"It's a safe space": self-harm self-help groups

Abstract

Purpose

The purpose of this paper is to present a qualitative analysis of the role of self-harm self-help groups from the perspective of group members.

Design / methodology / approach

A qualitative case study approach guided the research, which involved working with two self-harm self-help groups and all regularly attending members.

Findings

A thematic approach to the analysis of the findings indicates that self-harm self-help groups can provide a safe, non-judgemental space where those who self-harm can meet, listen and talk to others who share similar experiences for reciprocal peer support. Offering a different approach to that experienced in statutory services the groups reduced members' isolation and offered opportunities for learning and findings ways to lessen and better manage their self-harm.

Research limitations / implications

This was a small-scale qualitative study, hence it is not possible to generalise the findings to all self-harm self-help groups.

Practical implications

The value of peers supporting one another, as a means of aiding recovery and improving well-being, has gained credence in recent years, but remains limited for those who self-harm. The findings from this research highlight the value of self-help groups in providing opportunities for peer support and the facilitative role practitioners can play in the development of self-harm self-help groups.

Originality / value

Self-harm self-help groups remain an underexplored area, despite such groups being identified as a valuable source of support by its members. This research provides empirical evidence, at an individual and group level, into the unique role of self-harm self-help groups.

Keywords: self-help group; peer support; self-harm; mental health; qualitative research

"It's a safe space": self-harm self-help groups

Introduction

Increasingly the value of peers supporting one another, as a means of aiding recovery and improving psychological well-being, has gained credence and acceptance in the area of mental health (Loat, 2011). Sometimes referred to as mutual support or self-help, peer support is characterised by individuals who share similar experiences coming together to give and receive support. The nature of this mutual support may be social, emotional or practical, but intrinsically it is reciprocal, allowing peers to benefit from the support whether they are giving or receiving it (Lawton-Smith, 2013). 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. And, it is in this latter category where the development of peer support in mental health services is largely located (Faulkner & Basset, 2012).

Despite this current interest in peer support, albeit of a formal nature in mental health services, development remains limited in certain areas. A scoping exercise, undertaken by Faulkner et al. (2013) to map the range of mental health peer support groups and projects across England, found it to be mainly lacking in minority and marginalised groups and communities. Whilst the minority and marginalised groups and communities are not explicitly defined in this report, self-harm is an area that remains heavily stigmatised and surrounded by misconceptions and assumptions. Indeed the term itself continues to be interpreted and applied in multiple, often-conflicting ways, due to a lack of agreement around what it involves.

Defining self-harm

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 this continuum model, self-harm is not viewed as a discrete disorder or phenomenon. Instead, 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 (Pembroke, 2006). Turp (2003:10) proposes that the dividing line between a socially tolerated and unacceptable act of self-harm is the level of "desperation and emotional distress involved" and the negative response it elicits. Within this model of interpretation self-harm is differentiated from suicidal intentions on the basis 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).

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 often subsumed within the same term. 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 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. 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.

Clearly there are no straightforward solutions in relation to definitional agreement between the meaning and intent behind acts of self-harm, but to minimise confusion and misunderstanding clarity in interpretation is crucial. In view of this, the term self-harm in this research was 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, where the emphasis is primarily on ending life. And in making a distinction between the meaning and intent behind acts of self-harm offers the potential for less controlling and risk aversive forms of support to exist and develop.

On the whole the notion of peer support for people who self-harm has raised concerns about safety, on the grounds that it might exacerbate an individual's level of self-harm through the potential sharing and comparing of techniques (Babiker & Arnold, 1997; Sutton, 2007; Inckle, 2010). However, people with direct experience of self-harm have found ways to come together and offer each other peer support, in the form of self-help groups.

Self-harm self-help groups

Located in the voluntary and community sector, self-help groups often develop organically from the grassroots in reaction against the stigma projected by others (Borkman, 1999). They are found in a wide range of areas that span, for example, mental health and physical illness to carers' and social issues (Wann, 1995). Groups vary in their size, form and function, but core characteristics involve members sharing a similar condition or life situation; the group

being run for and by its members; the provision of peer support being offered by and for group members; the self-organising and voluntary nature of membership of the group (Seebohm, Munn-Giddings & Brewer, 2010).

In relation to self-harm the numbers of self-help groups that meet on a regular basis are not considered widespread in the UK (Arnold, 2006). One possible explanation is that these groups may not be highly visible. For example, research on the lifecycle of self-help groups undertaken by 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. Parker and Lindsay (2004) further suggest that some professionals have been reluctant to encourage self-help groups for self-harm due to concerns about risk and safety. This resistance and concern may have had a role to play in the limited development of self-harm self-help groups, as research indicates that professionals and practitioners can have a pivotal role in the support and development of self-help groups generally (Ben-Ari, 2002; Borkman, 2006; ESTEEM, 2013).

To date there have been few empirical studies that 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. 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 need resource for many individuals", as members were able to "gain help and support that there 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. The authors suggest that meeting others with shared experiences reduced feelings of guilt, shame and

isolation and facilitated a process of empowerment. Narrative accounts from people with direct experience of attending self-harm self-help groups further identify that meeting with peers reduces feelings of isolation and can provide alternative ways of managing and coping (Arnold, 1995; Babiker & Arnold, 1997; Foster, 2013).

As a peer-based source of informal support, self-harm self-help groups remain very much on the periphery as a viable source of help for people that self-harm. The limited research undertaken in this area means that little is known about what takes place in a self-harm self-help group, as studies have tended to examine the perspectives of individuals, rather than looking at the group as a whole. Therefore, the aim of this research was to explore the role of self-harm self-help groups from the perspective of group members. In doing so a more informed comprehensive understanding was sought, along with potentially providing insights into the value of peer support for those who self-harm.

Methods

The research design was informed by a qualitative case study approach, which involved working with two self-harm self-help groups, and all regularly attending members, for 12 months. A purposive sampling strategy was applied to select the groups. The main criteria in identifying potential groups was that the group was run for and by its members with direct experience of self-harm. Groups meeting this criteria were identified through online searches and reviewing the national list of support groups, complied by the voluntary organisation Self Injury Support (formerly Bristol Crisis Service for Women). In total, 22 groups were identified, and were ordered into a list of geographical proximity to the lead author. An invitation letter and information about the study was sent to the first two groups listed. After meeting face-to-face to discuss what participation in the research would involve, both groups

were keen to be involved, facilitated by similar motivations to explore and promote the potential value of self-harm self-help groups.

In-depth semi-structured interviews were the main data collection method, as they can provide rich data grounded in lived experience, whilst remaining flexible and responsive to exchanges between the interviewer and participant (Robson, 2011; May 2011). Both recruited case study groups were similar in size with four regularly attending members, all of whom were individually interviewed with interviews lasting between 60 – 180 minutes. Additional interviews were also undertaken with the groups' key members to capture the history and development of the groups. Written consent was gained from all those who participated in the research.

The two groups that participated in the research were similar in size with four regularly attending core members and had been in operation for a comparable amount of time, 12 years for group A and 8 years for group B. The instigation of group A was in response to a lack of support, particularly of a peer support nature at the time in the local area and was only open to women with direct experience of self-harm who were 18 years or older. Over the years the group had been awarded small amounts of funding from local and national organisations, but was currently self-funded by its members, who met once a week in the room of a local housing project. In contrast group B was initially established by a clinical psychologist who brought a number of his clients who self-harmed together in a group for peer support. After a couple of years the group evolved into a member-led group and since then had been regularly funded by a local service user involvement project to provide support outside normal working hours to mental health service users. As a result group B hosted meetings after 5pm, provided a 24-hour crisis support mobile telephone line and held a number of social activities. Twice

weekly meetings were hosted by this group that were open to both men and women with a minimum age restriction of 18 years.

The average age of group members was 46 years, and all were female, except for one male member from group B. The majority of members started self-harming as teenagers, although two group members started in their late 20s/early 30s. 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.

A thematic approach to data analysis was applied following the six steps presented by Braun and Clarke (2006). This inductive approach 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). Following Braun and Clarke's six steps the lead author firstly analysed the data from the case study groups separately, at an individual and group level. 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. Coding all parts of the various data sources meant a large number of codes were initially generated. The codes were reduced through a process of reviewing and refining into themes by looking within and across the two case study group datasets to illuminate similarities and differences. The final stage of analysis involved the review and refinement of the emerging findings by the research team. The software programme NVivo 10 was used to aid the organisation and retrieval of the data.

Ethical approval was given by the Faculty of Health, Social Care and Education Research Ethic Committee at the university concerned and the research was completed in 2016.

Findings

The findings begin by describing the members' experiences before joining their groups. The roles of the groups are then grouped under four themes that relate to: "a safe space"; a different approach; alleviation of isolation; learning from others.

Members' experiences prior to joining their groups

With the average age of 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:

> 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)

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 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 strongly felt and experienced:

> 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. (A4)

> 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. (B3)

"A safe space"

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)

The commonality of experience between group members meant the case study groups were identified as a safe space where members could listen and talk to others about their self-harm free from judgement and dismay:

> 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. (B3)

Finding shared experiential understanding meant the peer support offered between group members was considered to be more heartfelt and genuine, which reaffirmed the group as 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. (A3)

> It's good to have…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…just to be sort of heard and acknowledged. (B3)

The shame and stigma that surrounds the area of self-harm meant building and maintaining trust between members was central to creating a space where group members felt safe to discuss their self-harm. 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. (B2)

A different approach

The safe space found within the groups offered its members a different approach to that experienced in statutory services. In group A stigmatising labels were actively rejected, whereas group B resisted completing monitoring outcomes, set by the funder, on the grounds that it did not reflect the group's work:

> In 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)

> I will tell them [funder] how many members use the service, but I won't tell them on a daily basis what members are using [name of group], because…it would not be a true representation of what we do. (B4)

On the whole few 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 and as a result many had looked outside this medical model:

> 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)

In neither group was the emphasis on cessation of self-harm, instead it was more on members helping each other to "*manage a bit better*" (B3). 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:

> 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)

Moving away from an emphasis on cessation in both 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, 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. (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. (B4)

Alleviation of isolation

In finding a safe space to meet, listen and talk to others who self-harmed, group members no longer felt so isolated and alone:

> 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)

Over time strong bonds developed between group members who were often in contact with each other, through text and phone calls, outside scheduled meeting times, providing each other with a network of peer support:

> 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…because you're all maybe experiencing all the same things…I think we are all welcome to ring each other if we've got an issue. (B3)

The regularity of weekly group meetings also 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)

Learning from others

Some group members spoke about how, before joining their 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:

> 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:

> I'm more open about, if somebody asks me something about self-harm I'm very open with it and that's it…because I accept it within myself now. (A4)

Whilst neither 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 peer support in and outside of the group, enabled most members to lessen and better manage their self-harm:

> It just really helps being with people that understand why you do it…But actually being able to talk openly about it makes a lot of difference because you're not going to get judged. (A2)

> 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. (A3)

Discussion

This was a small-scale qualitative study, hence it is not possible to generalise the findings to all self-harm self-help groups. However, whilst the findings may not be representative of all groups, the detailed examination from the perspectives of group members provides in-depth insights into the role of self-harm self-help groups. Distinctly, the findings from this research illustrate the unique position self-help groups hold in offering a safe space where people who self-harm can meet peers for support.

The judgemental and stigmatising attitudes that surround the area of self-harm mean that a sense of isolation and difference are a common response expressed by many that self-harm (Babiker & Arnold, 1997; Warm, Murray & Fox, 2002). The findings from this study illustrate that having the opportunity to meet others who share similar experiences in a self-harm self-help group can reduce individual feelings of isolation and loneliness. Through

meeting peers the shared condition or experience is collectively accepted and facilitates a sense of normalcy and likeness, thus alleviating the negative effects of perceived difference (Helgeson & Gottlieb, 2000; Yalom, 2005). Before entering into their groups, few opportunities presented themselves to case study group members where they could meet others who self-harmed face-to-face. Friends and family often struggled to understand and accept their self-harm and few received support in statutory services. Entering into and regularly attending their groups, members gradually realised they were not alone with their self-harm and that there were others like them in the "*same boat*".

The establishment and development of trusting, supportive relationships in the case study groups has been identified as a positive feature that often emerges when peers come together in a self-help group (Adamsen, 2002; Kurtz, 2004; Visram et al., 2012). Having a network of support, in and outside of the group, has recently been aided by the development of mobile electronic tools that enable connections to be easily and quickly made, such as through a text message (Boyce et al., 2014). Whilst support in and outside the group might be a regularly occurring feature of self-help groups generally, findings from the study indicate that such a feature is highly valued in self-harm groups where support 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.

Concerns and reservations by some practitioners and professionals remain that a self-harm self-help 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. Borkman (1990) notes that it is through this process of sharing personal stories that group members can identify commonalities of their experiences to others and reflectively learn from one another.

Being labelled a 'self-harmer' often means the person becomes defined by their label and is no longer seen beyond this (McAllister, 2003). The interchanges between the case study 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 judgment and stigma. 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 finding 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.

Despite these identified benefits peer support for those who self-harm remain contentious and largely undeveloped in formal services (YouthNet, 2012). The implications for practitioners and funders that the findings from this study demonstrate are evidence to question the concerns and reservations around the value and benefit of self-harm self-help 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 talking and sharing experiences with peers were crucial features that facilitated members' awareness and ability to find better ways to cope. 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 (Munn-Giddings et al., 2016).

Conclusion

In recent years peer support has gained greater credence and recognition in mental health services, yet its delivery and focus remains limited. Concerns about the risk and safety of self-harm self-help groups were found to be unsupported in this research. Instead, such groups can offer a safe space where the feelings behind self-harm can be shared free from stigma and judgement. Meeting with others who self-harm helped alleviate members' isolation and provided opportunities to share and learn better ways of coping and managing. This paper thus provides evidence in the value of peer support for people who self-harm and the unique position self-help groups occupy in its delivery.

Implications and recommendations

In providing evidence that illustrates the value of peer support for people who self-harm and dispelling concerns about the safety of self-harm self-help groups, the implications and recommendations in mental health policy and practice relate to the potential and expansion of

peer support for people that self-harm. In an inpatient setting this might involve providing a space where peers can come together for mutual support, whilst in the community practitioners could be encouraged to engage with self-harm self-help groups, as means of supporting their position and development from the periphery to the mainstream.

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