember there was one session where somebody got really, really upset and actually walked out and left, that was quite a young woman and she was very shocked by what the person had been talking about, doing like self-harming in quite a life threatening way and I think she was really shocked and walked out. But I contacted her after and just said, "Is there anything you want to talk through?", and she just said, "I couldn't hear that stuff, I didn't want to hear it so I left"…and it felt to me when I spoke to her quite briefly that it was the shock of like hearing somebody in their sort of forties still kind of... and I don't think... from what she described about her experience it wasn't life threatening, and for her to hear that somebody was doing it or, you know, putting their life at risk was difficult to hear. (C3)

Similar situations had occurred in the group participant C1 facilitated, as the majority of the women attending the group were older and had been accessing services for a number of years. When younger women would enter the group, participant C1 felt that the group could be perceived as a discouraging place for younger members, as it potentially presented to them a lack of hope and prospect of change:

> Quite a few of the members were people that women sort of age who had been in contact with mental health services for a long time, you know, who were, I don't know, chronic is the sort of word I'm thinking of really, who had been self-injuring over a long period of time and who had probably got other kinds of difficulties, and had been in touch with services for a long period of time. And then every now and again a young women would turn up whose like 18 or 22, you know, something like that, maybe a student in [place] or something like who had come to the group and it would just feel like such a different, so different and I think something really discouraging for that person to see women who you know imagining you know is that the only sort of path for me sort of thing. (C1)

Differing needs in relation to gender were also identified by the case study groups as an issue in facilitating the group's safe space. From the outset, group A had prioritised the needs of women by excluding men from the group to enhance the safe space:

> I don't think I'd have felt so comfortable if there had been men. I'm not saying my problems are caused by men…I just wouldn't have felt so comfortable if men were included. (A1)

> We don't tend to have men involved because some of us have got problems with men. (A2)

In contrast, group B had run for a number of years as a mixed group, but during my time with the group members had decided to offer an additional women only group to facilitate a safe space for those women who might struggle being in a mixed group:

> We've always wanted a women's only meeting, because there are obviously issues in women's backgrounds, some of which has got to do with sexual abuse in the past etc. that they wouldn't feel comfortable talking to a man about. (B4)

Anonymity and control

A sense of safety within case study group A was to some extent only partial for two group members, both of whom were accessing online self-help forums for additional peer support. The anonymity associated with participating in these online forums was felt to offer an additional sense of safety and control that the face-to-face group itself could not provide:

> I kind of like the anonymous bit of it. It's kind of feeling safety, because you can say things to people and not worry that they can see your face. You know you're very, very rarely likely to meet them so you kind of feel safer. (A2)

> If you're talking to somebody on the internet you could be more honest about how you were feeling because they can't get you and they don't know who you are…because you're keeping in control. (A3)

The assured anonymity online meant customary rules of face-to-face engagement did not have to be observed, as questions did not have to be answered immediately, if at all:

> You can say, "I can't answer you right now, but I'll send you a message later"… I think one of the main things about the internet for me is that if I don't feel able to answer a question I don't have to, because I can just say, "I've got to go now, I'll talk to you later." Whereas if somebody asks you a direct question in a group, you feel like you need to talk and answer the question. (A2)

Guarantees of anonymity online also meant one member from group A felt safer in making more critical statements than in a face-to-face group setting:

> I think they're both very different, internet support and group support, they're just very different. They're different in that they're anonymous, they're different in that probably somebody on the internet would dare to say something that somebody wouldn't say face-to-face in the group. About how they're feeling about the service or about the way they've been treated. They wouldn't feel able to say it on a personal level, one-to-one in a group but would be able to say it on the internet. (A3)

Whilst some members from group A felt that in some respects greater safety could be attained through accessing online groups and forums, this was nevertheless outweighed by the opportunities for real intimacy and care that can occur through meeting face-to-face. In a face-to-face group, members can hug and remind each other of their strengths and contributions, and problems can be acknowledged and discussed immediately:

> We can get real human contact from a group, because you get a hug from somebody, you get more intimacy…We can also remind people how brilliant they are, because often people feel real crap and not very good as people, but then we can remind them of what sort of things they've done in the group and how they've made us feel better and things like that. (A3)

> I prefer the group. I like to meet people face-to-face. When you're just getting messages it doesn't mean so much, does it, as when you can sit and talk things

> through with somebody. You can see how many people have viewed it because I've posted quite a lot on it recently…and loads of people have viewed it but hardly any people have replied, and so that makes you feel a bit, you know. So I much prefer to come here and talk to these about it. I think the difference with coming to a group, you can talk about things and you get responses straight away and you can have a discussion. When you're posting on the internet it could be one or two days later before you get a reply and by then those feelings that you had at that particular time have long gone. (A1)

Lack of access to the internet and unfamiliarity with computers were the main reasons members from group B were not using online self-harm groups and forums. However, one group member had made an active decision not to engage with online support over concerns about safety:

> I've heard some a few horrific stories of websites that people have found so from just hearing that I'd steer well clear because if I was in a crisis and went to a website and they didn't give handy advice and you were vulnerable, I think you would maybe be inclined to follow it, so no, I wouldn't. (B3)

5.10.3 Issues relating to harm minimisation

In neither case study group was the emphasis on cessation of self-harm; rather as previously discussed (see 5.5.3), the emphasis was on supporting group members to manage better. Hence acceptance and understanding of an individual's need to self-harm at times of distress underpinned the ethos of both groups. Finding such acceptance was experienced as immensely valuable, but it also brought with it nuances in relation to looking forward as very few group members, from either case study group, spoke about or envisaged a time when self-harm would no longer be part of their lives:

> It's like hearing voices you can never get rid of it, there's no cure for it. There's no medication you can take but you can learn to live with it…you never seem to give it up actually if you self-harm…You're not proud of it, but as [B4] would put it, it's part of your life, it's you. (B2)

There was, however, one exception, in that the youngest case study group member explicitly expressed clear hopes and goals for a time in the future when she no longer self-harmed:

> I have a bit of a different view about it. I hope to stop. I don't hope to learn to live with it, I do hope to stop. I hope that through recognising why I do it at the time, distressed and often when I'm really distressed I hear voices, but I know when I hear them that I'm really distressed. So by sort of making the link I do hope to one day stop and it's sort of, yeah the gaps get slowly bigger and bigger apart but it's. you know every time it crops up it's kind of devastating because I think, "Oh I really thought I'd never do it again", it does normalise coming and having other people to talk about it with, but I try and think you know… I choose to look at it as, "Yeah that's the bit of me that's not quite right" if you like, but I accept that I do it in a bad time…I'm kind of working towards hopefully never doing it again, but you know you can't say that. (B3)

This at times meant group member B3's hopes and goals differed to those of other members, as she felt it was important that the group discussed alternative ways of coping, particularly for new members, as a means of offering hope and possibility of change:

> I don't know, I think it changes because the older members of the group would say that they're not going to stop, but in my opinion the aim is always to stop, so I think it's kind of up to the individual… In my head I would like to manage a bit better and eventually stop, so yeah, because I sometimes feel a bit horrified when people say you know, "I don't want to stop", and I think "Oh you don't want to stop", but I suppose it's the individuals choice and you have to kind of respect that, but I think, I think it's important that the group, you know, the elastic band theory, snapping it on your arm, drawing on yourself in red pen I think it is good that people know there are other options and then it's the individual's choice whether they try something or they don't. (B3)

Whilst other group members, from each case study group, did not explicitly refer to or envisage a time when self-harm would no longer be part of their lives, nearing the end of my time working with group B the facilitator's expectations and assumptions shifted. This

shift was instigated outside the group and occurred as a result of attending a talk delivered in the local community by a consultant psychiatrist. Having previously felt self-harm would always have a role in her life, she now felt hopeful and optimistic that there might be a time in the future when she no longer self-harmed. Such a shift in position illustrates that hopefulness and the possibility of change can evolve over time:

> I saw myself as here to help everybody else. I sincerely believed that at the age of 49, having been self-harming for so many years, that there was nothing anyone could do for me. I thought my sole purpose was here to look after other self-harmers and to get them better, because they were younger and they had that chance, but I didn't dream that it would be possible for me…To make these changes. Okay, some will be easier than others, but even just the belief of knowing that yes, it's possible, well you can tell, I'm just brimming with it, I just can't get enough of it…it's the only time I've actually listened to a psychiatrist where he's actually made sense. (B4)

The current age restrictions in funding for self-harm services described earlier (see 5.9.2.) were considered by participant C2 to be linked to the notion of hope and change being associated with youth. Hence participant C2 thought the underlying assumption was that those under 25 years are more likely to stop self-harming with support and thus are less likely to need services in the future:

> I think it's kind of linked to hope. I think if you can support young people's hope that they won't become entrenched in services, as they won't have as great a need in the future. There's probably more money generally sloshing around for young people…I think it's also linked to change as well. Young people can potentially be seen to change their problem; maybe adults are seen to deal with their problem and keep it on a level playing field, maybe that hope that possibility is seen greater in young people and therefore young people's funding is greater. Maybe cynically they'll be less dependent on statutory services in the future if they'd helped supported when they're younger. (C2)

But such an assumption, as participant C1 pointed out, ignores and further marginalises those above this age range:

> It is quite difficult I think because I do believe this thing, in a way, if we meet the needs of younger people perhaps there won't be the sort of population of older people who need that, but actually those people are still there. (C1)

Similarly, the terms of the funding grant for the group participant C3 co-facilitated meant the group was initially only open to women between 16 to 25 years, although this was abandoned in agreement with the funder when they struggled to recruit women in this age range. Participant C3 felt linking the possibility of change with age to be a particularly damaging message. Indeed, she reported that it was a message older women in the group were not immune to, describing how such women had felt ignored and distressed in believing that they had missed their chance of stopping their self-harm:

> And people who were older, like in their sort of forties, were talking about if they'd been supported well, they felt that if they'd been supported effectively when they were younger they wouldn't still be in the situation, and they felt very distressed that they felt that it was not going to end, they'd kind of missed their opportunity to get the support they needed to stop doing it, stop self-harming... if services are kind of saying, "Well, we can't help you because you're over 25" and then women are thinking, "Well I can't be helped because I'm over 25". It is a very damaging message. (C3)

5.10.4 Leadership and responsibility

At an individual level, running and maintaining a self-harm self-help//mutual aid group could at times be emotionally challenging and burdensome in relation to keeping momentum going and to boundary issues, both intrinsically linked to the style of facilitation and the external support available.

Keeping momentum going

The case study groups and phase two participants, who facilitated peer-led groups, approached leadership differently. For instance, the facilitator of group B and participant C3 both felt a sense of responsibility in keeping things going within the group. This related to the overall running of the group for the facilitator of group B, whereas participant C3 felt responsible in keeping the momentum of the group discussion going, but both adopted a more directive approach in their leadership styles:

> We'd start talking about how the week had been and people would, and just kind of like, gently encouraging people to speak about certain things or asking questions about that, sort of like not wanting people to feel like they had to say anything, but keeping the kind of momentum going, that was quite a new skill… So I did feel a responsibility to kind of keep it going. (C3)

> I'm in a position where I'm in charge here and in charge at [group]. I suppose the sensible thing is, don't put yourself in that position in the first place. (B4)

Recently the facilitator of group B had begun to realise that the pressures involved in assuming responsibility in the overall running of the group could be minimised if a shared approach to leadership and responsibilities was taken:

> I think it's also important, which I struggled to do to start with, was actually getting other people to do other stuff and to say, "Right, look, I can't do it all, I need to delegate some things to people"… I find that hard. (B4)

In contrast, leadership and responsibility for participant C4 meant making things happen, rather than "*running it*". Likewise participant C1 felt her role within the group was to hold the group together rather than leading it:

> I think it needed someone just kind of holding something together. (C1)

Over the years the founding member of case study group A's leadership style had evolved from one where she felt a degree of responsibility to keep momentum going, such as with group discussions, to one where she felt comfortable to let the group and its members decide and lead the flow of momentum. In some instances this meant being comfortable with silence in the group:

> We had no idea how to run a group to be perfectly frank with you. And so I think, we just talked incessantly and couldn't allow silence really, we thought we had to talk all the time… If other people were quiet you thought you had to, and then I suppose gradually we learned you don't have to and people will chip in if they want

> to, or they might want to be quiet anyway, that's okay. Silence is very unnerving I think, until you're used to it. (A3)

Boundary issues

The directive approach the facilitator of case study group B adopted in the running of the group meant she felt largely responsible for leading and delivering tasks within the group, like completing funding records and monitoring forms. But it was being solely responsible for the 24 hour crisis mobile telephone support that she found to be most burdensome and which at times affected her own well-being and relationships with others:

> I've had calls at all times, including again, quite a few at 4 o'clock in the morning…because the Crisis Line is down as 24 hours and I do, God help me, I do answer or say, leave a message, I'll phone back, or something like that… I've just had enough, I'm drained. I'm drained, I'm gone. I just can't pick up another phone for a while, you know. And then of course that affects your own relationship with people... even my partner, he said he never sees me anymore and he said, "You give up all your time for them, you haven't got any time for me", sort of thing. I think yes, but you're not in trouble, I'd rather help the people that's in trouble still. But it does take over your life. (B4)

Even though the funding grant group B had secured placed geographical boundaries on the group (as only those living in the local borough were entitled to access the group and its services), it was a boundary the facilitator of the group struggled to adhere to as it conflicted with her own personal motivation of helping others. Consequently, she would provide support to whoever contacted her, regardless of location, which left her feeling further overwhelmed:

> When I started I used to break down on a regular basis just under the pressure of dealing with [group] and the people… and I could limit it, I could limit it if I stuck to the rules, which I'm not very good at sticking to rules, admittedly, because I am literally only supposed to be helping people in this borough, but I can't do that. If somebody phones me up from Wandsworth, from the Isle of bleeding Sheppey or wherever and they say, "I'm a self-harmer, can you help me?", I will say, "Yes, come on, let's have a chat about it, what's happening, have you had any input at all

> in the past?", find out where they are, try and find out if there's a group local to them. If there isn't, I will just say to them, "Right, keep my phone number, if you're in trouble, phone me". I won't turn people away. I can't. (B4)

The facilitator of case study group B did not only feel a sense of responsibility in leading and delivering tasks, but she also felt a degree of duty to keep group members safe, which was intensified with the suicide attempt by the male member of the group:

> I do panic if I think he's gone missing and so now he regularly keeps contact with me and I always write it down now when he's away and when he's due back and, like I said, he's going away this weekend and the first words out of my mouth were "Where are you going." And he didn't have an idea but I said, "You will keep in touch?" and he knows that I will sit at home and worry and he doesn't want to put me through that no matter what he's going through. (B4)

A shared rule in both case study groups was around "no rescuing", which was established to maintain group member safety. This meant group members were not expected to immerse themselves too much in helping others within the group to the detriment of their own well-being. However, this was a rule the facilitator of group B particularly struggled with:

> Because I'm one of life's rescuers, it actually says in our ground rules, do not rescue people, but I fail that one every time. I just never want anyone to have to go through what I had to go through when I was younger. (B4)

Through wanting to protect and support other group members the facilitator of group B struggled to share and confide in members in the group and gain support. This was in contrast to the position taken by the founding member of case study group A, who adopted a less protective position by being open and honest about how she was feeling with other group members:

> I will sort of confide in them and say, "Yes, life's a bit shit sometimes", but when I know they're vulnerable then well, I just wouldn't, I would put on a front to them that everything was fine, everything was great, even if I've gone home and went

> boo-hoo, because I would not want to put anything else on them. But when they're strong, they're there for me, you know what I mean? (B4)

> And that we haven't… got to be always OK, like we could have difficult times too, we weren't the leaders who were fine, we were just jogging along like the other people and having difficult times and then having OK times. (A3)

In case study group A, the members were quite clear what their boundaries of responsibility were to each other as none felt they were responsible for taking on and feeling burdened by other group members' difficulties:

> We're a self-help group, we're not to support everybody else…when you go out the door you leave that behind. (A1)

Clarity in boundaries of responsibility had taken members in case study group A time to negotiate to the point where they no longer felt responsible to "*fix things*" (A3). Instead, the group policy was to signpost members to other more appropriate sources of support:

> We signpost, so we'd say, have you tried such and such, or did you know you can get counselling from this organisation, or there's a walk-in centre where you could go and get steri-strips, so we can give them information but we don't feel responsible that we have to do something. To sort out somebody's problems or to give them immediate support, we will try and help them find somebody else, but we couldn't do that. (A3)

External facilitation and support

At times, not having anyone within case study group A who adopted a leadership role had caused difficulties, particularly when another group member was in a distressed state and no-one in the group would take on the role of managing the situation:

> I think the only time we've felt we needed it facilitated is when things have come unstuck in the room, like when one person gets really stressed and the group as a whole feels as though they can't cope with that, they just get worried about that.

> There's no one person who will take over responsibility for supporting that person, so I think that's when there's a difficulty. (A3)

Whilst direct experience was identified by both participants C1 and C2 as beneficial in running a self-harm self-help/mutual aid group, both also raised concerns over the distinct challenges this can bring in threatening the sustainability of the group and limiting the support a key member might receive:

> Personal experience is helpful as well, but it can all just be too close I think, because that's fine if that person is in quite a good place, but if they're going through, if they're kind of the key person and they're going through a difficult time and you can't actually hold the group together, then I think it's difficult for everyone.So I think maybe that sort of point they did pull facilitation in, so with people that were kind of known a bit but weren't actually wanting to be group members at the same time. (C1)

> It limits support for those people as well, doesn't it? Because even if they're willing, even if they are in a good place and happy to kind of facilitate, the relationship with others varies, it's not quite the same if they were just coming in as a group member. (C2)

But participant C3 believed sharing her own direct experience of self-harm with members of the group had helped to facilitate a deeper connection with group members:

> My own personal experience…made people feel comfortable that we kind of knew where some of their feelings what some of the feelings were like… I kind of said to the women like the reason that part of the reason why I was recruited to facilitate the group is because I've had my own personal experience, and I said, like, obviously everyone's experiences are different and I wouldn't say that I can understand everything that you feel about it, but I just want you to know that I have my own journey around it, so that I think. And people did seem to really respond to that in a kind of like, "Oh right, you know, that's different to some places", so it seemed to be helpful. (C3)

External support was identified by participant C1 as important to those leading a self-harm self-help group, "*I do think having some external support away from the group is really important*". During my time with case study group B, the facilitator was also starting to recognise her need for external support and planned to budget for it in the following year's funding application for the first time:

> At the moment the core members, I call them, have each got a problem and if I had a problem now, I haven't, as luck would have it I'm feeling quite strong, but if I had a problem now, who do I go to? I couldn't go to them, I need something external, because if I went to them I could crush them, they've got enough problems of their own at the minute… What I'm in the process of doing… is to get some support yourself, it's important that you've got that support yourself, because it can take you over and it can drag you down as well as it can lift you… You need to be able to take that outside to someone you can trust… I have put that in the budget this time, because we're growing as well and it's getting, it does get hard at times, especially if I'm not on top form, it can sort of weigh you right down. (B4)

Similarly participant C3, who also felt responsible for maintaining momentum in the group, had found the role burdensome at times, but this was alleviated by sharing the challenges and demands of the group with a co-facilitator:

> It was interesting, the week that went quite, was really heavy and quite difficult, that was the week that [co-facilitator] wasn't there, and it really I really noticed that sort of like there wasn't somebody else to, I don't know, almost like be in the room and hold it, and when the person left she could have, if she'd been here, could have like gone after. So we decided like it would be best not to do it with just one person. (C3)

5.11 Summary of Part Three: challenges facing the groups

Attending a self-harm self-help/mutual aid group brings with it many benefits at an individual and wider collective level, but it nevertheless raises a number of internal and external challenges. External challenges facing these groups relate to the ongoing difficulty in fostering and maintaining appropriate links and networks. Such links and networks have

been identified as playing an important role in the sustainability of the group with new members being signposted to the group and the group having a source of external support and guidance, but fostering such relationships takes time and resources. A lack of funding had impeded group A's efforts in maintaining its presence with other potentially beneficial external links, but the security of a regular funding amount can also bring with it distinct challenges, such as those to do with spending the full awarded amount, monitoring forms and funders' expectations.

Whilst these external challenges could threaten the sustainability of a group, internal processes and dynamics were also found to impact at an individual and wider collective level. The ongoing challenge of attracting new members to the group as a way of securing its survival was juxtaposed with the potential lifecycle and lifespan of the groups. The nuances in establishing and maintaining a safe space for group members meant features that facilitated this also could threaten group development and sustainability, particularly those around exclusions, differing needs and levels of intimacy. Finding acceptance from others and within oneself in relation to self-harm was a feature of the groups that was personally highly valued, but the findings presented indicate that it brings with it unique challenges in maintaining a message of hope and possibility for change. In addition, the individual impact of taking a leading role in running and maintaining a self-harm self-help/mutual aid group cannot be underestimated. At times that role could be burdensome and overwhelming, particularly if a more directive, controlling leadership style was adopted.

5.12 Chapter summary

The findings presented illustrate that self-harm self-help/mutual aid groups can offer their members a unique form of support that is largely missing in other sources of informal and formal support, like statutory services and friends/family. Finding a safe, non-judgemental space where group members can meet others who self-harm assists in breaking down the isolation and loneliness commonly experienced. The commonality of experience between group members facilitates an implicit understanding and acceptance between group members that often means the support offered is received as heartfelt and genuine. Situated outside dominant models of support, these groups offer group members a different approach where individual control and harm minimisation is emphasised, rather than there

being a focus on cessation powerlessness. The findings illustrated that such groups can benefit group members individually but also that the effects can be at a wider, collective level, with some group members taking on an informative and educative role outside the group. However, these groups are not without challenges and tensions.

The resistance and concern self-harm self-help/mutual aid groups generate in relation to their benefits and value can make the fostering of external links and networks, particularly with mental health services, challenging, especially if these are not continually maintained. But such links can be a useful form of support and a potential source of client referral that can assist in the sustainability of the group. As with other types of community groups, funding remains an ongoing struggle and challenge, but often crucial to securing suitable and appropriate meeting spaces. The terms of some funding grants can also hamper the delicate and distinctive ethos of such groups owing to an emphasis on monitoring and outcomes.

Challenges related to the internal group processes and dynamics are varied and very often nuanced. Thus exclusion of those without direct experience from the group is a feature that can be valued in facilitating a safe space, but also has been shown to potentially impede group development and sustainability. Similarly, finding acceptance within the group can potentially promote a message of no hope of change, a message that appears to be endorsed in statutory services with services being restricted to those younger than 25 years of age. At an individual level, running a self-harm self-help/mutual aid group can be emotionally challenging and burdensome, but such challenges appear to be very much influenced by the leadership approach adopted.

In the next chapter these findings are considered and discussed in relation to the wider literature.

Chapter Six
Discussion

6.1 Introduction

This chapter discusses the main findings of the research that aimed to explore the role of self-harm self-help/mutual aid groups from the perspective of group members and those who support these groups. The findings are contextualised within two frameworks of inquiry. The first framework examines the individual and wider gains of participation in self-harm self-help/mutual aid groups. The second framework considers the competing tensions and dilemmas specific to the running and development of self-harm self-help mutual aid groups.

The implications of the findings are then presented in relation to self-harm self-help/mutual aid groups, self-help/mutual aid groups generally and the area of self-harm specifically. This then leads to a discussion of the implications of the findings in relation to the barriers affecting the development of self-harm self-help/mutual aid groups. The practice implications for funders, practitioners and groups themselves are then examined.

In a final section my own personal learning, through undertaking this research, is shared and the chapter concludes with an overall summary.

6.2 Contextualisation of the research findings

6.2.1 Individual and wider gains of self-harm self-help/mutual aid groups

The research findings are firstly considered in relation to the benefits participation in a self-harm self-help/mutual aid group can offer. Direct individual gains relate to: feeling less isolated and lonely; finding others in the same boat; receiving support from those who understand; gaining new trusting supportive relationships; feeling less stigmatised; gaining confidence in new roles. The findings from the study also illustrate that wider gains are attributed beyond individual ones and are presented with an emphasis on: active participation and contribution; subtle forms of local resistance; challenging silence and stigma.

Individual gains

Feeling less isolated and lonely

Self-harm is an area that continues to remain heavily stigmatised and surrounded by misconceptions and judgemental attitudes (Sutton, 2007). Therefore, it is perhaps not altogether surprising that the case study group members preferred to try and keep their self-harm hidden and concealed, rather than risk potential judgement and misunderstanding. The effectiveness of strategies of secrecy and withdrawal to avoid negative stigmatising reactions is not, as Verhaeghe and Bracke (2011) argue, always guaranteed. Instead, such strategies can have a detrimental effect, as withdrawal often impacts on an individual's wider social relationships and, as findings from this study illustrate, compound individual feelings of isolation, shame and loneliness. Conversely, the findings from this study illustrate that having the opportunity to meet others who share similar experiences in a self-harm self-help/mutual aid group can minimise the negative effects associated with withdrawal and secrecy, by reducing individual feelings of isolation and loneliness.

Participants' reports of feeling less isolated and lonely, through attendance of self-harm self-help/mutual aid group, echo findings from the study by Smith and Clarke (2003) that examined members' individual experiences of attending self-harm self-help/support groups. In this study Smith and Clarke (2003) found that more than two-thirds of participants reported feeling less isolated from attending their groups. Likewise in the study by Corcoran, Mewse and Babiker (2007), which examined the role of self-injury support groups, group members also reported that they no longer felt so alone through participation in their groups.

Finding others in the same boat

Entering into and regularly attending their groups, most case study group members gradually realised they were not alone with their self-harm and that there were others like them in the "*same boat*". The value of meeting others who share a similar condition or experience in a self-help/mutual aid group has been identified as having a powerful role to play in reducing feelings of difference (Helgeson & Gottlieb, 2000). As the condition or experience is collectively shared, this can facilitate a sense of normalcy and likeness, thus alleviating the negative effects of perceived difference (Adamsen, 2002; Yalom, 2005).

Before entering into their groups, few opportunities presented themselves to case study

group members where they could meet others who shared similar experiences face-to-face. Instead, a limited or lack of available formal, and indeed informal, support largely typified group members' experiences. Friends and family often struggled to understand and accept their self-harm and few received support in statutory services. This lack of support echoes Pembroke's (2006b) claim that support for those who self-harm is often only available for those in acute crisis or those who have a specific mental health diagnosis.

This void of formal and informal support for those who self-harm appears to be in contrast to the experiences of members of self-help/mutual aid groups more generally. Munn-Giddings and McVicar (2006) argue that there is misconception that those who attend a self-help/mutual aid group always have limited social supports. Instead, they maintain that many group members do have outside support but fundamentally they are looking for something qualitatively different, which is only available from people with experiential knowledge. Whilst some group members within this study were actively looking to meet others who shared similar experiences, for many the peer support provided in the groups was the only form of support they received in relation to their self-harm. The case study group members' lack of available formal and informal support reflects Smith and Clarke's (2003) finding that self-help/mutual aid groups are often the only option for people who self-harm to gain support.

Receiving support from those who understand

Concerns and reservations by some practitioners and professionals remain that a self-harm self-help/mutual aid group might increase group members' levels of self-harm, through the sharing and comparing of techniques (Babiker & Arnold, 1997; Sutton, 2007; Inckle, 2010). However, such fears were found to be unsupported in the findings from this study, as the dialogue within the group was not about the "*mechanics*" of self-harm, but more to do with the issues behind it. Receiving support from those with shared experiences and having the opportunity to be able to listen, reflect and talk to other group members about their self-harm facilitated individual understanding and learning about members' own self-harm.

Borkman (1990) notes that it is through this process of sharing personal stories that group members can identify commonalities and idiosyncrasies of their experiences to others and reflectively learn from one another and ultimately find better ways of coping. The aims of

both case study groups emphasised improved coping and management, rather than cessation from self-harm, which echoes findings from the small body of research in this area (Smith & Clarke, 2003; Parker & Lindsay, 2004; Arnold, 2006). Whilst the groups did not advocate self-harm as a suitable coping strategy it was accepted as a reasonable response in coping with distress, ideas that are more akin with a survivors' framework of understanding self-harm (Pembroke, 1994; Smith & Clarke, 2003; Shaw, 2013a).

Findings from this study also indicate that having an emotionally safe, non-judgemental space where members could talk, listen and offer each other support, in and outside of the group, enabled most members to better manage, and indeed in some cases to lessen their self-harm. This substantiates the ideas suggested by Corcoran, Mewse and Babiker (2007) who argue that sharing similar experiences with others in a group setting assists in reducing the secrecy and isolation associated with self-harm, and is the process that can ultimately lessen the need to self-harm.

Gaining new trusting, supportive relationships

Trust in a group aids group cohesion, Butler and Wintram (1995) argue, as it encourages the taking of risk by members' to share and confide personal experiences. More than that, Sabhlok (2011) suggests it is an essential feature of cooperation between members that ensures the group's formation, functioning and sustainability. In a self-harm self-help/mutual aid group, findings from this study demonstrate that forming and maintaining trusting, supportive relationships was of upmost importance. Members often entered the groups with a degree of wariness and concern, due to the stigmatising attitudes they had faced in the past. To alleviate individual fears of potential judgement and dismay the development of trusting, supportive relationships was found to be key in enabling members to share personal and often painful experiences**.** As a result, confidentiality and group rules were of particular importance, as such features were found to be crucial in facilitating and building trust between members. However, trust, as Sabhlok (2011) identifies, is not a fixed feature, it can develop, transform and even be destroyed through group members' interactions. To accommodate this the revision and reminding of rules to both established and new members was found to be crucial in the groups to facilitate trusting supportive relationships and ultimately a safe, emotional space for all.

The establishment and development of trusting, supportive relationships in the case study groups is identified as a positive feature that often emerges when peers come together in a self-help/mutual aid group (Adamsen, 2002; Kurtz, 2004; Visram et al., 2012). The regularity of meetings and a consistent membership helped to establish and form these relationships in the case study groups and over time offered, as found in previous studies (Wituk et al., 2002; Munn-Giddings & McVicar, 2006), a network of support in and outside of the group for members that transcended scheduled meeting times. Having a network of support, in and outside of the group, has recently been aided, Boyce et al. (2014) argue, by the development of online and mobile electronic tools that enable connections to be easily and quickly made, such as through a text message. Whilst support in and outside the group might be a regularly occurring feature of self-help/mutual aid groups generally, findings from the study indicate that such a feature is highly valued in self-harm groups where support, either formal or informal, is often limited or lacking. Text messaging allowed members to easily stay in touch with one another and offer support in times of need outside scheduled group meetings. These tools helped to maintain the trusting, supportive relationships between group members and further contributed to reducing members' isolation and loneliness.

Feeling less stigmatised

McAllister (2003) argues that being labelled a 'self-harmer' in statutory services means the person often becomes defined by their label and is no-longer seen beyond this. As previously discussed (see 2.5.1) current dominant understandings of self-harm are largely framed within an individualistic model of understanding. This model of understanding locates explanations of self-harm within the individual and tends to gloss over or ignore the potential social reasons and realities (Chandler, Myers and Platt, 2011). In contrast, in a self-harm self-help/mutual aid group the findings from this study illustrate that the interchanges between group members looked beyond the act of self-harm and encompassed broader aspects of group members' lives. In doing so, members came to know each other in ways that moved beyond the label of a self-harmer. Ultimately this enabled members to enter and find a space where they felt free from judgement and stigma.

Gaining confidence through new roles

Having the opportunity to take on a range of roles and learn new skills enabled some case study group members' to gain confidence and increase their self-esteem, which facilitated,

as Smith & Clarke (2003) also found, a sense of personal achievement and self-worth. Yet findings from this study draw attention to the potential fragility of adopting certain roles within a self-harm self-help/mutual aid group, particularly of a quasi-parental nature.

Riessman and Carroll (1995) note that adopting a helping role within a self-help group often facilitates a number of benefits for the person taking on this role, as they become less dependent, have the chance to perceive their own problems in perspective and obtain a feeling of usefulness. Additionally, the authors suggest that the person assuming this role tends to carry out the expectations and requirements attributed to it, by displaying control over their condition or behaviour, leading to the individual seeing themselves and adopting this role as their own. However, the adoption of a quasi-parental helping role by some group members was not always beneficial, as it was found to limit the opportunity for reciprocal support. Furthermore, in their presentation to others of an image of control and management of their self-harm, concerns were raised about the effect on the individual and other group members when this presentation can sometimes breakdown.

Wider gains

Emphasis on active participation and contribution

In a self-help/mutual aid group, as previously discussed (see 3.3.4), a foundational distinctive feature of these groups generally is an emphasis on mutual support. This means that group members often act as both the giver and receiver of support (Borkman, 1990). Similarly, the case study groups offered members a safe space where they could be both a contributor and beneficiary in the group through the collective and active processes of mutual support and reciprocity. Having the opportunity to gain support from those with shared experiences was found to facilitate individual understanding and learning in those directly receiving the advice and support. In addition, these gains indirectly benefited the giver of this support and advice as they re-emphasised situations and scenarios that might trigger their own self-harm. These collective and active processes offered members something unique to what exists or is available in current formal support settings.

In statutory services support is primarily delineated along the lines of helper and helpee, with the professional in a position of authority, power and control, whilst the person who is receiving the help often occupies a more passive, powerless position (Loat, 2011). In the area of self-harm this emphasis is often pronounced and hence passivity and helplessness

often typifies experiences of the support those who self-harm receive in statutory services (Pembroke, 1994; Shaw & Shaw, 2007). Dissatisfaction with the support available in statutory services is thus not an uncommon response in those with direct experience of self-harm (Warm, Murray & Fox, 2002). Findings from this study indicate that being part of a self-harm self-help/mutual aid group offers individual group members the opportunity to occupy a more active position by participating and contributing to the support of their own and others' self-harm. Moreover, having a space with an emphasis on collective responsibility, resilience and reliance offers an alternative to the passivity of support prevalent in statutory services and outwardly demonstrates the capability and value of peer support for those who self-harm.

Subtle forms of local resistance

Criticisms often levelled generally at self-help/mutual aid groups are that they are apolitical by being primarily concerned with individual rather that institutional or social change (Rapping, 1997, 2001; Adamsen & Rasmussen, 2001). As a result, suggestions that self-help/mutual aid groups can be considered part of a wider social movement (Katz, 1981, 1993; Chaudhary, Avis & Munn-Giddings, 2013), are often refuted on the grounds that these groups are too personal and localised to be considered a force for political change. Such a judgement, Riessman and Carroll (1995) argue, is often informed by the Alcoholics Anonymous (AA) twelve-step model, which largely rejects political action and social activism in favour of individual ownership and change. Whilst AA groups are perhaps most widely known, they constitute only one form self-help/mutual aid groups might take, in relation to political action, as such groups are characterised more by their diversity than their similarity (Powell & Perron, 2010). The findings from the study further illustrate that there are varying degrees of what it means to be 'political' in a self-help/mutual aid group, from an overt, outward campaigning political stance to, as reflective of the case study groups, more subtle forms of local resistance.

Actively rejecting the application of labels and questioning stereotypes was one way the groups resisted and challenged dominant frameworks to understanding self-harm. Additionally, emphasising less restrictive, effectiveness goals in favour of a more accepting harm-minimisation approach resisted a treatment perspective that often fails to grasp the complex, multi-dimensional and diverse nature of self-harm (Shaw, 2013a). The refusal by the facilitator of group B to fully complete the funder's monitoring forms might

be considered a small gesture of resistance, yet such an act subtlety displays the taking back of some control and power. These subtle acts of resistance had an empowering effect on individual group members and at a wider level challenged and resisted dominant assumptions that prevail around those who self-harm.

Challenging silence and stigma

The case study groups offered members a safe, non-judgemental space where they could share and discuss personal experiences. The voicing of personal experiences of self-harm amongst peers remains, Shaw (2013a) argues, one of the most important actions that can be taken, as it challenges the silence and stigma that surrounds the area. Findings from this study indicate that the voicing of personal experiences within the case study groups played an important role in gently shifting individual members' feelings of shame and guilt associated with their self-harm. This process led to some members challenging prejudicial assumptions outside the group and admitting their self-harm to others beyond the group. Such actions indicate that some group members were no longer being silenced or remaining silenced within or outside the group. Clearly the voicing of personal experiences has direct, individual benefits but there are also indications of broader benefits as a result of offering an alternative to dominant models of understanding and moving towards a more personal and political framework.

6.2.2 Competing tensions and dilemmas specific to the running and development of self-harm self-help/mutual aid groups

In the previous section the findings were contextualised in relation to the gains participation in a self-harm self-help/mutual aid group can offer at an individual and wider level. In this second framework of inquiry the findings are considered in relation to the competing tensions and dilemmas specific to the running and development of self-harm self-help/mutual aid groups. These relate to: ongoing versus time limited operation; open versus closed membership; personal boundaries versus collective responsibility; finding acceptance versus maintaining hope; group versus funder's priorities.

Ongoing versus time limited operation

A key feature that often differentiates self-help/mutual aid groups from professionally managed groups is their ongoing nature (Kurtz, 2004). However, such a feature is not

necessarily attributable to all self-help/mutual aid groups, as in more stigmatised areas research suggests that these groups are more likely to struggle to become established and survive (Chaudhary, Avis & Munn-Giddings, 2010). Having no or limited links and networks was found to be a contributing factor to poor group survival in the research undertaken by Bohmer (1995) into self-help groups for members who had experienced sexual abuse and exploitation. The findings from this study indicate that stigmatised groups can survive, as both case study groups had been in existence for more than five years. The on-going survival of the groups was aided by having well established and supportive links with local, voluntary organisations. Hence the findings from this study indicate that it is the quality of these local collaborative relationships that are of importance, rather than necessarily the scope and range.

The ongoing nature of self-help/mutual aid groups has, however, led to a number of criticisms, particularly around value and effectiveness. There is some concern that long-standing groups can become stagnant, diminishing the group's individual and wider impact over time (Wright, 2004), echoing the concerns raised by some of the phase two participants in this study. Assessing the value of a self-help/mutual aid group, however, is fraught with complexities, as it raises the question as to who in is in the best position to make such a judgement. Unlike professionally managed time-limited groups, self-help/mutual aid groups are not founded on external outcome measures and goals; instead, effectiveness is mostly framed by the individual's own position of reference (Pistrang, Barker & Humphreys, 2008). For example, Bohmer (1995) found that although the groups for members who had experienced sexual abuse and exploitation did not always have well-attended meetings or an extensive membership, the groups were still framed as successful by their members, even if at times they appeared to be barely functioning. This position reflects the perspectives of group members in this study. On the whole, a reduced and static membership was not considered by group members as a factor impeding or limiting the ongoing support they were able to give and receive from each other. Instead, the findings from the study suggest that the ongoing nature of the group was key to facilitating the group's safe space, as it offered consistency and regularity.

Open versus closed membership

Wituk et al. (2002) argue that an active, vibrant self-help/mutual aid group requires new members regularly entering and joining the group. The findings from this study

demonstrate that such a feature raises a distinct tension in groups for self-harm, as a small, consistent membership was found to be key to establishing the groups' safe space. This was further enhanced by one group choosing to endorse a strict closed membership that excluded those without direct experience and who were in crisis. A tension with a closed membership, Borkman (1999) argues, is that it can affect the degree to which a group develops and evolves its liberating meaning perspective, which is deemed key if members are to negotiate a less stigmatizing identity.

Borkman (1999) identifies three stages of development that self-help/mutual aid groups can move between from fledging, to developed and then mature. It is in the mature stage where the group can either evolve or develop an open learning or a closed fixed meaning perspective. In an open learning group a liberating meaning perspective is more likely to become established, as the group remains open to different views brought forward from new members entering the group, whereas in a closed, mature group the meaning perspective is largely fixed and new perspectives or insights are largely disregarded. The findings from this study offer a level of complexity to this theoretical perspective, as it highlights that a closed, discrete membership is often crucial to facilitating a safe space in areas that are highly stigmatised. Whilst a closed membership might be argued as limiting the group's access to different perspectives that can assist in the group's evolving, flexible meaning perspective. Certain exclusions and restrictions, particularly around members who are in crisis or highly distressed can, as the findings from this study illustrate, make a group unsafe, as such individuals can raise other group members' distress and often struggle to observe the groups' grounding principles of reciprocal, mutual support (Helgeson & Gottlieb, 2000; Adamsen, 2002; Wright, 2004).

Conversely, whilst an open group membership might inadvertently affect the safety of the group, the findings from this study also illustrate that it can help to build potentially beneficial relationships with external organisations and individuals if they are permitted, on the groups' term, to enter the group space. These findings resonate with the wider literature where the sustainability of self-help/mutual aid groups have been found to be closely aligned to links and networks fostered by such groups (Ben-Ari, 2002; Kurtz, 2004; ESTEEM, 2011).

The demographic membership profile of the case study groups also question a number of established assumptions often associated with the member profile of self-help/mutual aid groups. Primarily such groups are often framed as being exclusionary and closed to people from diverse backgrounds (Borkman, 1997; Kurtz, 2004; Forsberg, Nygren & Fahlgren, 2005). For instance Elsdon, Reynolds and Stewart (2000), in their review of the demographic features of self-help groups in a UK context, found that groups were less likely to be attended by those who were unemployed. In contrast, the case study groups were based in areas of high deprivation and unemployment and all members were unemployed and in receipt of benefits, except one member who worked part-time. Whilst receipt of benefits is not a reliable indicator of class, it is often associated with low socio-economic status (Backwith, 2015). Hence, the profile of the case study group members question the dominant membership demographic in relation to privileged socio-economic status. Furthermore, the age of case study group members' further challenge assumptions around the profile of a 'typical' self-harmer, as the average age of group members was mid-40s. This finding challenges the assumption that self-harm spontaneously ends by adulthood (Moran et al., 2011).

Closely aligned to the importance of establishing trust to facilitate an emotionally safe space was the commonality of experiences between group members. As Williams (2004) suggests, finding and meeting others who share similar experiences often fosters a tacit understanding and acceptance between members, which had the dual benefit of reassuring group members that they were in a safe space. But the shared experience, Avis et al. (2004) argue, is not always enough to ensure this tacit understanding and development of mutual trust between group members. In examining the reasons as to why some ethnic groups have not participated in self-help groups to the same extent as the rest of the community, the authors found that other factors, such as class, age, gender and religion influenced whether or not people would connect with each other. Similarly, the findings from this study raise a more nuanced understanding around the strengths of commonality of experience, as large differences in age between group members was found to sometimes hinder group cohesiveness and discourage younger members from joining the groups. Primarily younger members entering the groups often struggled upon hearing that older members were still self-harming as it presented to them a similar trajectory.

Personal boundaries versus collective responsibility

The organisational structures of self-help/mutual aid groups are often framed as egalitarian, anti-bureaucratic and member-governed (Adamsen & Rasmussen, 2001; Karlsson, Grassman & Hansson, 2002). As organisational structures are typically diverse, these definitions are no more than an 'ideal' type (Kurtz, 1997). Indeed, the findings from this study illustrate the various organisational structures these groups can take, as in relation to leadership, group A adopted a more collective approach, whilst group B favoured a more directive style, both of which raised distinct challenges.

A collective approach is very much akin to the core characteristics of self-help/mutual aid groups, as it reflects an emphasis on the ideal of members' shared responsibility and ownership that can alleviate the level of burdens and demands on one or two key members (Wilson & Myers, 1998). Whilst the collective approach endorsed in group A meant the overall demands and burdens on members were largely reduced, the absence of a clearly defined leader in the group raised a distinct challenge when no-one within the group felt responsible for managing another member's distress. Hence although a directive leadership style might appear to be in conflict with the ideals of self-help/mutual aid groups, such an approach, Chaudhary, Avis and Munn-Giddings (2013) suggest, might be appropriate in stigmatised groups where a dominant leader takes on the responsibility for running and directing the group, thus easing the demands on other groups' members. However, the findings from this study indicate that in adopting a more directive, dominant leadership style the facilitator of group B found herself in the position where she felt unable to openly share how she was feeling with other group members for fear of over burdening them. She would often breach personal boundaries in favour of supporting and helping others that left her feeling burnt out and overburdened at times. Such an outcome echoes the cautionary guidance Arnold and Magill (1996) propose that when running a self-harm self-help group, clear and consistent boundaries are paramount to ensure all group members' safety and containment within such groups.

Finding acceptance versus maintaining hope

Tew et al. (2012) suggest that developing peer relationships with others who have experienced mental health difficulties offers a unique opportunity in finding, from others and within oneself, acceptance and understanding that can be hard to find in other types of relationships, a position which reflected the relationships that developed within the groups.

Finding understanding and acceptance were features highly valued by group members, as it was found to lessen the negative feelings of shame and guilt members experienced prior to entering the group. Yet in relation to self-harm, Spandler and Warner (2007) argue that whilst acceptance and understanding can be powerful features, there needs to be more than just acceptance with an active encouragement of hope for change.

Hope and optimism are intrinsic features that are assigned to the principles of recovery (Bonney & Stickley, 2008). The concept recovery has, as Castillo, Ramon and Morant (2012) identify, a range of meanings, between the traditional mode of recovery as cure that locates the concept within an illness framework, with a personal definition of recovery that emerged from service user narratives, which emphasises the understanding of recovery as something other than the absence of mental illness. Inspiring hope and hopefulness are seen as key features for building and leading fulfilling lives with or without the mental health problem (Roberts & Wolfson, 2004), as inherent in the notion of hope is the development of a sense of purpose and optimism for the future (Spandler & Stickley, 2011).

A competing dilemma facing the groups, therefore, was through emphasis of a harm-minimisation approach, with less focus on future possibility for change, as the groups were more concerned with here-and-now support. Hence for younger members, it was difficult upon entering these groups to find that self-harm was still part of the lives of older members, as it suggested a similar future path. This raises doubts as to whether, as Borkman (1990) advises, there should always be a mixture of new and established members in a self-help/mutual aid group. The assumption is that such a mixture encourages newer members to learn from the longer-attending members. But the concern, in a self-harm self-help/mutual aid group, is that this might lead to a loss of hope and optimism for new members.

The findings from this study also revealed that those who self-harm and are older than 25 years old are further marginalised, as they are excluded from a range of services, which attribute hope and possibility of change with youth. This emphasis fails to appreciate, as the findings illustrate, that the lifecycle of self-harm can continue past early adulthood. Hence, whilst the groups may not privilege future change, they hold and offer a safe,

empathetic space to those who are currently largely ignored and disregarded in mainstream services.

Group versus funder's priorities

Wilson (1994) suggests that self-help/mutual aid groups occupy a different world to that of funders and professionals, as different agendas and needs are highlighted. The findings from this study would appear to support this, as at times these relationships were framed by misunderstandings and frustrations. Particular features and terms of the funding grants awarded to the groups were found to cause competing tensions, by being contrary to the ethos and principles of the groups. For instance, geographical boundaries in relation to who the group was open to fail to appreciate that a fundamental characteristic of self-help/mutual aid groups is an emphasis on helping and supporting others who share similar experiences (Borkman, 1999). So to turn members away on the grounds of where they live placed the group and its members in a conflicted position. Likewise the monitoring processes set by the funders were, as Seebohm et al (2013) found, often inappropriate and crucially could threaten the informal, voluntary ethos that underpinned the groups. A potential loss of autonomy and independence was found to be the reason why some groups in the ESTEEM (2011) study preferred to remain self-funded than seek external funding. The findings from this study, however, echo the arguments raised by Wilson and Myers (1998) that external funding can help facilitate the running of the group, particularly in securing suitable meeting venues, which was vital to maintaining the groups' safe space. Nevertheless, the criteria by which groups are funded and evaluated needs careful consideration (ESTEEM, 2011).

Self-help/mutual aid groups vary in size from two or three core members to more than 30 regularly attending group members (ESTEEM, 2011). Yet typically, Karlsson, Grassman and Hansson (2002) suggest that groups are usually small (of between five to eight members), which reflected the size of the groups in this study. This raised a distinct tension between the funders and groups' priorities, as the funder emphasised a preference for larger groups, but from the group member perspective discrete, consistent membership was preferred to foster a sense of safety within the group. Moreover, this study found that a small group membership can place a sense of obligation and duty on members to attend meetings, as well as affect and limit the opportunities for equally sharing tasks amongst members in the running of the group (Wilson & Myers, 1998).

Group members emphasised the value in having a space where they could safely talk about their self-harm, as very few opportunities of either a formal or informal nature existed where they could do this. The findings from this study demonstrate that an emphasis on the verbal sharing of experiences was not something funders were always comfortable with. Wann (1995) notes that the sharing of experiences can cause practitioners concern on the grounds that inaccurate information might be shared. In a self-harm self-help/mutual aid group the underlying concern appears to be that it might trigger members to self-harm, and they might learn from others more damaging ways to hurt themselves. Yet, this assumption fails to appreciate how sharing personal stories with others can benefit both the individual and the collective group as it offers a space for reflection, learning and potentially the renegotiation of a less stigmatizing identity (Rappaport, 1993; Steffen, 1997).

6.2.3 Self-harm and the paradoxical meaning of 'safe space'

Underpinning the contextualisation of the findings above is a central theme of the importance and value of self-help/mutual aid groups as a 'safe space' for those who self harm. Therefore, in this section this theme is explored in greater detail, through drawing on feminist ideas, with the intention of deepening insight and understanding of its meaning in a self-help/mutual aid group for those who self-harm. In order to contextualise the discussion the features that were found to facilitate a safe space for group members will be summarised first, followed by the tensions and dilemmas that hindered the groups' safe space. My rationale for drawing on feminist ideas to illuminate this theme will then be discussed and applied to the related notions of stigma and shame and safe space.

Mechanisms that facilitate a 'safe space' in a self-harm self-help/mutual aid group

The mechanisms that facilitated the groups' safe space were divided between practical features and group values.

The practical features that were found to facilitate the groups' safe space for its members related to the groups' approach to rules, confidentiality, regularity of group meetings, and consistency of group members, small group size and having a suitable meeting venue.

The groups' values associated with fostering a safe space related to a conviction to facilitating a non-judgemental setting, along with a focus on harm minimisation rather than

cessation and an emphasis to the commonality of shared experiences, which in some instances was enhanced by exclusions.

The combination of both these practical features and group values facilitated the processes by which the groups were perceived, by their members, as being an emotionally and physically safe and accepting space for sharing experiences.

The tensions and dilemmas that could hinder the groups' safe space related to exclusions, the age of group members and associated different needs and the intimate nature of the groups compared with the anonymity and control that could be obtained online.

Feminist perspectives on self-harm and self-help/mutual aid groups

Self-harm remains a gendered area with the enduring assumption that it largely affects girls and young women. Chandler, Myers and Platt (2011) argue that restrictive gender constructions, particularly in the latter half of the twentieth century, meant it was more acceptable to view self-harm as a passive feminine behaviour than view the act, in both genders, as aggressive and therefore masculine. This gendered assumptive profile, as discussed in 2.3.2, continues to influence current interpretations, as many studies are solely carried out on female samples and as a result the male experience of self-harm has largely been ignored or marginalised (Brickman, 2004; Hogg, 2010; Inckle, 2014).

In the same way that self-harm is considered a gendered female act, research indicates that the majority of members of self-help/mutual aid groups are women. For example, Elsdon et al. (2000) found membership to be 63.2% female, and women-only groups are not uncommon (Hastie, 2000). Borkman (1999) suggests that the women's consciousness-raising groups that emerged from the women's movement in the 1960s and 1970s played an important role in the expansion of self-help/mutual aid groups, as many of the women who were involved in consciousness-raising groups founded or participated in self-help/mutual aid groups. Feminists heralded women-only spaces as a way where patriarchy could collectively be discussed and examined in relation to the oppression and subordination of women (Kravetz, Marecek, & Finn, 1983). Since then, Lewis et al. (2015) argue that women-only spaces, in Western societies, have fallen out of favour due to the underlying assumption of the attainment of equality, which means such spaces are no longer deemed needed or relevant in the twenty-first century.

A feminist examination therefore offers a relevant framework to explore the theme of safe space in a self-help/mutual aid group for those who self-harm, as it recognises the gendered constructions that surround the area of self-harm and self-help/mutual aid groups. Furthermore, feminist perspectives offer a nuanced framework to explore the paradoxes of safe spaces that were raised in this research.

Stigma and shame: a safe space 'from' and 'to'

Before entering the case study groups' stigma and shame was profoundly felt and experienced by group members, as over the years most had attempted to keep their self-harm hidden from others. Craigen and Foster (2009) argue that such a response is indicative of the experiences of many people who self-harm and illustrates an awareness of the social stigma self-harm incurs. Long, Maktelow and Tracey (2015) argue that stigma has a profound significance in relation to self-harm, which the findings from this study also echo.

The social theory of stigma, developed by Erving Goffman in the pivotal 1963 text "*Stigma: Notes on the management of spoiled identity",* views stigma as a process by which the discriminating and negative reactions of others isolates people based on prejudicial assumptions (Goffman, 1990). Stigma is a social response to various attributes, behaviours or reputations that are constructed as socially unacceptable by others and which leads to social disapproval (Sanders, 2014). Therefore, as self-harm falls outside the realms of acceptable behaviour, it is constructed, Shaw (2002) argues, as pathological by others and hence is heavily stigmatised. Individuals are labelled, classified and in some way perceived as different from the 'normative' group. Whereas stigma is outside the self and a perception, shame, Sanders (2014) argues, is experienced inside the self and a felt emotion.

The judgemental and stigmatizing attitudes that surround the area of self-harm mean that shame and guilt are a common response expressed by many that self-harm (Babiker & Arnold, 1997; Warm, Murray & Fox, 2002). Sanders (2014) identifies this as 'problematic shame', which is long-lasting, chronic and intense as it becomes part of an individual's identity. This can lead, the author maintains, to pervasive feelings of unworthiness, isolation and blamefulness. Such sentiments reflected many of the case study group members' experiences as they spoke about feeling "*alone*" and "*guilty*" in self-harming, particularly before finding the case study groups. Hence the stigma and lack of

understanding that continues to surround the area of self-harm often perpetuates, Long, Manktelow and Tracey (2013) argue, the cycle of shame and guilt.

In looking at feminist perspectives on stigma and shame it is argued that women often face a double standard that leaves them with an extra burden to overcome. For example, in the study by Sanders (2014), who examined stigma and shame in relation to drug addiction in women-only Narcotics Anonymous (NA) self-help groups in the U.S.A., it is argued that addiction to illicit drugs is not simply viewed as an act of over-indulgence for women. Instead drug addiction is constructed as an act against womanhood through the violation of the woman's body and thus her reproductive capacity. Similar arguments have also been raised by feminists in relation to self-harm, as Shaw (2002) suggests that in girls and women it transgresses cultural, gendered norms and is less tolerated than other forms of harm, such as eating disorders, as it does not reflect Western ideals of what women's bodies should look like.

Although men's experience of self-harm, from a feminist perspective, have received less attention a similar double standard argument has been raised by Inckle (2014) who argues that gender norms also impact on males' distress. Conventional structures mean that boys and men are expected to act aggressively and domineering. As a result wounds and bruises are viewed part and parcel of a normative masculinity that can increase the status of men and boys. Inckle (2014) concludes that the current feminized gendered nature of self-harm decreases the likelihood of male self-harm being recognised, with the bodily norms of masculinity further adding to this concealment. Whilst differences in gender were not explored specifically in this study the sense of shame, by both the female and one male group member, were similarly negative and destructive. For instance, the one male group member described how he felt like "*scum*" before entering into the case study groups and expressions of feeling different and not "*normal*" in relation to others outside the group was expressed by many of the female case study group members. Sanders (2014) argues that if there is no outlet to overcome these internalised emotions of shame the destructive behaviour will continue, thereby overcoming stigma and shame is crucial to facilitate a sense of recovery.

In examining the experiences of safety in women-only spaces Lewis et al. (2015) use the analytical framework of 'safety from' and 'safety to' to elucidate the meaning of such

spaces. Applying this framework to the findings from this study illustrates that the self-harm self-help/mutual aid groups offered their members a 'safe space from' stigma and judgement, as members were not made to feel ashamed or guilty about their self-harm: "*You're told not to feel so bad about it*". In having a group that was free from stigma and judgement provided members, both female and male, a 'safe space to' share and let go of the shame and guilt they felt regarding their self-harm and gain a sense of acceptance: "*Somewhere you can come and be accepted*". The findings therefore support Sanders' (2014) view of the importance of having an 'outlet' where the negative effects of stigma and shame can be explored and overcome for those who self-harm. Added to this, my research highlights the importance of finding acceptance in the process of overcoming stigma and shame.

The paradox of 'safe space'

The findings of the research raised, as summarised above, a number of specific tensions and dilemmas in facilitating the groups' safe space. These varying challenges place self-harm self-help/mutual aid groups in a precarious position. To ignore the realities of the tensions the groups can face is to present a misleading and glossed account. However, the peripheral position self-harm self-help/mutual aid groups occupy means that there is the danger these tensions could be used to maintain their marginal position. In finding a realistic resolution to this dilemma I turn to the theoretical ideas put forward by The Roestone Collective, established by the feminist geographers Heather Rosenfeld and Elsa Noterman (The Roestone Collective, 2014). In this review the authors examine and analyse the notion of 'safe space' (The Roestone Collective, 2014). Whilst the authors discuss safe space in the context of women-only groups I draw upon their analysis to illuminate the paradoxical meaning of safe space in the context of the findings from my study.

Rosenfeld and Noterman suggest that efforts to create a united safe space can often produce exclusions of their own through valuing a specific identity (The Roestone Collective, 2014). The findings from this research illustrate that whilst exclusions, such as only allowing those with direct experience of self-harm and the excluding of those in acute distress, maintained the group's safe space, they made the groups vulnerable to the development of cliques. The membership in both case study groups was small, consistent and bonded, which at times made them difficult for new members to enter into. Furthermore, the age range in both groups was clustered around the mid-40s, which

indirectly excluded younger members from joining, as needs and aspirations did not always match. These findings support Rosenfeld and Noterman's suggestion that the idea of a fully inclusive safe space is unrealistic, as no space, the authors claim, can ever truly be free from domination or power differentials (The Roestone Collective, 2014). As a result Rosenfeld and Noterman argue that safe spaces are inherently paradoxical, as they are often inclusive as they are exclusive, and that a safe space is never completely safe (The Roestone Collective, 2014).

Rosenfeld and Noterman's paradoxical interpretation of a 'safe space' offers a nuanced explanation as to why some group members felt greater safety could be attained through accessing online self-harm groups and forums for support. In doing so this does not necessarily imply that the groups were perceived as unsafe, but that a sense of safety takes place on a continuum, rather than a binary either/or position. For example, when new members entered into the groups rules around confidentiality would be shared with the new members. The purpose was twofold, as it reassured new members it was a safe space, but similarly older members felt comforted to know that the groups' safe space and their sense of safety within the group would be maintained through the respecting of others disclosures. New members entering into the groups did not necessarily make it an unsafe space, but it had the potential to disrupt the levels of safety members felt. Furthermore, the findings from this research illustrate that a sense of safety within self-harm self-help/mutual aid groups can vary depending upon the position members occupy within the group. For those who take on a rescuing standpoint the danger is that their emotional safety may be impeded as their energies and efforts are taken up with supporting others, rather than adopting a more protective approach that emphasises mutual, reciprocal support.

The recognition that 'safe spaces' by their very nature are often paradoxical, contradictory and fluid provides a framework to work with the tensions and dilemmas this research raised in the facilitation of the groups' safe space. Through doing so I would argue that equally acknowledging these contradictions, as to the gains and benefits, offers a more nuanced understanding into the role of self-harm self-help/mutual aid groups. Lastly, given that feminist practice and literature highlights the importance of separate spaces for women, which the predominance of female members in self-help/mutual aid groups supports, I would argue that it is reasonable to infer that a safe, separatist space may be particularly important to women who face stigmatisation and marginalisation. This

inevitably raises questions as to whether those features that contribute to the creation of the safe space for women are similar and as relevant for men in similar circumstances. Since only one participant in my study was male it is not possible to conjecture further about these issues, but they do offer useful areas for future research.

6.3 Implications of findings

Turning now to the implications of the findings, these are presented in three sections. The first section discusses and summarises the implications and insights the findings raise. The second examines the implications of the findings in relation to the barriers affecting the development of self-harm self-help/mutual aid groups. The third and final section then considers the practice implications of the findings.

6.3.1 Summary of insights and implications

The contextualisation of the findings in the previous section highlights implications and insights in three core areas. These relate to self-harm self-help/mutual aid groups, self-help groups generally and the area of self-harm specifically.

Self-harm self-help/mutual aid groups

The findings from this study illustrate that participation in a self-harm self-help/mutual aid group can have a wide range of individual benefits and gains. As discussed, these relate to feeling less isolated and lonely, finding others in the same boat, gaining new trusting supportive relationships, feeling less stigmatised and potentially gaining confidence through new roles. Participation in self-help/mutual aid groups does not, as Folgheraiter and Pasini (2009) argue, only lead to individual benefits as active participation often leads to wider gains beyond the group and its members.

The findings from this study support this idea and extend our knowledge into what the broader benefits might be in relation to self-harm self-help/mutual aid groups. The wider gains this study illustrates are that such groups can provide an alternative to the passive nature of support that tends to dominate in statutory services, as involvement in the groups required active participation and contribution by group members. An emphasis on collective responsibility, resilience and reliance further demonstrates the capability and value of peer support for those who self-harm.

Further wider gains the study illustrates are that self-harm self-help/mutual aid groups can offer a subtle form of local resistance through the rejection of and resistance to dominant frameworks and assumptions that prevail around self-harm. In addition, self-harm self-help/mutual aid groups provide a safe space where personal experiences can be voiced and heard. In doing so these groups can provide a space that challenges the silence and stigma of self-harm within and beyond the group.

Self-help groups

The findings also offer distinct implications in relation to the broader self-help literature as they provide nuanced insights into the running of groups in the stigmatised area of self-harm. The findings question established ideas about the value of an open and mixed membership, in terms of established and new members, as being key to maintaining a vibrant and effective group (Borkman, 1999; Wituk et al., 2002). In stigmatised areas such as self-harm, the findings from this research illustrate that a closed, restrictive and consistent membership was at times key to facilitating the groups' safe space.

Findings from this study also contribute to the idea that commonality of experience is not always enough to ensure and facilitate mutual support and understanding (Avis et al., 2004; Faulkner et al., 2013). Large differences in age between members were found to inhibit group cohesiveness and discouraged younger members from joining such groups as this presented a potential similar future where self-harm remained part of their lives. The findings additionally indicate that establishing and maintaining trust between group members with an emphasis on rules and confidentiality are key features in stigmatised groups, such as self-harm self-help/mutual aid groups, as they were found to be pivotal in sustaining the safe space of such groups.

Self-harm

Finally the findings also highlight particular insights and implications in the area of self-harm relating to the marginalisation of those who self-harm and who are older than 25 years old. The experiences of the case study group members illustrate a lack of available formal support for those who self-harm and are older than 25 years. Hence the peer support available in their groups was for many the only source of regular and consistent support available.

Furthermore, insights from the study indicate that it is often difficult to secure funding for services that offer support for those above the age of 25 years who self-harm. The findings from this study indicate that the embedded assumption is that change is less likely to occur. The implications of ignoring those who self-harm above the age of 25 years perpetuate the assumption that the lifecycle of self-harm is something that naturally ends in adulthood and thus further marginalises such individuals.

6.3.2 Barriers affecting the development of self-harm self-help/mutual aid groups

The findings from this study illustrate the value of collective peer support, in a self-help/mutual aid group, for those who self-harm. Despite these benefits and strengths, self-harm self-help/mutual aid groups are not widely available (Arnold, 2006) and continue to face concerns and reservations by some professionals around their safety and value (Parker & Lindsay, 2004; Sutton, 2007). These concerns and reservations appear to be in conflict to the growing interest in the value of peer support in mental health services, seen in the recent development of peer support programmes within the NHS (Faulkner & Basset, 2012).

Repper and Carter (2010) suggest that peer support is another term for self-help or mutual support as it generally refers to the mutual aid provided by people with similar life experiences as they move through difficult situations. And it is in the form of a self-help group, Bott (2008) argues, that peer support has the longest history. Bradstreet (2006) suggests that there are three main types of peer support: the informal, unintentional and naturally occurring; participation in peer-run groups/programmes; and the formal/intentional peer support. It is in this latter category where the development of peer support in mental health services is largely located, whereas the peer support facilitated in self-help/mutual aid groups is largely considered to be situated in groups and programmes. Basset et al. (2010) argue that the current delivery of peer support in statutory services is largely provided on a formalised one-to-one basis by trained peer support workers who are expected to have completed structured, often accredited, training programmes. One of the defining features of peer support delivered in a formal and intentional programme is that peer support workers are often paid members of the workforce (Gribbon, 2011). Furthermore, as most peer support workers' roles are based on a one-to-one relationship, Repper and Carter (2010) argue that this inevitably suggests a less equal relationship than

those that develop in collective initiatives: as one is the giver and the other is the receiver, one is the experienced and the other is the inexperienced.

Faulkner and Basset (2012) argue that this formal and intentional delivery of peer support in mental health services is grounded within recent policy developments that promote individualisation. Current mental health policy, outlined in the policy document *No Health Without Mental Health* (Department of Health, 2011), emphasises personalisation with greater individual choice and control over the support services received. Within this document recovery is framed as being the responsibility of the individual to make and effect personal changes within their own life (Harper & Speed, 2012). Emotional distress, like self-harm, is thus situated as an explicit problem of the individual that ignores the effect of social conditions and structures.

This current emphasis on individualisation in mental health policy and practice ignores and often fails to consider the potential benefits of fostering collective approaches and initiatives (Loat, 2011). The privileging of a formalised, individualistic delivery of peer support on a one-to-one basis in mainstream services is in conflict with the collective peer support that is gained in a self-harm self-help/mutual aid group. An emphasis on formal and intentional peer support hence shifts the ethos from mutuality, reciprocity and equality to a more hierarchical relationship. This inequality, Faulkner and Basset (2012) argue, drives the need for boundaries, training and supervision, thus imitating statutory models of service provision. Furthermore, privileging an individualistic approach to peer support, the authors argue, may ultimately lead to its professionalisation.

Despite this current interest in the value of peer support in mental health services, albeit of a formal, individualistic basis, expansion and development has not occurred equally in all areas. In a recent study by Faulkner et al. (2013) which examined the range of mental health peer support across England, the authors found that peer support was largely lacking or limited in minority and marginalised communities. Whilst the minority and marginalised communities are not explicitly defined in this report, the findings from the study indicate that collective peer support, on a face-to-face basis for those who self-harm, remains limited and is not necessarily considered a viable source of support in both statutory and voluntary services. For these reasons it is perhaps not surprising that it is online where the greatest proliferation of peer support for self-harm exists (Rodham, Gavin & Miles, 2007;

Adler & Adler, 2013), as such groups and forums are less hindered by prejudicial assumptions and misgivings.

Nonetheless there are, as the findings from this study illustrate, a range of individual and wider benefits for those who self-harm in receiving and giving collective peer support in the form of a self-help/mutual aid group. The current emphasis on the formal and intentional delivery of peer support in mainstream services, however, offers distinct challenges and barriers to the potential development of self-harm self-help/mutual aid groups, which is further impeded by the notion of risk.

Scott, Doughty and Kahi (2011) report that peer support holds an ambiguous position in areas of risk in statutory settings, such as self-harm. Primarily in such settings there is an emphasis on the management and elimination of risk. This emphasis, the authors argue, is in contrast to the ethos and philosophy of peer support, which often means working with risk. In doing so risk is often seen as a learning opportunity and something to be engaged with and worked through, such as adopting a harm minimisation approach in relation to self-harm. Therefore the challenge is, as Wilson (1994) identified, to find a way to bridge the divide between the different ontological positions and knowledge bases, from those dominant in mainstream services with an emphasis on an individualistic approach that privileges professional knowledge and risk management, and those self-help/mutual aid groups with an emphasis on experiential knowledge and collective peer support.

Self-harm self-help/mutual aid groups are one form of peer support, which are not without their tensions, as the findings from this study demonstrate. Additionally, they may not be the most appropriate source of support for those in times of deep crisis. Despite such challenges they offer a consistent source of support, particularly for those who self-harm and who are above the age of 25 years. Rather than privileging one form of peer support over another, Faulkner and Basset (2012) argue that a plurality of peer support approaches is needed. To do so there needs to be more investment in exploring peer support in all its forms, plus support of community-based peer support initiatives with more funding and resources (Faulkner & Kalathil, 2012).

In considering the barriers affecting the development of self-harm self-help/mutual aid groups, a theme consistently raised throughout this thesis is highlighted in the privileging

of an individualistic approach, in both policy and practice, over a collective one. This is seen in the dominant ways self-harm is currently framed as being attributed within the individual and in the tendency to examine self-help/mutual aid groups solely on their individual gains. The implications of the findings from this research thus present an alternative to current individualistic dominant frameworks of understanding in relation to self-harm and self-help/mutual aid groups with its emphasis on the value of the collective approach.

6.3.3 Practice implications

In examining the strengths and challenges of self-harm self-help/mutual aid groups, the findings raise a number of practice implications for funders, practitioners and groups themselves. The main implications for practitioners and funders that the findings from this study demonstrate is evidence to question the concerns and reservations that remain around the value and benefit of self-harm self-help/mutual aid groups. Primarily the fear is that from talking and listening to others discuss their self-harm, members will be encouraged to learn potentially more damaging ways to hurt themselves. However, the findings from this study illustrate that such fears are largely unfounded, as talk and dialogue with peers were crucial features that facilitated members' awareness and ability to find better ways to cope. This is not to deny that these groups are without tensions and challenges, yet with suitable and appropriate external support the groups were able to overcome many of the challenges they faced.

The peripheral position such groups occupy mean that practitioners and funders can play an influential role in encouraging the development of these groups, by offering, for example, suitable meeting venues, promoting and publicising the group to potential new members and providing support and guidance when required (ESTEEM, 2011). These relationships are most effective, as the findings illustrate, when those external to the group appreciate and respect the core values and ethos of such groups and strive to work in ways that support these features. Hence this may require practitioners and funders having to adapt usual ways of working, for example looking beyond evaluating these groups in efficiency terms (Karlsson, Grassman & Hansson, 2002) and by looking beyond what currently constitutes effectiveness.

The practice implications that the findings raise for self-harm self-help/mutual aid groups are the importance of groups establishing trust within the group by emphasising confidentiality and group rules to facilitate a safe, emotional space. Likewise, the findings illustrate that groups need to be aware that relying on commonality of experience might not always be enough to bring members together, as the findings illustrated that age could be a divisive feature to establishing group cohesion. The findings also highlight the value of groups having established supportive links and networks, as it can help to sustain the group, which is perhaps of greatest importance for marginalised groups that often struggle to become established. The implications of the findings also means that groups need to be aware of the challenge that ongoing groups can face in maintaining hope and optimism.

6.4 Personal learning journey

When I began this study I had already been working as a researcher within an academic institution for a number of years and I remember at the time, somewhat naively, believing that undertaking a doctoral thesis would be very similar to completing a piece of funded research. As I was a part-time student for the first few years I was cocooned within this bubble of misunderstanding. Unlike other fellow students who started the same time as me, I was not daunted by certain processes, such as completing ethics forms and gaining ethical approval or making contact with unknown groups and individuals, as I had had plenty of experience of this in my working role. The crunch point came after all the data had been collected and the realisation gradually dawned on me that from here on in it was my responsibility to make sense of all that had been gathered and to write it up in a consistent, coherent way.

This was a very different way of working to what I was familiar with as I was used to working as part of collaborative research teams, where there would be plenty of opportunities to share emerging analytical ideas, thoughts, frustrations and workload! Gradually, though, I began to appreciate that undertaking a doctoral thesis essentially requires the confidence and ability to work independently and to be self-directed. And I would say that it was at this stage of learning that I really started to appreciate the level and depth of work a doctoral thesis demands and I began to fully own the label of a PhD student.

However, my personal learning has not just been about a greater awareness and appreciation of what is involved in undertaking a doctoral thesis. Through this process I have gained and developed new skills and qualities that undoubtedly support and benefit me in my current professional role, but also extend beyond this into other aspects of my life. Perhaps the greatest qualities I have developed is a degree of resilience and flexibility to keep going when numerous and often unforeseen events can sometimes appear to halt progress. For instance, from my underestimation in the time it would take to undertake and complete the fieldwork (as discussed in 4.4.4), taking a year's intermission from the study whilst on maternity leave and then returning to the thesis and trying to balance work, study and motherhood. At each of these points, and various others, by keeping going and pushing through the difficult and low points is what got me through, and in doing so I have found it has increased my confidence and self-belief in my own abilities and strength of character that transcends the generation of this thesis.

Turning to my academic learning, this process has also taught me that even though particular ways of undertaking research may appear conducive to certain subject areas, this may not always work in the nitty-gritty of real-world lives. At the early stages of planning this research I was very keen that it would be undertaken in a collaborative manner and so was initially drawn to applying a participatory approach, as I felt the supportive and empowering principles behind this approach were meaningful to the area of self-harm where feelings of disempowerment are common narrative themes. I also felt this approach reflected the ethos of self-help/mutual aid groups generally, with its emphasis on member empowerment and democratic decision-making. To start facilitating a participatory approach between myself and the groups I thought that by allowing the groups and myself to come together and collaboratively agree how the research might be undertaken would make the process a more equal one, as power and control would be shared and negotiated. When I met with the groups the first few times I was prepared to do this by having a number of activities to generate ideas about how we might go about it.
However, it quickly became apparent that neither group or its members were looking to have this level of involvement in the direction of the study, instead they both encouraged me to advise, direct and lead the process. I remember at the time feeling disappointed that the study was not developing into my ideal of a collaborative experience and I was concerned about the impact it would have on ensuring the study was undertaken sensitively and considerately. But over time I began to appreciate that if I continued pursuing this

methodology I was in danger of forcing the groups down a route they were not comfortable with, which was the exact opposite of how I wanted to work! When I made the decision, in discussion with my supervisors, to revise my methodology to a more interpretative approach the tensions and concerns I had been facing immediately lifted and the process became less stressful and more rewarding. I recognised that although on the whole I would be leading the process, this did not necessarily mean the research could not be undertaken sensitively. Indeed, I found the flexibility of the approach particularly suited the subject area as it meant I could adapt and take up opportunities as they arose.

Finally, from this process I have learnt that no amount of reading can fully prepare or inform us about the realities of real-world settings and other people's lives. Before I started working with the study groups the aim of this thesis had been to examine the role self-help groups might play in the development of members' strategies to manage their self-harm. From my first meetings with the groups, though, I quickly realised that such an emphasis did not match the aims of the groups involved. Indeed, my initial emphasis on the management of self-harm illustrates a somewhat narrow understanding and appreciation on the role of these groups for those who self-harm. Similarly, looking back I recognise now that to some extent I had formed an image of what a 'typical' self-help/mutual aid group looks and functions like. Therefore it was quite a shock to me when I entered the study groups to find they did not match this image. The assumptions I held meant I envisaged that group meetings would involve members' sitting around in an orderly circle taking it in turns to talk. Instead I found the case study groups to be much more free-flowing and places of laughter and sociability, which came as a bit of a shock, particularly given the subject area, as I had assumed the groups would be intense, emotionally difficult places. At the time I remember questioning whether the groups actually fitted my interpretation of a self-help/mutual aid group. Since then I have come to realise that although the literature can give us various frameworks of understanding, as social science researchers we need to remain open to new and competing insights and understandings and to be prepared to challenge our own assumptions and stereotypes.

6.5 Chapter summary

In this chapter I have presented and discussed the findings within two frameworks of inquiry. Firstly, in examining the findings in relation to benefits of self-harm self-

help/mutual aid groups a more nuanced understanding of the gains attributable through participation has been presented. This framework of inquiry moves our current individual understanding of the benefits involved in participating in such groups to a more complex, wider focus. Secondly, by examining the challenges self-harm self-help/mutual aid groups' face and conceptually framing them within this chapter as competing dilemmas and tensions, I have presented a more multifaceted and in-depth interpretation of the strengths and limitations of these groups to what is currently known.

The implications of the findings raise distinct insights in the area of self-harm self-help/mutual aid groups, self-help groups generally and also the area of self-harm specifically. This chapter has also delineated a further implication of the findings by examining the barriers that currently affect the development of self-harm self-help/mutual aid groups. I conclude that these groups will continue to remain on the periphery until there is a shift in perceptions of the value of collective peer support for self-harm. The chapter then examined the practice implications of the findings for funders, practitioners and groups themselves. I concluded the chapter with a reflection and consideration of my own personal learning through undertaking this study and research.

Chapter Seven
Conclusion

7.1 Introduction

This thesis explored the views and experiences of members of self-harm self-help/mutual aid groups, along with the perspectives of those who support these groups with the goal and intention of contributing to our understanding of the role of such groups. The study was framed within an interpretive paradigm of inquiry and guided by a qualitative case study approach that allowed for a rich understanding of the key concepts to emerge. There were two phases to the data collection process, with the first stage involving working with two self-harm self-help/mutual aid groups and the second phase entailing the participation of those who support these groups. The strengths of and challenges facing such groups were examined in both phases and provided an in-depth and nuanced understanding on the value and tensions specific to self-harm self-help/mutual aid groups.

In this chapter the limitations of the research are considered and the original research contribution to knowledge is then presented. Suggested areas for further research and examination are then discussed, before the chapter and the thesis concludes with a closing brief summary.

7.2 Limitations of the research

This was a small-scale qualitative study, hence it is not possible to generalise the findings to all self-harm self-help/mutual aid groups. However, generalisation was not the goal or intention of this research, as the aim was to explore these groups in-depth to facilitate a more detailed understanding of the role of self-harm self-help/mutual aid groups. Therefore the small-scale and exploratory nature of the research is not necessarily seen as a limitation. Indeed, the lengthy process that was involved in initially negotiating access with the case study groups, developing trust with group members, maintaining momentum and access cannot be underestimated, particularly within the context of this being an unfunded study with resource and time constraints.

However, I recognise that the recruitment design for the phase two participants has limitations and potentially introduces bias into the study. Only those participants who had experience of working with self-harm self-help/mutual aid groups were invited to participate in the study. My rationale for this was I considered that the views and opinions shared would be informed by direct experience and insider knowledge, rather than anecdotal assumptions. But I recognise that by only seeking the perspectives of those participants with experience of working with self-harm self-help/mutual aid groups means that the views shared might not necessarily be impartial, because of having a vested interest in these groups. Whilst I appreciate and accept this as a potential limitation I would argue that the views shared by the phase two participants were on the whole balanced in their sharing of the strengths and challenges of such groups, which was informed and grounded in direct experience.

Turning to methodological limitations the interpretivist paradigm of inquiry that informs and guides this study means that, fundamentally, I have led and directed all stages of the research process from, for example, the questions asked in the interview guides to the analysis of the findings. A recognised limitation of this approach is that the contextualisation and discussion of the findings is therefore mine, the researcher's interpretation, rather than those who participated in the study. Cotterell (2008) suggests that by not involving research participants in the analysis of the data, any interpretations are potentially less likely to be fully reflective of participants' experiences and concerns. Whilst I acknowledge this as a potential limitation of the study, I maintain that my being systematic and transparent in the presentation and interpretation of the findings offers the means by which others can judge the quality and trustworthiness of this research overall.

A final consideration is that as this was an exploratory study, meaningful and potentially pertinent areas of insight and focus gradually emerged through the research process, rather than being distinctly defined for examination at the start of the process. Consequently, this means that these areas of interest, such as maintaining hope and optimism in these groups, were not explored in as great depth if they had been determined at the start of the study. I would nonetheless argue that, by allowing these areas of interest to iteratively emerge, the study presents a more accurate representation of the central areas of insight and emphasis

in self-harm self-help/mutual aid groups than if I had initially pre-defined the areas of focus and relevance.

7.3 Original research contribution

This thesis makes an extensive and important contribution to the conceptual development in understanding the role of self-harm self-help/mutual aid groups on a methodological and theoretical level.

7.3.1 Methodological contributions

The interpretivist paradigm of inquiry that frames this study enabled a rich, detailed understanding of self-harm self-help/mutual aid groups to emerge which is grounded in the lived experiences of people who both attend and support such groups. Furthermore, this paradigm of inquiry supported a feminist ethics of care which meant the research was able to be undertaken in a sensitive and responsive manner. As the data collection in phase one occurred over a sustained period of time and often involved repeated visits and meetings, it was crucial that the research was carried out in a considerate manner at a pace determined by the case study group members. An interpretivist paradigm of inquiry, with an emphasis on the study of social phenomena from the inside, was flexible and supportive of the need to undertake the research at this considered pace, which was crucial in the completion of the fieldwork with the case study groups.

Similarly, the qualitative methods chosen within this paradigm of inquiry were suitable and flexible enough to meet the different needs of the case study group members and phase two participants. Consequently, this meant the findings generated in each phase of the research were able to be combined, which provided a broader and more in-depth, nuanced understanding of the role of self-harm self-help/mutual aid groups.

Lastly, the chosen qualitative data collection methods encouraged and supported collaboration and learning between the case study groups and some of the phase two participants. The impact of this collaboration meant the case study groups were linked and networked with each other and were able to provide each other with support and guidance in relation to funding applications. Sharing early emerging findings from the semi-structured interviews with the phase two participants meant participants were made aware

of the marginalisation experienced by those who self-harm and who are above the age of 25 years. These discussions during the interviews and subsequent reflections by the phase two participants from the same organisation afterwards meant they were reconsidering their current service exclusions.

These reflections and considerations of the interpretivist paradigm of inquiry and qualitative data collection methods adopted in this study offer methodological contributions and insights in undertaking research with marginalised and stigmatised groups.

7.3.2 Theoretical considerations

This thesis highlights the value of self-harm self-help/mutual aid groups. In doing so it provides robust evidence of the benefit of peer support for those who self-harm. Despite a current interest in the value of peer support in mental health services, this thesis illustrates that this is an area of support largely missing in mainstream services for those who self-harm. The thesis illustrates how concerns about the risks and safety of peer support for those who self-harm remain a barrier limiting the development of self-harm self-help/mutual aid groups, which is further constrained by a privileging of a formal, individualistic approach to peer support in mainstream services.

In equally examining the gains and benefits of self-harm self-help/mutual aid groups, along with their competing tensions and dilemmas this thesis also contributes new insights in the following areas. Firstly, in the area of self-harm self-help/mutual aid groups it highlights the potential individual benefits gained through participation in such groups. These relate to: feeling less isolated and lonely; findings others in the same boat; gaining new trusting supportive relationships; feeling less stigmatised and gaining new confidence through new roles. The thesis also identifies wider gains from attending these groups with an emphasis on: active participation and contribution; subtle forms of local resistance; and challenging stigma and silence. Secondly, this thesis contributes to the broader self-help literature by providing nuanced insights into the running of stigmatised groups and questioning assumptions around the commonality of experience always ensuring group cohesiveness. Thirdly, this thesis raises distinct questions and tensions in the area of self-harm around the marginalisation of those who self-harm and who are above 25 years.

Finally, this thesis offers new knowledge concerning the paradoxical meaning of 'safe space' in a self-help/mutual aid group for those who self-harm. The recognition that the safe space is often contradictory, for it is inclusive as it is exclusive, and that it is not fixed, but rather fluid and shifting, provides a broader and more nuanced understanding of the role of self-harm self-help/mutual aid groups.

7.3.3 Practice and policy contributions

In addition to the practice implications I have discussed in 6.3.3 I consider here the specific practice and policy contributions this doctoral study makes in order to highlight the value of self-harm self-help/mutual aid groups to commissioners, practitioners and carers.

In reviewing a range of treatment models applied in the management of self-harm in mainstream services Simpson (2006) concludes that health services often struggle to provide meaningful and empathic care for those who self-harm. A lack of awareness around the meaning and nature of self-harm and an emphasis on risk management in health care environments often results, the author continues, in health professionals and those who self-harm operating within different realms of understanding. Hence, Simpson (2006) suggests that service user-led organisations might be better placed to foster the required supportive space where those who self-harm can share their distress with others who understand.

The findings from this research now provide evidence to practitioners, commissioners and carers of the value of collective peer support, in the form of a self-help/mutual aid group, for those who self-harm, as the user-led groups in this research offered members a supportive safe space that was free from stigma and judgement. Having a safe, accepting space allowed members to collectively share and gradually liberate themselves from the shame and guilt they felt regarding their self-harm, a process that is crucial to facilitating positive change (Sanders, 2014). Furthermore, self-harm self-help/mutual aid groups have the potential to provide an invaluable source of support for members who are often excluded from other services where there is an upper age limit of 25 years.

Whilst the findings from this research illustrate the value of collective peer support for those who self-harm, current mental health policy, as discussed in 6.3.2, with its emphasis on individualisation, favours the delivery of peer support on a one-to-one basis. This

privileging of peer support on an individual one-to-one basis denies the value of collective, group-based approaches, which has its roots in user-led organisations (Faulkner & Basset, 2012). To encourage the development of a plurality of peer support approaches Faulkner and Kalathil (2012) argue that more funding is needed in community-based initiatives. The findings from this study provide helpful insights into funding requirements that can hinder rather than facilitate the development of self-harm self-help/mutual aid groups. These relate to inappropriate conditions and outcome measures such as placing a number on expected group size, an emphasis on activity rather than dialogue and criteria for target populations. Self-harm self-help/mutual aid groups are not a substitute for services, but rather they offer a particular type of support that is not available through either statutory or one-to-one provision. Although self-harm self-help/mutual aid groups are not without tensions and dilemmas the findings from this thesis illustrate that collective peer support for those who self-harm is a suitable source of support worthy of development and consideration.

7.4 Future research

There are three main areas where future research in this area would benefit from further consideration and examination. Firstly, the findings have highlighted the dilemma self-harm self-help/mutual aid groups face in relation to favouring a more accepting harm-minimisation ethos and how this can have an impact on facilitating future hope and optimism in the group and for its members. Hence, examining the links between these two features in greater detail would offer detailed insights and understanding into how the recovery agenda fits within the experiences and narratives of self-harm self-help/mutual aid groups and their members.

Secondly, the harmful and destructive effect of stigma on the identity of those who self-harm was found to be subtly re-negotiated through members actively participating in their groups. Examining in greater detail the mechanisms that potentially facilitate this change would offer insights and learning around the collective processes involved in enabling such transformation. This examination would potentially contribute to the broader agenda of supporting peer support for those who self-harm beyond a formal, one-to-one approach.

Thirdly, this thesis acknowledges that it is online where the greatest proliferation of peer support for self-harm currently exists. Further examination in this area is needed to understand more fully the specific features of online peer support for those who self-harm, particularly around the notion of establishing trust and reciprocal relationships in a virtual setting. In doing so it is likely greater insights would be gained in understanding the challenges affecting the development of peer support for self-harm on a face-to-face basis generally and in relation to self-harm self-help/mutual aid groups specifically.

7.5 Closing summary

This thesis has demonstrated that the role of self-harm self-help/mutual aid groups is to provide a safe, non-judgemental space where those who self-harm can meet, listen and talk to others who share similar experiences for mutual and reciprocal peer support. Participation in these groups has the potential to offer individual and wider gains for those who are often marginalised and stigmatised. Despite a current interest in the value of peer support in mental health services, the thesis illustrates that this is largely missing for those who self-harm. Concerns about the risk of peer support for those who self-harm remain a barrier affecting the development of self-harm self-help/mutual aid groups, which is further constrained by an emphasis on a formal, individualistic approach to peer support in mainstream services.

Whilst there are specific tensions and dilemmas facing self-harm self-help/mutual aid groups, this thesis highlights that collective peer support for those who self-harm is a viable and valuable source of support worthy of development and consideration in both mainstream and voluntary services. Finally, in exploring the concept of ‘safe space’ this thesis contributes new knowledge about the paradoxical meaning of safety in a self-harm self-help/mutual aid group. It illustrates that a safe space can be inclusive, as it is exclusive, and that a sense of safety is experienced on a continuum and hence is fluid and shifting. In equally acknowledging the gains and tensions this thesis therefore provides a broader and more nuanced understanding of the role of self-harm self-help/mutual aid groups.

References

Adamsen, L. & Rasmussen, J.M. (2001). Sociological perspectives on self-help groups: Reflections on conceptualization and social processes. *Journal of Advanced Nursing,* 35(6), pp.909-917.

Adamsen, L., Rasmussen, J.M. & Pedersen, L.S. (2001). 'Brothers in arms': How men with cancer experience a sense of comradeship through group intervention which combines physical activity with information relay. *Journal of Clinical Nursing,* 10(4), pp.528-537.

Adamsen, L. (2002). 'From victim to agent': The clinical and social significance of self-help group participation for people with life-threatening diseases. *Scandinavian Journal of Caring Sciences,* 16(3), pp.224-231.

Adler, P.A. & Adler, P. (2011). The tender cut: inside the hidden world of self-injury. New York University Press. *RESET: Social Science Research on the Internet,* 1(2), pp.16-47.

Adler, P.A. & Adler, P. (2013). Self-injury and the internet: Reconfiguring the therapeutic community. *Social Science Research on the Internet,* 1(2). Available at: http://www.journal-reset.org/index.php/RESET/article/view/12 [Accessed 26 November 2014].

Aglen, B., Hedlund, M. & Landstad, B.J. (2011). Self-help and self-help groups for people with long-lasting health problems or mental health difficulties in a Nordic context: A review. *Scandinavian Journal of Public Health,* 39(8), pp.813-822.

Alexander, N. & Clare, L. (2004). You still feel different: The experience and meaning of women's self-injury in the context of a lesbian or bisexual identity. *Journal of Community & Applied Social Psychology,* 14(2), pp.70-84.

Allen, S., (2007). Self-harm and the words that bind: a critique of common perspectives. *Journal of Psychiatric and Mental Health Nursing,* 14(2), pp.172-178.

Archer, T. & Vanderhoven, D. (2010). *Growing and sustaining self help: taking the Big Society from words to action.* Community Development Foundation. Available at: http://cdf.org.uk/wp-content/uploads/2011/12/Growing-and-Sustaining-Self-Help.pdf [Accessed 19 November 2014].

Arnold, L. (1995). *Women and self-injury: a survey of 76 women*. Bristol: Bristol Crisis Service for Women.

Arnold, L. & Magill, A. (1998). *The self-harm help book*. Bristol: Basement Project.

Arnold, L. (2006). *Understanding self-injury.* Bristol: Bristol Crisis Service for Women.

Avis, M., Elkan, R., Patel, S., Walker, B.A., Ankti, N. & Bell, C. (2008). Ethnicity and participation in cancer self-help groups. *Psycho-Oncology,* 17(9), pp.940-947.

Babiker, G. & Arnold, M. (1997). *The Language of Injury: comprehending self-mutilation*. Leicester: British Psychological Society.

Backwith, D. (2015). *Social work, poverty and social exclusion.* Open University Press.

Barnes, M. & Cotterell, P. (2012). From margins to mainstream. In: Barnes, M. & Cotterell, P. eds. 2012. *Critical perspectives on user involvement*. The Policy Press. Ch.1.

Barton-Breck, A. & Heyman, B. (2012). Accentuate the positive, eliminate the negative? The variable value dynamics of non-suicidal self-hurting. *Health, Risk & Society,* 14(5), pp.445-464.

Basset, T., Faulkner, A., Repper, J. & Stamou, E. (2010) *Lived experience leading the way: Peer support in mental health.* Together for Mental Wellbeing.

Bauman, Z. (1999). *In search of politics*. Oxford Polity.

Baxter, P. & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report,* 13(4), pp.544-559.

Ben-Ari, A.T. (2002). Dimensions and predictions of professional involvement in self-help groups: A view from within. *Health & Social Work,* 27(2), pp.95-103.

Bhardwaj, A., (2001). Growing up young, Asian and female in Britain: A report on self-harm and suicide. *Feminist Review,* 68(1), pp.52-67.

Bhopal, K. (2010). Gender, identify and experience: Researching marginalised groups. *Women's Studies International Forum,* 33(3), pp.188-195.

Birch, M., Miller, T., Mauthner, M. & Jessop, J. (2012). Introduction to the second edition. In T. Miller., M, M. Birch., Mauthner. J, Jessop. (eds). *Ethics in qualitative research.* 2nd ed. London: Sage. Ch.1.

Bjerke, T.N. (2006-2007) Cross-cultural gateway to recovery: A qualitative study of recovery experiences in International AA online groups. *International Journal of Self Help & Self Care,* 5(1), pp. 73-104.

Blaikie, N. (2007). *Approaches to social enquiry*. 2nd ed. Cambridge: Polity Press.

Bonney, S. & Stickley, T. (2008) Recovery and mental health: A review of the British Literature. *Journal of Psychiatric & Mental Health Nursing,* 15(2), pp. 140-153.

Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *The Social Service Review,* 50, pp.445-456.

Borkman, T. (1990). Experiential, professional and lay frames of references. In T.J Powell ed 1990. *Working with self-help.* NASW Press. Chp. 1.

Borkman, T. (1997). A selective look at self-help groups in the United States. *Health & Social Care in the Community,* 5(6), pp.357-364.

Borkman, T. (1999). *Understanding Self Help / Mutual Aid: Experiential Learning in the Commons*. New Jersey: Rutgers University Press.

Borkman, T., Munn-Giddings, C., Smith, L. & Karlsson, M. (2005). Social philosophy and funding in self help: A UK-US comparison. *International Journal of Self-Help & Self-Care,* 4(3), pp.201-220.

Borkman, T. (2006). Partnering with empowered clients and citizens: Creative synergy for new models of rehabilitation and self-management of chronic diseases and disabilities. In: *5th International Conference on Social Work in Health and Mental Health: Living in Harmony – Creative Synergy in a Stressful World*. Hong Kong, China. 10-14 December 2006.

Borkman, T. & Munn-Giddings, C. (2008) The contribution of self help groups and organizations to changing relations between patients/consumers and the health care system in the US and UK. In S. Chambre & M. Goldner eds. 2008. *Patients, Consumers and Civil Society.* Bingley: Emerald JAI. Chp.6.

Bott, S. (2008) *Peer support and personalisation*. National Centre for Independent Living.

Boyce, M.J., Seebohm, P., Chaudhary, S., Munn-Giddings, C. & Avis, M. (2014). Use of Social Media by Self-help/Mutual Aid Groups. *Groupwork.* 24(2), pp.26-44.

Bradstreet, S. (2006) Harnessing the 'lived experience': Formalising peer support approaches to promote recovery. *The Mental Health Review,* 11(2), pp.33-37.

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

Breton, M. (2004) An empowerment perspective. In C.D Garvin, L.M Guiterrez & M.J. Galinsky eds. 2004. *Handbook of social work with groups*. New York: Guilford Publications. Chp. 4.

Brickman, B. (2004). 'Delicate' cutters: gendered self-mutilation and attractive flesh in medical discourse. *Body & Society,* 10(4), pp.87-111.

Brooks, A. & Hesse-Biber, S.A. (2007). An invitation to feminist research. In: S.N. Hesse-Biber & P.L. Leavy, (eds). *Feminist Research Practice.* London: Sage. Ch. 1.

Brumberg, J.J. (2006). Are we facing an epidemic of self-injury? *The Chronicle of Higher Education,* 8 Dec. 53.16.

Bryman, A. (2012). *Social research methods.* 4th ed. Oxford University Press.

Burns, D. & Taylor, M. (1998). *Mutual aid and self-help: coping strategies for excluded communities*. Bristol: Policy Press.

Burns, D. & Chantler, K. (2011). Feminist methodologies. In: B. Somekh & C. Lewin, (eds). *Theory and method in social research.* 2nd ed. London: Sage. Ch. 8.

Burstow, B. (1992). *Radical feminist therapy: working in the context of violence.* Basingstoke: Palgrave Macmillan.

Butler, S. & Wintram, C. (1995) *Feminist groupwork*. London: Sage.

Carlsen, B. (2003). Professional support of self-help groups: A support group project for Chronic Fatigue Syndrome patients. *British Journal of Guidance & Counselling*, 31(3), pp. 289-303.

Castillo, H., Ramon, S. & Morant, N. (2012) A recovery journey for people with personality disorder. *International Journal of Social Psychiatry*, 59(3), pp. 264-273.

Chamberlin, J., Roger, S.E. & Ellison, M.L. (1996). Self-help programs: A description of their characteristics and their members. *Psychiatric Rehabilitation Journal,* 19(3), pp.33-41.

Chandler, A., Myers, F. & Platt, S. (2011). The construction of self-injury in the clinical literature: A sociological exploration. *Suicide and Life-Threatening Behavior*, 41(1), pp.98-109.

Chandler, A. (2012). Self-injury as embodied emotion work: Managing rationality, emotions and bodies. *Sociology,* 46(3), pp.442-457.

Chantler, K., Burman, E. & Batsleer, J. (2003). South Asian women: Exploring systemic service inequalities around attempted suicide and self-harm. *European Journal of Social Work,* 6(1), pp. 33-48.

Charlton, G.S. & Barrow, C.J. (2002). Coping and self-help group membership in Parkinson's disease: an exploratory qualitative study. *Health & Social Care in the Community,* 10(6), pp.472-478.

Chaudhary, S., Avis, M. & Munn-Giddings, C. (2010). The lifespan and life-cycle of self-help groups: A retrospective study of groups in Nottingham, UK. *Health and Social Care in the Community*, 18(4), pp.346-354.

Chaudhary, S., Avis, M. & Munn-Giddings, C. (2013). Beyond the therapeutic: A Habermasian view of self-help groups' place in the public sphere. *Social Theory & Health*, 11(1), pp.59-80.

Claes, L. & Vandereycken, W. (2007). Self-injurious behavior: differential diagnosis and functional differentiation. *Comprehensive Psychiatry,* 48(2), pp.137-144.

Codd, H. (2002). 'The ties that bind': Feminist perspectives on self-help groups for prisoners' partners. *The Howard Journal,* 41(4), pp.334-347.

Corcoran, J., Mewse, A. & Babiker, G. (2007). The role of women's self-injury support-groups: A grounded theory. *Journal of Community & Applied Social Psychology,* 17(1), pp.35-52.

Cooper, J., Murphy, E., Webb, R., Hawton, K., Bergen, H., Waters, K. & Kapur, N. (2010). Ethnic differences in self-harm, rates, characteristics and service provision: three-city cohort study. *British Journal of Psychiatry*, 197(3), pp.212-218.

Cotterill, P. (1992). Interviewing women: Issues of friendship, vulnerability and power. *Women's Studies International Forum,* 15(5/6), pp.593:606.

Cotterell, P. (2008). Exploring the value of service user involvement in data analysis: "Our interpretation is about what lies below the surface". *Educational Action Research,* 16(1), pp. 5-17.

Cresswell, M. (2005). Psychiatric survivors' testimonies of self-harm. *Social Science & Medicine,* 61(8), pp.1668-1677.

Cresswell, M. (2007). Self-harm and the politics of experience. *Journal of Critical Psychology, Counselling & Psychotherapy.* 7(1), pp.9-17.

Crotty, M. (1998). *The foundations of social research.* London: Sage.

Dace, E., Faulkner, A., Frost, M., Parker, K., Pembroke, L. & Smith, A. (1998). *The 'hurt yourself less' workbook.* London: National Self-Harm Network.

Dadich, A. (2003-2004). Self-help support groups and issues in research. *International Journal of Self-help and Self Care*. 2(1), pp.41-55.

Damen, S., Mortelmans, D. & Van Hove, E. (2000) Self-help groups in Belgium: Their place in the care network, *Sociology of Health & Illness,* 22(3), pp. 331-348.

Dargan, P. (2013). Self-harm: An intelligent language for subjugation and stigma. In C.Baker, C.Shaw & F.Biley, eds. 2013.*Our encounters with self-harm*. Ross-on-Wye: PCCS Books. Ch.25.

Darke, P., Shanks, G. & Broadbent, M. (1998). Successfully completing case study research: combining rigour, relevance and pragmatism. *Information Systems Journal,* 8(4), pp.273:289.

Denzin, N.K. & Lincoln, Y.S. (2013). Introduction: The discipline and practice of qualitative research. In: Denzin, N.K. & Lincoln, Y.S. (eds). The landscape of qualitative research. London: Sage. Ch. 1.

Department of Health (2011). *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*. London: HMSO.

Douglas, T. (1993). *A theory of groupwork practice.* London: Macmillan.

Doy, R. (2003). Women and deliberate self-harm. In: G. Boswell and Poland. F, eds. *Women's Minds, Women's Bodies: An interdisciplinary approach to women's health*. Basingstoke: Palgrave. Chp. 6.

Dutta, K. (2015). Teaching unions warn of self-harm epidemic among students. *The Independent*, 7 January. Available at: http://www.independent.co.uk/life-style/health-and-families/health-news/teaching-unions-warn-of-selfharm-epidemic-among-students-9961669.html [Accessed 17 January 2015].

Edwards, R. & Mauthner, M. (2002) Ethics and feminist research: Theory and Practice. T. In: T. Miller., M. Birch., M. Mauthner & J. Jessop. (eds). *Ethics in qualitative research.* 2nd ed. London: Sage. Ch. 2.

Elsdon, K., Reynolds, J. & Stewart, S. (2000) *Sharing experience, living and learning: a study of self-help groups*. London: Community Matters.

Emerick, R. (1991). The politics of psychiatric self help: Political factions, interactional support and group longevity in a social movement. *Social Science and Medicine,* 32(10), pp.1121–1128.

ESTEEM, (2011). *Effective support for self-help/mutual aid groups: Stage 1 Interim Report*. [online] Self Help Connect UK. Available at: http://www.selfhelp.org.uk/reports/ [Accessed 19 November 2014]

ESTEEM, (2013). *Effective support for self-help/mutual aid groups: Stage 2 Report*. [online] Self Help Connect UK. Available at: http://www.selfhelp.org.uk/reports/ [Accessed 19 November 2014]

Faulkner, A. & Basset, T. (2012) A long and honourable history. *The Journal of Mental Health Training, Education & Practice,* 7(2), pp. 53-59.

Faulkner, A. & Kalathil, J. (2012) *The freedom to be, the chance to dream: Preserving user-led peer support in mental health.* Together for Mental Wellbeing.

Faulkner, A., Hughes, A., Thompson, S., Nettle, M., Wallcraft, J., Collar, J., de la Haye, S. & Mckinley, S. (2013) *Mental health peer support in England: Piecing together the jigsaw*. MIND.

Favazza, A. (2011). *Bodies Under Siege.* 3rd ed. Baltimore: John Hopkins University Press.

Feigenbaum, J., (2007). Dialectical behaviour therapy: An increasing evidence base. *Journal of Mental Health,* 16(1), pp.51-68.

Fielding, N. & Thomas, H. (2008). Qualitative interviewing. In: N.Gilbert (ed) *Researching Social Life.* 3rd ed. London: Sage. Ch.13.

Finn, J. (1999). An exploration of helping process in an online self-help group focusing on issues of disability. *Health & Social Work,* 24(3), pp.220-231.

Finn, L.D., Bishop, B.J. & Sparrow, N. (2009). Capturing dynamic processes of change in GROW mutual help groups for mental health. *American Journal of Community Psychology,* 44(3-4), pp.302-315.

Folgheraiter, F. & Pasini, A. (2009). Self-help groups and social capital: New directions in welfare policies? *Social Work Education,* 28(3), pp.253-267.

Forsberg, B., Nygren, L. & Fahlgren, S. (2005). Self-help groups for women with pain: A research review with a gender perspective. *International Journal of Self-Help & Self-Care,* 3(1-2), pp.133-148.

Foster, L. (2013). Self-harm and suicide: Doubts and dilemmas. In C. Baker, C. Shaw & F. Biley, eds. 2013.*Our encounters with self-harm*. Ross-on-Wye: PCCS Books. Ch.26.

Frith, M. (2004). New figures reveal hidden epidemic of self-harm. *The Independent,* 27 July. Available at: http://www.independent.co.uk/life-style/health-and-families/health-news/new-figures-reveal-hidden-epidemic-of-selfharm-6164765.html [Accessed 17 November 2014].

Gardner, F. (2002). *Self-harm: a psychotherapeutic approach.* Hove: East Sussex Brunner-Routledge.

Giddens, A. (1991). *Modernity and self-identity: self and society in the late modern age.* Cambridge: Polity.

Giddens, A. (1994). *Beyond left and right: the future of radical politics.* Polity Press.

Gladstone, G.L., Parker, G.B., Mitchell, P.B., Malhi, G.S., Wilhelm, K. & Austin. M.P. (2004). Implications of childhood trauma for depressed women: an analysis of pathways from childhood sexual abuse to deliberate self-harm and revictimization. *American Journal of Psychiatry,* 161(8), pp.1417-1425.

Goffman, E. (1990). *Stigma: Notes on the management of spoiled identity.* Penguin.

Gratz, K.L., Conrad, S.D. & Roemer, L. (2002). Risk factors for deliberate self-harm among college students. *American Journal of Orthopsychiatry,* 72(1), pp. 128-140.

Gratz, K.L. (2003). Risk factors for and functions of deliberate self-harm: an empirical and conceptual review. *Clinical Psychology: Science & Practice,* 10(2), pp. 192-205.

Gray, R., Fitch, M., Davis, C. & Phillips, C. (1997) A qualitative study of breast cancer self-help groups. *Psycho-Oncology*, 6(4), pp. 279–289.

Gribbon, D. (2011). *Scoping review of peer support models in mental health.* Anglia Ruskin University.

Gunnell, D., Bennewith, O., Peters, T.J., House, A. & Hawton, K. (2004). The epidemiology and management of self-harm amongst adults in England. *Journal of Public Health,* 27(1), pp.67-73.

Gutridge, K., (2010). Safer self-injury or assisted self-harm? *Theoretical Medicine & Bioethics,* 31(1), pp.79-92.

Harper, D. & Speed, E. (2012) Uncovering recovery: The resistible rise of recovery and resilience. *Studies in Social Justice,* 6(1), pp. 9-25.

Harrison, D., (1995). *Vicious circles: an exploration of women and self-harm in society.* London: Good Practices in Mental Health.

Hastie, N. (2000). Origins and activities of self-help support centre in Nottingham, UK. *International Journal of Self-help & Self-Care,* 1, pp.123-128.

Hawton, K. & Fagg, J. (1992). Trends in deliberate self poisoning and self injury in Oxford, 1976-1990. *British Medical Journal,* 304(6839), pp.1409-1411.

Hawton, K., Rodham, K., Evans, E. & Weatherall, R. (2002). Deliberate self-harm in adolescents: self report survey in schools in England. *British Medical Journal,* 325(7374), pp.1207-1211.

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

Hawton, K. & Harris, L., (2008). Deliberate self-harm by under 15-year-olds: characteristics, trends and outcomes. *Journal of Child Psychology and Psychiatry,* 49(4), pp.441-448.

Hawton, K., Townsend, E., Arensman, E., Gunnell, P., Hazell, P., House, A. & van Heeringen, K. (2009). *Psychosocial and pharmacological treatments for deliberate self harm (Review)*. London: The Cochrane Collaboration.

Hatzidimitriadou, E. (2002). Political ideology, helping mechanisms and empowerment of mental health self-help / mutual aid groups. *Journal of Community & Applied Psychology,* 12(4), pp.271–285.

Helgeson, V.S. & Gottlieb, B.H. (2000) Support groups. In S. Cohen, L.G. Underwood & B.H. Gottlieb eds. 2000. *Social support measurement, and intervention: A guide for health and social scientists.* New York: Oxford University Press. Chp. 7.

Hennink, M., Hutter, I. & Bailey, A. (2011) *Qualitative research methods*. London: Sage.

Hewitt, D. (2010). Self-harm minimization and the law. *Primary Health Care,* 20(1), pp.24-25.

Hill, A. (2006). Teenagers' epidemic of self-harm. *Guardian,* 26 March. Available at: http://www.theguardian.com/society/2006/mar/26/socialcare.medicineandhealth [Accessed 17 November 2014].

Hodgson, S. (2004). Cutting through the silence: A sociological construction of self-injury. *Sociological Inquiry,* 74(2), pp.162-179.

Hogg, C. (2010). Exploring the issues of men and self-injury. *Mental Health Practice,* 13(9), pp.16-20.

Horrocks, J. & House, A. (2002). Self-poisoning and self-injury in adults. *Clinical Medicine,* 2(6), pp.509-512.

Howell, K.E. (2013). *An introduction to the philosophy of methodology.* London: Sage.

Hume, M. & Platt, S. (2007). Appropriate interventions for the prevention and management of self-harm: a qualitative exploration of service-users' views. *BMC Public Health,* 7(9), pp.9-18.

Humphreys, K. & Rappaport, J. (1994). Research self-help/mutual aid groups and organisations: Many roads, one journey. *Applied & Preventative Psychology,* 3, pp.217-231.

Humphreys, K. (1997). Individual and social benefits of mutual aid and self-help groups. *Social Policy,* 27(3), pp.12-19.

Husain, M., Waheed, W. & Husain, N. (2006). Self-harm in British South Asian women: psychosocial correlates and strategies prevention. *Annals of General Psychiatry,* 5(1), pp.7-7.

Inckle, K., (2007). *Writing on the Body? Thinking through gendered embodiment and marked flesh*. Newcastle: Cambridge Scholars Publishing.

Inckle, K. (2010). *Flesh wounds? New ways of understanding self-injury.* Ross-on-Wye: PCCS books.

Inckle, K. (2014). Strong and silent: Men, masculinity and self-injury. *Men & Masculinities,* 17(1), pp.3-21.

Jacobs, M. & Goodman, G. (1989) Psychology and self-help groups: Predictions on a partnership. *American Psychologist,* 44(3), pp.536–545.

Jeffery, D. & Warm, A., (2002). A study of service providers' understanding of self-harm. *Journal of Mental Health,* 11 (3), pp.295-303.

Jeffreys, S. (2005). *Beauty and misogyny: harmful cultural practices in the West.* New York: Routledge.

Karlsson, M., Grassman, E.J. & Hansson, J. (2002). Self-help groups in the welfare state: treatment program or voluntary action? *Non-Profit Management and Leadership,* 13(2), pp.155–167.

Katz, A.H. & Bender, E.I. (1976). The strength in Us: Self-help groups in the modern world. New York: New Viewpoints.

Katz, A.H. (1981). "Self-help and mutual aid: An emerging social movement?". *Annual Review of Sociology,* 7, pp.129-155.

Katz, A.H. (1993). *Self-help in America: A social movement perspective.* New York: Twayne.

Kilby, J. (2001) Carved in skin: bearing witness to self-harm. In S. Ahmed & J. Stacey, eds. *Thinking through the skin.* London: Routledge. Ch.7.

King, M., Semlyen, J., See Tai, S., Killaspy, H., Osborn, D., Popelyuk, D. & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*, 8(1), pp.70-87.

King, S.A. & Moreggi, D. (2006). Internet self-help and support groups: The pros and cons of text-based mutual aid. In: J. Gackenback (ed). *Psychology and the internet: Intrapersonal, interpersonal and transpersonal implications.* 2nd edition. London: Elsevier. Ch.9.

de Kloet, L., Starling, J., Hainsworth, C. & Berntsen, E. (2011). Risk factors for self-harm in children adolescents admitted to a mental health inpatient unit. *Australian & New Zealand Journal of Psychiatry,* 45(9), pp.749-755.

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

Klonsky, D.E. & Muehlenkamp, J.J. (2007). Self-injury: A research review for the practitioner. *Journal of Clinical Psychology,* 63(11), pp.1045-1056.

Koski, J.P. (2014) "I'm just a walking eating disorder": The mobilisation and construction of a collective illness identity in eating disorder support groups. *Sociology of Health & Illness*, 36(1), pp.75-90.

Kravetz, D., Marecek, J. & Finn, S.E. (1983). Factors influencing women's participation in consciousness-raising groups. *Psychology of Women's Quarterly,* 7(3), pp. 257-271.

Kropotkin, P. (1989). *Mutual aid: A factor of evolution (collected works of Peter Kropotkin).* Black Rose Books.

Kurtz, L.F. (1997). *Self-help and support groups: A handbook for practitioners.* London: SAGE.

Kurtz, L.F. (2004) Support and self-help groups. In C.D Garvin, L.M Guiterrez & M.J. Galinsky eds. 2004. *Handbook of social work with groups*. New York: Guilford Publications. Chp. 8.

LeFevre, S.J. (1996). *Killing me softly.* Gloucester Handsell.

Letherby, G. (2003). *Feminist research in theory and practice.* Buckingham: Open University Press.

Levenkron, S. (2006). *Cutting: Understanding and overcoming self-mutilation*. New York / London: W. W. Norton.

Levine, J. (2005). An exploration of female social work students' participation in online and face-to-face self-help groups. *Groupwork,* 15(2), pp.61-79.

Lewis, R., Sharp, E., Remnant, J. & Redpath, R.. (2015). 'Safe space': Experiences of Feminist women only space. *Sociological Research Online,* 20(4).

Lieberman, M.A. & Russon, S. (2001). Self help groups and the internet: Breast cancer newsgroups. *International Journal of Self Help & Self Care,* 1(4), pp.323-344.

Lincoln, Y.S. & Guba, E.G. (2007). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Directions for Evaluation,* 114, pp.15-25.

Lindgren, B.M., Wilstrand, C., Gilje, F. & Olofsson, B. (2004). Struggling for hopefulness: a qualitative study of Swedish women who self-harm. *Journal of Psychiatric and Mental Health Nursing,* 11(3), pp.284-291.

Lindgren, B.M., Oster, I., Astrom, S. & Graneheim, U.H. (2011). "They don't understand…you cut yourself in order to live": Interpretative repertoires jointly constructing interactions between adult women who self-harm and professional caregivers. *International Journal of Qualitative Studies on Health & Wellbeing,* 6(3), pp.1-13.

Loat, M. (2011). *Mutual support and mental health: A route to recovery.* Taylor & Francis Group.

Lombardo, C. & Skinner, H. (2003-2004). "A virtual hug": Prospects for self-help online. *International Journal Self Help & Self Care*, 2(3), pp.205-218.

Long, M., Manktelow, R. & Tracey, A. (2013). We are all in this together: Working towards a holistic understanding of self-harm. *Journal of Psychiatric & Mental Health*, 20(2), pp. 105-113.

Madara, E.J. (1997). The mutual-aid self-help online revolution. *Social Policy,* 27(3), pp.20-26.

Maguire, P. (2001). Uneven ground: Feminisms and action research. In P. Reason & H. Bradbury (eds). *Handbook of action research: Participative inquiry and practice*. London: Sage. Ch. 5.

Marshall, H. & Yazdani, A. (1999). Locating culture in accounting for self-harm amongst Asian young women. *Journal of Community & Applied Social Psychology,* 9(6), pp. 413-433.

Martins, V. (2007). 'To that piece of each of us that refuses to be silent': Working with self-harm and black identity. In H. Spandler & S. Warner, eds. 2007. *Beyond Fear and Control: Working with young people who self-harm*. Ross-on-Wye: PCCS books. Ch.8.

Mason, J. (2002) *Qualitative researching.* 2nd ed. London: Sage.

Matson, J.L. & Turygin, N.C. (2012). How do researchers define self-injurious behavior? *Research in Developmental Disabilities,* 33(4), pp.1021-1026.

Matthews, B. & Ross, L. (2010). *Research methods: A practical guide for the social sciences*. Harlow: Longman.

Matzat, J. (2002). The development of self-help groups and support for them in Germany. *International Journal of Self-Help & Self-Care,* 1(4), pp.307-322.

May, T. (2011). *Social research: Issues, methods and process.* 4th ed. Open University Press.

Maynard, M. (1994). Methods, practice and epistemology: The debate about feminism and research. In M. Maynard & J. Purvis, (eds). *Researching women's lives from a feminist perspective.* London: Taylor & Francis. Ch. 1.

McAllister, M., Creedy, D., Moyle, W. & Farrugia, C. (2002). Nurses' attitudes towards clients who self-harm. *Journal of Advanced Nursing,* 40(5), pp.578-586.

McAllister, M., (2003). Multiple meanings of self-harm: A critical review. *International Journal of Mental Health Nursing,* 12(3), pp.177-185.

McAndrew, S. & Warne, T. (2005). Cutting across boundaries: A case study using feminist praxis to understand the meanings of self-harm. *International Journal of Mental Health Nursing,* 14(3), pp.172-180.

McCabe, A. & Phillimore, J. (2009). *Exploring below the radar: issues of theme and focus*. TSRC Working Paper 8. [online] Available at: http://www.birmingham.ac.uk/generic/tsrc/documents/tsrc/working-papers/working-paper-8.pdf [Accessed 17 November 2014].

McMahon, E.M., Reulbach, U., Keeley, H., Perry, I.J. & Arensman, E. (2010). Bullying victimisation, self-harm and associated factors in Irish adolescent boys. *Social Science & Medicine,* 71(7), pp.1300-1307.

McShane, T. (2012). *Blades, blood and bandages: The experience of people who self-injure.* Basingstoke: Palgrave Macmillan.

Medvene, L.J. (1990). Family support organizations: The functions of similarity. In T.J.Powell (ed). (1990). Working with self-help. NASW Press. Chp.6.

MHF (2006). *Truth Hurts: Report of the national inquiry into self-harm among young people.* London: Mental Health Foundation.

MHF (2014). *Mental Health Statistics: Self-Harm*. [online] Available at: http://www.mentalhealth.org.uk/help-information/mental-health-statistics/self-harm/ [Accessed 17 November 2014].

Miller, D. (2005). *Women who hurt themselves: A book of hope and understanding*. New York: Basic Books.

Miller, A.L. & Smith, H.L. (2008). Adolescent non-suicidal self-injurious behavior: The latest epidemic to assess and treat. *Applied & Preventive Pscyhology,* 12(4), pp.178-188.
Moran, P., Coffey, C., Romaniuk, H., Olsson, C., Borschmann, R., Carlin, J.B. & Patton, G.C. (2011). The natural history of self-harm from adolescence to young adulthood: a population-based cohort study. *The Lancet,* 379(9812), pp. 236-243.

Moro, C.B. (2007). A comprehensive literature review defining self-mutilation and occupational therapy intervention approaches: Dialectical behavior therapy and sensory integration. *Occupational Therapy in Mental Health,* 23(1), pp.55-67.

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

Munn-Giddings, C. (2003) *Mutuality and Movement: An exploration of the relationship of self-help/mutual aid to social policy*. Ph.D. Loughborough University.

Munn-Giddings, C. & Borkman T. (2005). Self-Help/Mutual Aid as a Psychosocial Phenomenon. In: J.E. Williams & S. Ramon eds. *Mental health at the crossroads; the promise of the psychosocial approach*. Aldershot: Ashgate, 2005. Chp. 10.

Munn-Giddings, C. & McVicar, A. (2006). Self-help groups as mutual support: What do carers value? *Health & Social Care in the Community,* 15(1), pp.26-34.

Munn-Giddings, C. & Stokken, R. (2012). Self-help/mutual aid in Nordic countries: Introduction to special Nordic issue. *International Journal of Self-Help & Self-Care,* 6(1), pp.3-7.

Munn-Giddings, C., Oka, T., Borkman, T., Matzat, J., Montano, R., Chikoto , G . (2016) Self-help and mutual aid group volunteering. In Horton-Smith & Grotz eds. *Palgrave Research Handbook of Volunteering and Non-profit Associations*. Palgrave Macmillan: New York.

Nelson, S. (2007). You need to have been there. *Mental Health Today,* Jul/Aug, pp.37-39.

NICE (2004) Self-harm: The short-term physical and psychological management and secondary prevention of intentional self-harm in primary and secondary care. *Clinical Guideline 16.* London: NICE (National Institute for Clinical Excellence).

NICE (2011) Self-harm: Longer-term management. *Clinical Guideline 133*. London: NICE (National Institute for Clinical Excellence).

Nixon, M.K., Cloutier, P. & Jansson, S.M. (2008). Nonsuicidal self-harm in youth: a population-based survey. *Canadian Medical Association Journal,* 178(3), pp. 306-312.

Nock, M.K. (2009). Why do people hurt themselves? *Current Directions in Psychological Science,* 18(2), pp.78-83.

O'Connor, R.C., Rasmussen, S., Miles, J. & Hawton, K. (2009). Self-harm in adolescents: self-report survey in schools in Scotland. *The British Journal of Psychiatry,* 194(1), pp.68-72.

Oka, T. & Borkman, T. (2011). Self-help groups, self-help supporters and social work: A Theoretical discussion with some case illustrations of family survivors of suicide in Japan. *Studies on Social Work,* 37(3), pp.168-183.

Örulv, L. (2012). Reframing dementia in Swedish self-help group conversations. *International Journal of Self-help & Self-Care,* 6(1), pp.9-41.

Owen, D., Horrocks, J. & House, A. (2002). Fatal and non-fatal repetition of self-harm. *British Journal of Psychiatry,* 181, pp.193-199.

Parker, K. & Lindsay, H. (2004). *Self-injury support & self-help groups.* Bristol: Bristol Crisis Service for Women.

Pembroke, L. (1994). Introduction. In: L. Pembroke, ed. 1994. *Self-harm: Perspectives from personal experience*. London: Survivors Speak Out. Ch.1.

Pembroke, L. (2000). *Cutting the risk: self-harm, self-care and risk reduction*. London: National Self-Harm Network.

Pembroke, L., (2006a). Offer us what we want. *Mental Health Today,* Jul-Aug, pp.16-18.

Pembroke, L. (2006b). Limiting self-harm. *Emergency nurse*, 14(5), pp.8-10.

Pembroke, L. (2006c). Limiting the damage. *Mental Health Today,* April, pp.27-29.

Pembroke, L. (2007). Harm minimisation: Limiting the damage of self-injury. In: H. Spandler and S. Warner, eds. *Beyond Fear and Control: Working with young people who self harm.* Ross-on-Wye: PCCS books. Ch. 11.

Pengelly, N., Ford, B., Blenkiron, P. & Reilly, S. (2008). Harm minimisation after repeated self-harm: development of a trust handbook. *Psychiatric Bulletin,* 32(2), pp.60-63.

Perseius, K-I., Ojehagen, A., Ekdahl, S., Asberg, M. & Samuelsson, M. (2003). Treatment of suicidal and deliberate self-harming patients with borderline personality disorder using dialectical behavioural therapy: The patients' and the therapists' perceptions. *Archives of Psychiatric Nuring,* 17(5), pp.218-227.

Pistrang, N., Barker, C. & Humphreys, K. (2008) Mutual Help Groups for Mental Health Problems: A Review of Effectiveness Studies. *American Journal of Community Psychology,* 42(1-2), pp.110-121.

Powell, T. & Perron, B.E. (2010). Self-help groups and mental health/substance use agencies: The benefits of organizational exchange. *Substance Use & Misuse,* 45(3), pp.315-329.

Ramazanoglu, C. & Holland, J. (2002). *Feminist methodology: Challenges and choices*. London: Sage.

Ramon, S. & Williams, J. E. (2005). Towards a conceptual framework: the meanings attached to the psychosocial, the promise and the problems. In S. Ramon & J.E. Williams, eds. *Mental health at the crossroads: The promise of the psychosocial approach.* Aldershot: Ashgate Publishing. Ch1.

Rappaport, J. (1993) Narrative studies, personal stories and identity transformation in the mutual help context. *The Journal of Applied Behavioural Science,* 29(2), pp.239-256.

Steffen, V. (1997) Life stories and shared experience. *Social Science & Medicine*, 45(1), pp. 99-111.

Rapping, E. (1997). There's self-help and then there's self-help: Women and the recovery movement. *Social Policy,* Spring, pp.56-61.

Rapping, E. (2001). *The culture of recovery: Making sense of the self-help movement in women's lives.* Boston: Beacon Press.

Rayner, G. & Warner, S., (2003). Self-harming behaviour: from lay perceptions to clinical practice. *Counselling Psychology Quarterly,* 16(4), pp.305-329.

Reece, J. (2005). The language of cutting: Initial reflections on a study of the experiences of self-injury in a group of women and nurses. *Issues in Mental Health Nursing,* 26(6), pp.561-574.

Riessman, F. & Carroll, D. (1995) *Redefining self-help*. San Francisco: Jossey-Bass Publishers.

Roberts, G. & Wolfson, P. (2004) The rediscovery of recovery: Open to all. *Advances in Psychiatric Treatment,* 10(1), pp.37-49.

Robson, C. (2011). *Real world research: A resource for users of social research methods in applied settings.* 3rd ed. Chichester: Wiley.

Rodham, K., Gavin, J. & Miles, M. (2007). I hear, I listen and I care: a qualitative investigation into the function of a self-harm message board. *Suicide & Life Threatening Behaviour,* 37(4), pp.422-430.

Royal College of Psychiatrists, (2010). *Self-harm, suicide and risk: helping people who self-harm*. London: Royal College of Psychiatrists.

Sabhlok, S.G. (2011) Development and women: The role of trust in self-help groups. *Indian Journal of Gender Studies,* 18(2), pp.241-261.

Sanders, J.M. (2014). *Women in Narcotics Anonymous: Overcoming stigma and shame.* Palgrave Macmillan.

Scholz, R.W. & Tietje, O. (2002). *Embedded case study methods.* London: Sage.

Scott, A., Doughty,C. & Kahi, H. (2011). 'Having those conversations': The politics of risk in peer support practices. *Health Sociology Review,* 20(2), pp. 187-201.

Schubert, M.A. & Borkman, T.J. (1991). An organizational typology for self help groups. *American Journal of Community Psychology,* 19(5), pp.769-787.

Seebohm, P., Munn-Giddings, C. & Brewer, P. (2010). What's in a name? A discussion paper on the labels and location of self-organising community groups with particular reference to mental health and Black groups. *Mental Health & Social Inclusion,* 14(3), pp.23-29.

Seebohm, P., Chaudhary, S., Boyce, M., Elkan, R., Avis, M. & Munn-Giddings, C. (2013). The contribution of self-help/mutual aid groups to mental well-being. *Health & Social Care in the Community,* 21(4), pp.391-402.

Selwyn, N. (2004). Reconsider political and popular understandings of the digital divide. *New Media & Society*, 6(3), pp.341-362.

Seymour-Smith, S. (2008). "Blokes don't like that sort of thing": Men's negotiation of a 'troubled' self-help group identity. *Journal of Health Psychology,* 13(6), pp.785-797.

Sharkey, V. (2003). Self-wounding: a literature review. *Mental Health Practice,* 6(7), pp. 35-37.

Shaw, S.N. (2002). Shifting conversations on girls' and women's self-injury: An analysis of the clinical literature in historical context. *Feminism & Psychology, 1*2(2), pp.191-219.

Shaw, C. & Shaw, T. (2007). A dialogue of hope and survival. In: H. Spandler and S. Warner, eds. *Beyond Fear and Control: Working with young people who self harm.* Ross-on-Wye: PCCS books. Ch.1.

Shaw, C. (2009). Steps. In: L. Cadman & J. Hoy, eds. *Cutting the risk: Self harm minimisation in perspective – teaching and learning guidelines*. National Self Harm Minimisation Group. p.6.

Shaw, C. (2012). Harm-minimisation for self-harm. *Mental Health Today,* September/October, pp.19-21.

Shaw, C. (2013a). "I do not believe in silence": Self-harm and childhood sexual abuse. In C. Baker, C. Shaw & F. Biley, eds. *Our encounters with self-harm*. Ross-on-Wye: PCCS Books. Ch.20.

Shaw, C. (2013b). Living with scars. *Asylum,* 20(2), pp.4-6.

Shepherd, M.D., Schoenberg, M., Slavich, S., Wituk, S., Warren, M. & Meissen, G. (1999). Continuum of professional involvement in self-help groups. *Journal of Community Psychology,* 27(1), pp.39-53.

Simons, H. (2009). *Case study research in practice.* London: Sage.

Simpson, A., (2006). Can mainstream health services provide meaningful care for people who self-harm: a critical reflection. *Journal of Psychiatric and Mental Health Nursing,* 13(4), pp.429-436.
Skegg, K., (2005). Self-harm. *Lancet,* 366(9495), pp.1471-1483.

Smiles, S. (2002). *Self-help*. Oxford University Press.

Smith, A. & Clarke, J., (2003). *Self-harm self help/support groups.* London: Mental Health Foundation.

Smith, G., Cox, D. & Saradjian, J., (1998). *Women and self-harm.* London: Women's Press.

Smithson, J., Sharkey, S., Hewis, E., Jones, R.B., Emmens, T., Ford, T. & Owens, C. (2011). Membership and boundary maintenance on an online self-harm forum. *Qualitative Health Research*, 21(11), pp.1567-1575.

Sourbati, M. (2012). Disabling communications? A capabilities perspective on media access, social inclusion & communication policy. *Media Culture & Society*, 34(5), pp.571-587.

Spandler, H. (1996). *Who's hurting who? Young people, self-harm and suicide.* 42nd Street.
Spandler, H. & Batsleer, J. (2000). Sparring Partners: Conflicts in the expression and treatment of self-harm. In: J. Batsleer and B. Humphries, eds. *Welfare, Exclusion and Political Agency*. London: Routledge. Ch.10.

Spandler, H. and Warner, S. (2007). Introduction. In H.Spandler & S. Warner, eds. 2007. *Beyond Fear and Control: Working with young people who self-harm*. Ross-on-Wye: PCCS books. Introduction.

Spandler, H. & Stickley, T. (2011) No hope without compassion: The importance of compassion in recovery-focused mental health services. *Journal of Mental Health*, 20(6), pp.555-566.

Stake, R.E. (2005). Qualitative case studies. In N.K. Denzin & Y.S. Lincoln, (eds). *The Sage handbook of qualitative research.* 3rd ed. London: Sage. Ch. 17.

Straiton, M., Roen, K., Dieserud, G. & Hjelmeland, H. (2013). Pushing the boundaries: Understanding self-harm in a non-clinical population. *Archives of Psychiatric Nursing*, 27, pp. 78-83.

Strong, M. (2005). *A bright red scream: Self-mutilation and the language of pain*. London: Virago.

Sutton, J., (2007). *Healing the hurt within.* 3rd ed. Oxford: Pathways.

Taylor, V. (1996). Rock-a-by baby: Feminism, self-help and postpartum depression. London: Routledge.

Taylor, B. (2003). Exploring the perspectives of men who self-harm. *Learning in Health and Social Care*, 2(2), pp.83-91.

Taylor, T.L., Hawton, K., Fortune, S. & Kapur, N. (2009). Attitudes towards clinical services among people who self-harm: systematic review. *British Journal of Psychiatry*, 194(2), pp.104-110.

Tew, J. (2005). Power relations, social order and mental distress. In J.Tew, ed. 2005. *Social perspectives in mental health: developing social models to understand and work with mental distress.* London: Jessica Kingsley. Ch.4.

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J. & Le Boutillier, C. (2012). Social factors and recovery from mental health difficulties: A review of the evidence. *British Journal of Social Work,* 42(3), pp. 443-460.

The Roestone Collective. (2014). Safe Space" Towards a Reconceptualization. *Antipode,* 46(5), pp. 1346-1365.

Thomas, G. (2011). *How to do your case study: A guide for students and researchers.* London: Sage.

Townsend, E. (2014). Self-harm in young people. *Evidence-Based Mental Health,* 17(4), pp.97-99.

Turp, M., (2003). *Hidden self-harm: narratives from psychotherapy.* London: Jessica Kingsley Publishers.
Twigg, J. (2006). *The body in health and social care.* Basingstoke: Palgrave Macmillan.

Van Der Avort, A. & Van Harberden, P. (1985). Helping self-help groups: A developing theory. *Psychotherapy,* 22(2), pp.269-272.

Verhaeghe, M. & Bracke, P. (2011). Stigma and trust among mental health service users. *Archives of Psychiatric Nursing*, 25(4), pp.294-302.

Visram, N., Roberts, A., Seebohm, P., Boyce, M. & Chaudhary, S. (2012) The role of self-help groups in promoting well-being: experiences from a cancer group. *Mental Health & Social Inclusion,* 16(3), pp.139-146.

Wallcraft, J. (2003). *On our own terms: Users and survivors of mental health services working together for support and change.* London: The Sainsbury Centre for Mental Health.

Wann, M. (1995) *Building social capital: self help in a twenty-first century welfare state*. Institute for Public Policy Research.

Warm, A., Murray, C. & Fox, J. (2002). Who helps? Supporting people who self-harm. *Journal of Mental Health,* 11(2), 121-130.

Warner, S. & Spandler, H., (2012). New strategies for practice-based evidence: A focus on self-harm. *Qualitative Research in Psychology,* 9(1), pp.13-26.

Warner, S. (2013). From state control to state support. *Asylum,* 20(2), pp. 13-15.

West, E., Newton, V.L. & Barton-Breck, A. (2013). Time frames and self-hurting: that was then, this is now. *Health, Risk & Society,* 15(6-7), pp.580-595.

Wilson J. (1994) *Two Worlds: Self Help Groups and Professionals.* Venture Press: BASW.

Whitlock, J.L., Powers, J.L. & Eckenrode, J. (2006). The virtual cutting edge: the internet and adolescent self-injury. *Developmental Psychology,* 42(3), pp.407-417.

Williams, F. (2004) Care, values and support in local self-help groups. *Social Policy & Society,* 3(4), pp.431-438.

Wilson, J. & Myers, J. (1998). *Self help groups: Getting started, keeping going*. London: R.A. Wilson.

Wilstrand, C., Lindgren, B.M., Gilje, F. & Olofsson, B. (2007). Being burdened and balancing boundaries: A qualitative study of nurses' experiences caring for patients who self-harm. *Journal of Psychiatric & Mental Health Nursing,* 14(1), pp.72-78.

Wilton, T. (1995) Madness and feminism: Bristol Crisis Service for Women. In G. Griffin, ed. *Feminist Activism in the 1990s,* London: Taylor & Francis. Ch.2.

Wituk, S., Shepherd, M., Warren, M. & Meissen, G. (2002). Factors contributing to the survival of self-help groups. *American Journal of Community Psychology,* 30(3), pp.349-366.

Wright, S. (2004). *Self-help groups*. London: Mental Health Foundation.

Yalom, I.D. (2005). *The theory and practice of group psychotherapy*. New York: Basic Books.

Yin, R.K. (2014). *Case study research: Design and methods.* 5th ed. London: Sage.

APPENDIX I

PHASE 1 INVITATION LETTER TO GROUPS

[HEADED PAPER]

[ADDRESS]

[DATE]

Dear [NAME]

I am writing to invite you and your group to take part in a research study. The study is part of my PhD studies, which I am undertaking part-time at Anglia Ruskin University, where I am also a full-time staff member in the Department of Mental Health and Learning Disabilities.

The aim of the study is to work collaboratively with two self-harm self-help groups to explore the role of such groups from the perspective of group members and those that support such groups.

I have enclosed an information sheet that provides further information about the study and some information about me.

I will ring within two weeks to find out your decision in relation to taking part in the study. I am also very happy to come and meet with you and the group to discuss further what participation would mean. Alternatively if you want to contact me directly my contact details are below and in the information sheet.

Thank you for taking the time to read this,

Warm wishes,

Melanie Boyce
Research Fellow
Anglia Ruskin University,
Faculty of Health & Social Care
William Harvey Building, Bishop Hall Lane
Chelmsford Essex
CM1 1SQ

0845 196 4198
Melanie.Boyce@anglia.ac.uk

APPENDIX II

PHASE 1 INFORMATION SHEET

Anglia Ruskin University

Cambridge & Chelmsford

Information Sheet

What is the role of self-harm self-help groups?

My name is Melanie Boyce. I am a PhD student at Anglia Ruskin University and I would like to invite you and your group to take part in this research study. Please read this information sheet before deciding whether to take part. This will tell you about the study and what you would be asked to do if you and your group members decided to take part. Please discuss it with other members of your group to aid you in this decision. You can also ask me for more information if there is anything that you do not understand or if you would like to know more. I would be happy to attend a group meeting to discuss the aims and purpose of this study further. My contact details are provided at the end of this information sheet.

What is the purpose of the study?
In this study I am exploring the role of self-harm self-help groups from the perspective of group members and those that support such groups.

Why has this group been invited?
Your group has been identified as a self-help group that regularly meets and provides face-to-face peer support to those who self-harm.

Do we have to take part?
No. It is up to you and your group members to decide whether you would like to take part. If you agree to take part but then change your mind, you will still be free to withdraw from the study at any time.

What will we have to do?

If you agree to take part I am proposing that collaboratively, with other members of your group who have agreed to participate, we work together to explore this area of study. This might involve an individual or group discussion.

Will my group and members' details in the study be confidential?

Anything that is said during this study will be strictly confidential. Any information that is provided will be reported in a way that makes sure that you and your group cannot be identified. If any of our discussions are recorded these will be erased once it has been transcribed. All participants will receive a copy of these discussions to agree accuracy and

the transcripts will be kept in a password protected computer file, which only I will have access to.

What are the possible benefits of taking part?
Whilst there are no direct benefits some may welcome the opportunity to potentially contribute to providing valuable insights to the future development of self-harm self-help groups.

What will happen to the results of this study?

The results will be written up as part of my PhD studies and published in service user publications and academic journals. It is hoped that the results of this study will be used to increase understanding of self-harm and the role of peer led self-help groups.

Who has reviewed the study?

The study has been approved by Anglia Ruskin University Research Ethics Committee.

What happens next?

I will contact you in two weeks time to find out your decision. If you do not want to take part you do not have to do anything else. If you would like to take part, we could arrange a date and time that is convenient to you and your members for me to discuss further the aims and purpose of the study.

Contact for further information:

Thank you for taking the time to read this information. If you have any questions or would like any further information about this project before I contact you my details are:

Melanie Boyce
Anglia Ruskin University
Faculty of Health and Social Care
William Harvey Building
Bishop Hall Lane
Chelmsford
Essex CM1 1SQ
Email Melanie.Boyce@anglia.ac.uk
Tel 0845 196 4198

Or alternatively my supervisor's contact details are:

Professor Carol Munn-Giddings
Anglia Ruskin University
Faculty of Health and Social Care
William Harvey Building, Bishop Hall Lane
Chelmsford Essex CM1 1SQ
Email Carol.Munn-Giddings@anglia.ac.uk
Tel 0845 196 4101

Some information about me…

For the past seven years I have worked as a Researcher at Anglia Ruskin University in the area of mental health and in 2009 I was accepted as a part-time PhD student.
The focus of the study developed a couple of years ago when I attended a seminar where the area of self-harm was discussed. The discussion was revealing as I felt it highlighted that there remains a lack of understanding and empathy to those who self-harm.

Since then and through working on a variety of different project my interests in peer led groups and self-harm has developed. There has been very little research in this area and from the few studies that have explored this it appears such groups provide a valuable and much needed resource for their members. My intentions are therefore to raise the profile and understanding of such groups by working collaboratively and respectfully with the groups involved.

APPENDIX III
PHASE 2 PARTICIPANT INFORMATION SHEET

Anglia Ruskin University
Cambridge & Chelmsford

Information Sheet

An exploration into the role of self-harm self-help groups

My name is Melanie Boyce. I am undertaking a PhD at Anglia Ruskin University in self-harm self-help groups and I would like to invite you to take part in this research study. Please read this information sheet before deciding whether to take part. This will tell you about the study and what you would be asked to do if you decide to take part. You can ask me for more information if there is anything that you do not understand or if you would like to know more. My contact details are provided at the end of this information sheet.

What is the purpose of the study?
In this study I am exploring the role of self-harm self-help groups. Phase 1 of the study involved collaboratively working with two self-harm self-help groups to explore individual and group members' views and experiences of attending these groups.

Why have I been invited?
You have been identified as someone who has developed and / or supported self-harm self-help groups.

Do I have to take part?
No. It is up to you to decide whether you would like to take part. If you do agree to take part you will be given a copy of this information sheet to keep. You will also be asked to sign a consent form. If you agree to take part but then change your mind, you will still be free to withdraw from the study at any time.

What will I have to do?

If you decide to take part you will be asked to take part in an interview at a time and place convenient for you. The interview will last about one hour and I will ask you about:

- Your views and experiences of self-harm self-help groups
- The strengths and challenges involved with self-harm self-help groups
- Future developments for self-harm self-help groups

If there are any questions you would prefer not to answer, just tell me and I will move on to the next question. So that I can listen to your views without having to take notes I would like to audio record the discussion and will ask your consent before it starts.

Will my part in the study be confidential?

Anything that you say during this interview will be strictly confidential. Any information that you provide will be reported in a way that makes sure you cannot be identified as an individual. If any of our discussions are recorded these will be erased once it has been transcribed. You will receive a copy of our discussion to agree accuracy and the transcript will be kept in a password protected computer file, which only I will have access to.

What are the possible benefits of taking part?

Although there are no direct benefits there is the opportunity to potentially contribute to providing valuable insights to the future development of self-harm self-help groups.

What will happen to the results of this study?

The results will be written up as part of my PhD studies and published in service user publications and academic journals. It is hoped that the results of this study will be used to increase understanding of self-harm and the role of self-harm self-help groups.

Who has reviewed the study?

The study has been approved by Anglia Ruskin University Research Ethics Committee.

What happens next?

If you would like to take part, you can either email me letting me know you would like to take part (details below). Alternatively you can fill in the consent form attached and return it in the stamped addressed envelope provided. I will then contact you to arrange a convenient time and date to undertake the interview. If you do not want to take part you do not have to do anything else.

Contact for further information:

Thank you for taking the time to read this information. If you have any questions or would like any further information about this project please contact me:

Melanie Boyce
Anglia Ruskin University, Faculty of Health, Social Care & Education
William Harvey Building, Bishop Hall Lane
Chelmsford, Essex CM1 1SQ
Email Melanie.Boyce@anglia.ac.uk Tel 0845 196 4198

Or alternatively my supervisor's details are:

Professor Carol Munn-Giddings
Anglia Ruskin University, Faculty of Health, Social Care & Education
William Harvey Building, Bishop Hall Lane
Chelmsford, Essex CM1 1SQ
Email Carol.Munn-Giddings@anglia.ac.uk Tel 0845 196 4101

I WISH TO TAKE PART IN THIS STUDY:

NAME: _____

SIGNATURE: _____

DATE: _____

CONTACT DETAILS

ADDRESS:

TEL NUMBER:

EMAIL:

APPENDIX IV

PHASE 1 INTERVIEW GUIDE

Interview Guide

Background

1. Can you tell me how you first heard about this group?

2. How long have you been coming to the group?
    - Have you been going to the group regularly since then?

Motivations and expectations

1. Can you tell me what encouraged you to join the group?

2. Are your reasons for joining the group the same as what encourages you to keep going now?

3. How did you think the group might support you?

Group ethos

1. How are major decisions made in the running of the group?
    - Explore roles – ascribed or informal

2. Are there any rules, written and unwritten, within the group?
    - What happens when rules are broken?
    - Are there any rules you disagree with?

3. Can you talk me through what takes place in a typical meeting?
    - What happens if: a new member joins/leaves?

4. How does your experience of the group compare with other sources of support you might have used?

5. Can you tell me how you feel the group supports you?
    - How do you support other members?

6. Can you share with me your experience of going to the group?
    - What was it like in the first meetings –how were you feeling, what did you do?

- Thinking about how you are in the meetings now, has this changed? If so, in what way?

7. Do you feel going to the group has helped you to understand why you self-harm? If so, in what way?

8. Has going to the group helped you to manage your self-harm? If so, in what ways?

9. Can you tell me how the group supports a member if they are in distress? Is there any support outside the group?

10. What do you feel are the most important things about the group?

11. Has being a member of the group improved your life in any other way?

Future developments

1. How do you see the group developing in the future?

2. How do you see your own future involvement in the group?

3. Is there anything else you would like to say about the group?

APPENDIX V

PHASE 1 HISTORY AND DEVELOPMENT INTERVIEW GUIDE

Interview guide: History and Development

1. Can you tell me how the group started?
    - When? Motivations? Involvement of others?

2. What are the aims and the objective of the group?
    - Has this changed over time?

3. How was the running and organisation of the group decided?
    - How was the structure of the meetings decided (format/time)?
    - Explore if there has been any changes over time in relation to roles/facilitation and meetings?

4. What were some of the challenges you faced in the early days?
    - How did you overcome these challenges?

5. The challenges you faced then are they the same ones to what you face now?
    - If not, why not?

6. In your opinion, what are some of the key skills/knowledge/experience members need to set up and run groups like yours?
    - What, if any, other types of support are needed/valuable?

7. What, if any, are the specific issues facing the running of the group?
    - Has this changed over time?

8. What have been some of the important events in the history of the group? +/-

9. How has the group managed to keep going over the years?

10. Does the group have/had any links with other groups/organisations?
    - How developed? Benefits/challenges?

---

11. **If the group receives funding**:
    - What is your relationship like with your funder?
    - How much funding do you receive?
    - What is it for?

- How, if at all, does it affect the running of the group?

12. **If the group is facilitated:**
    - How does being the facilitator affect the support you receive from the group?
    - What, if any, support as a facilitator do you receive?

---

13. Can you tell me what have been some of the achievements of the group over the years?

14. Is there anything else you would like to mention about the history and development of the group?

APPENDIX VI

PHASE 2 INTERVIEW GUIDE

Interview Guide

Involvement and role

1. To start with can you tell me about your involvement with self-harm self-help groups?

2. What encouraged you to be involved with these types of groups?

3. Thinking about your skills and knowledge what have you found useful/relevant in your role with these types of groups? What, if any, new skills have you gained?

Ethos

1. What would you say are the values underpinning these types of groups?

2. How would you define these types of groups?

3. In what ways do you think these types of groups differ from professionally managed groups?

Structure, purpose and activities

1. What would you say were the aims and objectives of the group?
    - Did these change over time?

2. Can you tell me about the running of the group?
   (*Prompts:* structure, roles, rules, decision-making, frequency of meetings etc.)

3. Can you talk me through what took place in a 'typical' meeting?
    - What happened if a new member joins / leaves?

4. What would you say were the main activities of the group?

5. How do you think the group supported its members with their self-harm?

6. How would a member in distress be supported?

- Was there any contact / support outside the group between members?

7. Thinking about the membership were the women of a similar age / ethnicity?
    - How long did members usually attend?
    - How did members hear about the group?

Challenges and tensions

1. Can you tell me what you feel are some of the challenges / tensions facing these types of groups?

2. Thinking about your role within the group what challenges have you faced then and now?
    - How did you overcome these challenges?
    - Did you have any external support whilst facilitating the group?

3. With the benefit of hindsight what, if anything, would you have done differently with your involvement in the group?

Achievements and successes

1. Over the years what do you feel were some of the group's achievements and successes?

2. What do you feel were / are the most important things about the group?

3. Are you aware of being a member of the group helped improve its members' lives in any other ways?

Future developments

1. How do you see self-harm self-help group developing in the future?

2. How do you see your own future involvement with these types of groups?

3. Finally, is there anything else you would like to say about the group and your involvement with it?

Appendix VII

Claire Mitchell: FREP Administrator
Anglia Ruskin University, FHSC
Webb 001, Cambridge, CB1 1PT
Direct Dial: 0845 196 2362
E-mail: claire.mitchell@anglia.ac.uk

11th June 2009

Melanie Boyce
Anglia Ruskin University
Faculty of Health and Social Care
William Harvey Building
Bishop Hall Lane
Chelmsford
Essex
CM1 1SQ

Dear Melanie

Re: Application for Ethics Approval (08/024)

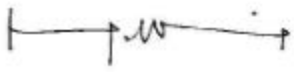
Project Title: 'What role do self-help groups play in their members' development of strategies to manage self-injury?'

Principal Investigators: Melanie Boyce

Thank you for resubmitting your documentation in respect of your application for ethics approval. This has been considered by the Chair of the Faculty (of Health and Social Care) Research Ethics Panel (FREP) in advance of the scheduled meeting in July.

I am pleased to inform you that your research proposal has been given approval under the terms of Anglia Ruskin University's *Ethics Guidelines for Research*. Approval is for a period of three years from June 2009 and is subject to random monitoring by the Research Ethics Subcommittee (RESC). Please note that, if your research has not been completed within three years, you will need to apply to FREP for an extension of ethics approval. Similarly, if your research should change significantly in any respect, or if risk of harm or breach of confidentiality becomes likely, you will be obliged to submit a new application.

Yours sincerely



Dr Leslie Gelling
For the Faculty (of Health and Social Care) Research Ethics Panel

cc:
Prof. Carol-Munn Giddings (First Supervisor)
Prof. Jenny Secker (Second Supervisor)
Dr Tim Schafer (FREP Sponsor)
Beverley Pascoe, Secretary to RESC
Caroline Struthers, Secretary to FRDSC

Appendix VIII

6 December 2011

Anglia Ruskin University

Cambridge & Chelmsford

Cambridge Campus
East Road
Cambridge
CB1 1PT

T: 0845 271 3333
Int: +44 (0)1245 493131
www.anglia.ac.uk

Melanie Boyce
Faculty of Health, Social Care and Education
William Harvey Building
Bishop Hall Lane
Chelmsford
Essex
CM1 1SQ

Dear Melanie,

Re: Application for Ethical Approval

Project Number:	11/007
Project Title:	'What role do self help groups play in their members' development of strategies to manage self injury? – Stage 2'
Principal Investigator:	Melanie Boyce

Thank you for resubmitting your documentation in respect of your application for ethical approval. This has been reviewed by the Chair of the Faculty (of Health, Social Care & Education) Research Ethics Panel (FREP) in advance of the next scheduled meeting in December.

I am pleased to inform you that your research proposal has been approved by the Faculty Research Ethics Panel under the terms of Anglia Ruskin University's *Policy and Code of Practice for the Conduct of Research with Human Participants*. Approval is for a period of three years from 6 December 2011.

It is your responsibility to ensure that you comply with Anglia Ruskin University's Policy and Code of Practice for Research with Human Participants and specifically:

- The procedure for submitting substantial amendments to the committee, should there be any changes to your research. You cannot implement these changes until you have received approval from FREP for them.
- The procedure for reporting adverse events and incidents.
- The Data Protection Act (1998) and any other legislation relevant to your research. You must also ensure that you are aware of any emerging legislation relating to your research and make any changes to your study (which you will need to obtain ethical approval for) to comply with this.

- Obtaining any further ethical approval required from the organisation or country (if not carrying out research in the UK) where you will be carrying the research out. Please ensure that you send the FREP Secretary copies of this documentation.
- Any laws of the country where you are carrying the research out (if these conflict with any aspects of the ethical approval given, please notify FREP prior to starting the research).
- Any professional codes of conduct relating to research or research or requirements from your funding body (please note that for externally funded research, a project risk assessment must have been carried out prior to starting the research).
- Notifying the FREP Secretary when your study has ended.

Information about the above can be obtained on our website at:

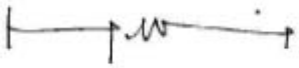
http://web.anglia.ac.uk/anet/rdcs/ethics/index.phtml/

Please also note that your research may be subject to random monitoring by the Panel.

Please be advised that if your research has not been completed within three years you will need to make a new application to FREP prior to the date your approval expires. The procedure for this can also be found on the above website.

Should you have any queries, please do not hesitate to contact me. May I wish you the best of luck with your research.

Yours sincerely



Dr Leslie Gelling
For the Faculty (of Health, Social Care & Education) Research Ethics Panel

T: 0845 196 2529
E: leslie.gelling@anglia.ac.uk

cc:

Prof. Sharon Andrew (FREP Sponsor)
Prof. Carol Munn-Giddings (Supervisor)
Beverley Pascoe (RESC Secretary)