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Introduction

In the UK, self-harm is broadly defined as, "any act of self-poisoning or self-injury carried out by an individual irrespective of motivation" (NICE, 2011:14). Yet despite this unitary definition self-harm remains an area where misconceptions and assumptions prevail. One of the most enduring assumptions is that self-harm is primarily undertaken by adolescents (Chandler, Myers & Platt, 2011; Troya et al., 2019a).

The assumption that self-harm generally affects adolescents is not without basis as prevalence studies frequently indicate that self-harm often first begins in early adolescence (Hawton et al., 2002; Favazza, 2011; Geulayov et al. 2018). Whilst the parameters of adolescence remain contested it is generally divided into three stages from early (10 to 13 years), middle (14 to 18 years) to late (19 to 25 years) (Steinberg, 2014; Lockwood et al., 2017). The onset of puberty and hormonal changes in early adolescence are often presented as probable reasons why self-harm frequently starts at this age and is considered to "spontaneously" decrease from 25 years due to maturation in brain development (Moran et al., 2011:242). Over the past 50 years hospital treated self-harm has increased internationally among adolescents (Griffin et al., 2018) and it is estimated that 10% of adolescents now self-harm (Doyle, Treacy & Sheridan, 2015). As a result, many studies focus on self-harm in adolescents in order to inform and design appropriate supports and services (Ogden & Bennett, 2015; McManus et al., 2019).

However, self-harm is not restricted to adolescents as it affects people of all ages. McManus et al. (2019) secondary analysis of data from the 2000, 2007 and 2014 Adult Psychiatric Morbidity Surveys highlights the potential lifelong adoption of this behaviour. These regular surveys randomly select a sample of participants aged 16 to 74 years to ascertain the mental health of the general population in the UK. In 2014 self-harm was most prevalent in the youngest age groups of 16 – 24 years (13.7%) and 25 – 34 years (10.3%). Rates then decreased to 6.4% in the 35 – 44 years and in the 45 – 54 years to 2.9%. In adults 55 – 64 years there was a slight increase to 3.3% and the rate then decreased to 1.1% in 65 – 74 years. Whilst the rate of self-harm in older populations is not as high when compared to younger populations literature that explores self-harm in older adults reports that self-harm is often the result of an attempt to die by suicide and is associated with an increased risk of subsequent suicide (Hawton & Harriss, 2008; Segal et al., 2016; Mitchell et al., 2017).

Murphy et al. (2012) found the risk of suicide was 67 times higher among individuals 60 years and above presenting to hospital with self-harm relative to the general population and the risk of suicide in older adults was almost three times greater than the risk among young people presenting with self-harm. However, the notion that self-harm in older adults is largely associated with suicidal intent is questioned by Troya et al. (2019a.b.c). Through their qualitative interviews with adults 60 years and above and third sector workers with experience of supporting older adults who self-harm they found older people used self-harm as coping mechanism throughout the life course (Troya et al., 2019a). The authors conclude that the relationship between self-harm repetition and possible suicide is more complex than previously conceptualised and that an understanding of self-harm in later life is essential to offer more effective healthcare provision (Troya et al. 2019a.b). Despite this the potential risk factor of suicide in older adults who self-harm and are 60 years and above and the higher prevalence rate of self-harm in adolescents has meant research has tended to focus within these age ranges. As a result, an understanding of the experience of self-harm in adults

outside these age ranges, from early adulthood to late middle age, remains limited, with some notable exceptions.

By the early 1990s a self-harm survivors' movement had begun to develop in the UK, which was started by adults who were influenced by feminism and the psychiatric survivor movement (Cresswell, 2005). Key publications were produced during this time, including the ground-breaking research by the Bristol Crisis Service for Women in 1995, which was undertaken and authored by Lois Arnold. Focusing on the experience of self-harm in women aged 18 to 59 years the study found that most women started self-harming during childhood or adolescence and that most had self-harmed at intervals over a long period of time, in some cases for 20 years or more (Arnold, 1995). Many women reported that self-harm provided a way to cope with distress and cutting was the most common type of injury reported. Similar, findings were reported in the online survey undertaken in 2008 by Outside the Box (a voluntary community development organisation in Scotland) that examined the role of self-harm in adults 25 years and above (Outside the Box, 2008). Of the 46 people that completed the survey the majority were women (N=40) and the age ranged from 25 to 55 years. The length of time participants had self-harmed varied from less than five years to over 20 years. As found within the study undertaken by Arnold (1995) the most common method was cutting and for many self-harm was a way to cope with distress.

The research undertaken by Ogden and Bennett (2015) offers insights into how adults who self-harm make sense of this behaviour and the implications of these explanatory frameworks in relation to help-seeking. A total of 25 participants aged between 19 and 45 years completed an online survey. The length of time participants had self-harmed ranged from 6 months to 32 years (mean length of time 10.5 years). The study found that self-harm functioned as a way for adults to manage their private selves in terms of a range of emotional issues, such as the validation of distress, regaining control and release. Ogden and Bennett (2015) suggest that adults use self-harm to manage their private and public selves. When self-harm enabled the private self to be managed effectively the public self was one of self-reliance and self-sufficiency. But when the process started to break down the public self became one of communication and a cry for help. The authors conclude that help-seeking is instigated when this balance is disrupted and continued if it offers a better form of self-management than the individual's own self-harming behaviour.

Clearly self-harm can and does affect people of all ages, yet knowledge about its life course from early adulthood to late middle age remains limited. Therefore, the aim of this exploratory study was to examine the lived experiences of self-harm in adults 25 to 60 years, with the intention of gaining greater insight and understanding in this underexplored area.

Methods

Gaining access to adults that self-harm posed unique challenges. Many people that self-harm do not receive formal support (Corcoran, Mewse & Babiker, 2007; McHale & Fenton, 2010). Instead, informal support is often sought in online communities, through interactive forums and peer support groups (Adler & Adler, 2011). In view of this an internet-based study design informed and guided the research. This involved gaining permission from a UK user-led online forum that supports people that self-harm. The forum was a closed site, which was strictly managed and monitored, and thus adhered to ethical standards that promote a level of moderation as pivotal to building a safe and positive online community (Webb, Burns & Collin, 2008).

An online survey was developed using Online Surveys (formerly BOS) and consisted of 23 questions, 21 of which were open-ended and enabled participants to share their individual experiences. Questions around demographics, length of time and at what age participants first started to self-harm provided a contextual background of participants. The remaining open-ended questions encouraged written reflective responses on: (1) Individual's experiences of self-harm (Has the way you self-harm changed over the years?) (2) Around the role of self-harm (Has the role of self-harm changed for you over the years?) (3) Access to support (What support, if any, have you received for your self-harm over the years?) (4) Experience of stigma (In your experience, have you found there is greater stigma for people that self-harm who are younger, or for people that self-harm and are older?). The forum's moderator reviewed an online flyer, which provided details on the aims of the research and a link to the survey. Once approved the flyer was posted in the research strand of the forum where members voluntarily opted into the study. The inclusion criteria for taking part in the study was participants to be aged between 25 to 60 years and have direct experience of self-harm. Participation into the survey was available from September 2018 until December 2018.

The responses to the open-ended questions were analysed using a thematic approach, following Braun and Clarke's six steps (2006). To achieve immersion the survey open-ended responses were read through multiple times. Responses were then read in-depth and initial codes were generated, using Nvivo 12 to aid the organisation and retrieval of the data. The next step involved reviewing and reducing the codes by combining some to form an overarching theme or sub-theme. The preliminary themes generated were then reviewed and refined to ensure the final themes provided an accurate representation of the data.

Ethical approval was given by the Faculty's Health, Social Care and Education Research Ethics Panel at the University concerned. All personal identifiers have been anonymised either by removal or replacement with meaningful alternatives in the quotes presented.

Findings

Descriptive background of participants

In total 19 respondents completed the online questionnaire, however as one participant did not fit the inclusion criteria, of being 25 years or above, her responses were excluded, resulting in the collection of data for 18 participants. The age of respondents ranged between 26 and 58 years. The mean age was 32 (SD 7). The majority of participants were female (n=15), as compared to the two participants that self-identified as male and one participant as fluid male. Eight participants self-identified as heterosexual, four as bisexual, two as asexual, two as gay, one as lesbian and one as demi-sexual.

In relation to employment status six participants were in full-time work and three were in part-time work. The remaining participants were self-employed (n=2), unemployed (n=5), student (n=1) and one participant was in part-time work and studying part-time. Most participants were single (n=13), three were married and two were in a relationship, and four respondents had caring responsibilities for either a partner or children. The age at which participants first started to self-harm varied. Four reported first starting between the ages of eight to ten years. The most common ages were between 11 to 13 years (n=7) and 14 to 16 years (n=6), with the oldest starting age of 17 years for one participant.

Role of self-harm

Over the years the role of self-harm, for most participants, had stayed the same, primarily as a way of coping with emotional distress:

> *It's always been a way for me to deal with immediate strong feelings, such as stress, sadness, despair.* (P6)

> *It has always been a coping mechanism, it allows a release of bottled up emotions, a feeling of control when all else feels uncontrollable.* (P13)

The method of self-harm had stayed the same for nearly half the participants, with cutting being the most frequently stated approach, whilst the remaining participants had seen a change in the way they self-harmed:

> *Initial self-harm was by methods such as head banging, and other non-marking. It progressed then to cutting with a Stanley knife blade.* (P1)

> *Methods have changed. I used to bite, but it changed to cutting as a teen, now it's a, mixture of methods, but mostly cutting and burning, and sometimes hitting or biting myself.* (P5)

One participant highlighted that although her method had stayed the same, she now self-harmed on areas that were less visible, due to concerns that her work colleagues might see her scars and wounds:

> *I self-harm on my legs and stomach, whereas I used to self-harm on my wrists and arms. I am also more concerned about being professional as I have quite a serious job now so I am worried about open wounds being seen.* (P8)

On the whole most participants reported that whilst the frequency of their self-harm had decreased from when they were younger, the severity of the harm inflicted had intensified:

> *It has decreased in frequency but is worse in severity than when I was younger.* (P14)

Participants did not always explain their motivations behind their increase in intensity, but for those that did it was linked to gaining the same level of release:

> *It used to be more frequent and more superficial, whereas now the injuries are more significant. I used to do lots of very superficial cuts, but a combination of that not working now and I'm running out of hidden space, means I now go over a single cut many times, but less frequent.* (P4)

Support received

Overall, most participants expressed receiving limited formal support, when they were younger, for their self-harm:

> *There was no help or services to help as far as I am aware when I was younger…I was always told as a teen to 'grow up' and I needed to 'grow out of such stupidity'. Teachers turned a blind eye at school, as did all others who could have helped. It was seen as something that was attention seeking behaviour and so it was best to give it no*

> *attention at all…I do not recall ever being offered anything directly regarding my self-harm, aside from the occasional leaflet telling me what self-harm was, all of which I knew already as I was doing it.* (P13)

Formal support for participants' self-harm continued to remain limited, although anti-depressants and cognitive behavioural therapy (CBT) had been prescribed to a number of participants in response to a diagnosed mental health condition:

> *Not directly for my self-harm. I've had support for depression/low mood/anxiety in the form of CBT and anti-depressants.* (P10)

> *I was offered anti-depressants when approximately 18 and have been predominantly on these ever since. I've never been offered help for my self-harming.* (P13)

A number of barriers were identified as continuing to impact on participants gaining support for their self-harm. These related to not meeting the assumed typical profile of someone who self-harms, that of being female and under the age of 25 years:

> *It's never been easy being a male who has had an eating disorder or a cutter, most programmes are for young women.* (P2)

> *I very recently had an assessment with IAPT who wanted to refer me to a self-harm support group, but it's not available to those over the age of 25, which is upsetting. Many resources online seem to be aimed at those under 25 too, so they don't always feel as applicable or helpful to me because they focus on issues typically faced by teens.* (P16)

Experience of sharing self-harm with others

Reponses were mixed as to whether participants found it easier to tell friends and family about their self-harm when they were younger or older. Some participants found they faced less judgement now they were older, whereas others felt it was easier when they were younger, due to the greater stigma facing adults' that self-harm:

> *I learnt how to discuss it without feeling like people would judge me for it.* (P18)

> *It was easier to do so when I was much younger, as it felt like everyone else was self-harming. As an adult it feels embarrassing in a way that I haven't "gotten over it".* (P8)

In general participants' family and friends were aware of their self-harm, but for many they believed this to be a thing of the past:

> *My family knows that I self-harm but not in detail, as I don't want to worry them. I think they think it finished a long time ago, but we don't talk about it.* (P8)

> *My family found out when I was at school but have no idea it is still an occasional issue.* (P10)

> *Some friends know I have a history of self-harm, but I don't think they know I still do it now.* (P16)

The fear of being judged and the negative consequences this could bring were the reasons many participants chose not to disclose their self-harm now, as an adult:

> *I fear people making judgments about me, not understanding why I self-harm or probing too deeply and asking difficult questions that I don't want to answer.* (P14)

> *Judgements lead to worsening self-worth, self-confidence and guilt. I already have a lot of demons, I don't need people's opinions and views to make them worse.* (P8)

For those participants, who were in employment, the fear of work colleagues finding out about their past and on-going self-harm was a source of intense concern. The fear was that they would be perceived differently and less capable, ultimately leading to a negative impact on their future career development:

> *I think it can often seem like I am less capable or mentally stable if I tell people, for example in a professional setting.* (P6)

> *People would see you differently. They would assume you are less strong or able to cope with things.* (P11)

> *Work colleagues they'd be horrified, not trust me, as they'd see me as having something deeply wrong with me. It would be a terrible move in terms of my career, as I would probably be fired as they'd want rid of me so they would find a way, if not I'd never be considered for any sort if promotion ever again.* (P13)

Nonetheless, one participant identified how work colleagues had responded positively upon finding out about her self-harm:

> *My scars mean it is visible to my colleagues. I work in children's nursing, but they are generally accepting and supportive.* (P4)

Stigma and shame

Overall participants felt that there was greater stigma facing older adults' who self-harm, which was deemed to be reinforced by the prevailing societal assumption that it largely affects adolescents:

> *I think that the stigma is worse for people who are older. Often people seem to associate self-harm with teenagers only, and label it as 'just a phase' or something to do with a subculture e.g. Emos. I think there is therefore very little understanding or compassion generally in society for people who are older that self-harm.* (P14)

> *I think it's sort of considered a moody adolescent thing. Also, when I was a teenager it was right in the middle of the 'emo' generation where it was seen that self-harm was part of trying to 'fit in' with that kind of crowd and that it was almost expected of you if you chose to dress in a certain way etc. I think if an adult is seen with healed scars it's acceptable, as if they have got past a bad time or phase. But to be an adult self-harmer is a different matter.* (P10)

Participants felt there was greater understanding and tolerance towards self-harm in adolescents, due to the pressures and struggles they often face at this time:

> *It is common for adolescents to be experiencing a lot of anxiety, school problems, mental health issues, or other problems, and therefore not so unexpected if they self-harm.* (P11)

Upon entering adulthood participants found that their self-harm was less tolerated by others, on the basis that they should have 'grown out' of it:

> *Now that I'm older I'm supposed to know that it's not an okay coping mechanism.* (P6)

> *People expect that you 'grow out of it' and that you're very highly strung, but it will level out as you grow up. When you don't fit that, people get frustrated and believe you are childish or juvenile.* (P18)

> *There is a view as an adult you should be more sorted by now and the old 'attention seeking' ideas are still there, it's acceptable for a teen to seek attention but not an adult, even though it is a misunderstanding of why people self-harm.* (P13)

As a result, feelings of shame and guilt were enhanced in most participants, as they felt additional judgement for continuing to self-harm as an adult:

> *It doesn't stop when you get to 18, but that is how it's portrayed. People have said to me "Haven't you grown out of that by now?". I wish people were better informed. I sometimes feel embarrassed because I am 33, which just makes it all worse. I hate that.* (P7)

> *It is seen as shameful, pathetic and something I should have grown out of.* (P13)

One fluid male participant highlighted how he faced additional stigma for not fitting the assumed typical age and gender profile of someone that self-harms:

> *Generally, when discussing self-harm, the conversation focuses on teenage girls. As a male, it is much more stigmatised, and less accepted. Adults who self-harm, generally I find are stigmatised even more, almost as though as an adult you should have more control of your emotions.* (P1)

Managing and lessening of self-harm

Four participants stated that they have self-harmed consistently over the years, whereas 14 participants reported periods of time when they had reduced or stopped self-harming. For the 14 respondents who had not self-harmed consistently other the years, the themes that were identified as helping them to reduce or stop their self-harm related to finding other ways to cope; positive changes in life situations; greater self-awareness through a formal diagnosis.

Finding other ways to cope

Improvements in mood, through the use of antidepressants, were identified by two participants as helping them to reduce their levels of self-harm, whereas for another participant this was attributed to the learning gained through CBT therapy:

> *I had CBT for a few years, from 22-24 [years]…CBT helped me understand my self-harm more and as a consequence learn the patterns of behaviour I needed to change in order to stop.* (P6)

> *I've never been offered help for self-harming, but I have been offered and taken anti-depressants, which do help me cope with life and I guess do reduce how often I harm, as I am happier.* (P13)

In contrast, self-management distraction techniques were identified by two participants as helping them to find other ways to cope and reduce their self-harm:

> *Multiple distraction techniques, including use ice and drawing on my skin.* (P12)

> *I managed to stop for about five straight years. [I] used alternatives, such as holding ice, writing poetry and drawing. I was so ashamed of the scars and knowing how addicted to it I was and how out of control and dangerous it had become helped me to stop.* (P15)

Largely informal support, from a partner and friends, was identified as the main source of consistent and valued support that helped participants to manage their self-harm. Having the opportunity to talk and be heard in a non-judgemental manner were valued features of these informal relationships, as it aided personal understanding and alleviated common feelings of guilt and shame:

> *Having someone non-judgmental to talk to about it has been the biggest support. It made me feel less guilty and like I wasn't the worst person in the world for hurting myself, which I think in turn helped to break the cycle of feeling awful about self-harming and that making me want to hurt myself even more.* (P14)

The loss of this informal support, through the ending of a relationship or changing friendship, was thus keenly felt:

> *One thing that has been difficult, as I get older, is sharing within relationships and friendships and then losing the relationship or friendship. This happens when you get older, I think, as you may be more likely to drift away from your peers or end up splitting from a partner for other reasons. It feels then that you have to start all over again, which can be difficult.* (P8)

One participant highlighted the value of these informal supportive relationships, being combined with more formal sources of support:

> *The couple I now live with have been great. They have been non-judgemental and accepting in a way that enables me to be honest and open. It would just be helpful if it was supplemented by good professional support/therapy.* (P4)

Improvements in personal circumstances

Two participants shared how improvements in their personal circumstances had helped them to reduce or stop self-harming over a sustained period of time:

> *Reduced life stress, with certainty in living arrangements.* (P14)

For another participant, having a break from academic study to travel and work overseas had seen a period of four years when she did not self-harm. This was attributed to a period where she experienced fewer pressures and thus less need to self-harm:

> *I stopped self-harming between the ages of 22 and around 26…I travelled to New Zealand after university and felt a lot more relaxed and out of the bubble that I'd been in before then…I had been working and had free time, and my job wasn't demanding, so there were fewer stress points. So the flip side of that would be removing the stress points, such as worrying about results, money and my career, by moving to New Zealand, benefitted me by lessening the need to self-harm.* (P8)

Although there was a sustained period when this participant did not self-harm, she shared how it was replaced with a less direct and immediate form of harm to the self:

> *So a change of scenery helped, although I did develop disordered eating patterns when I was there.* (P8)

The pressures of postgraduate study, whilst working full-time, was identified as the trigger to self-harm again, to cope with these demands, which reduced after leaving higher education:

> *The trigger for me to start again was returning to university to do a master's degree while working full time…Since I have been out of academia, I have self-harmed much less frequently. When I was writing my master's thesis I would self-harm on nearly a daily basis, due to the feeling of constant pressure and insecurity, but now that those moments are rarer I self-harm a lot less frequently.* (P8)

Greater self-awareness, through a formal diagnosis

A small number of participants identified the value of receiving a formal diagnosis, as a way of gaining greater insight and understanding behind their motivations to self-harm. For one participant the connection between her diagnosis of psychosis and acts of self-harm became clearer:

> *I developed psychosis and the self-harm, burning, was a response to that.* (P3)

Another participant had recently received a diagnosis of premenstrual dysphoric disorder (PMDD), the symptoms of which are severe irritability, depression and/or anxiety before menstruation. Receiving this diagnosis had meant she was now aware of how her self-harm was linked to her menstrual depressive cycle:

> *I have been recently diagnosed with PMDD and my self-harm is closely associated with my cycle…I am more aware now that my depression is linked to my menstrual cycle and that this is a clear trigger.* (P8)

A recent diagnosis of autism, for another participant, had helped her to comprehend the additional difficulties she had faced in life, and to find new and helpful ways of living that were sensitive to her needs. This shift in understanding and ways of living had led to her no longer self-harming:

> *I stopped after getting an autism diagnosis. It meant I had a better understanding of why I find some things more difficult than other people seem to and ways I could help myself with them.* (P18)

Discussion

Self-harm can affect people of all ages, yet the high prevalence rate in adolescents and the potential risk factor of suicide in adults 60 years and above has meant research has tended to focus within these areas. As a result, the experience of self-harm in people outside these age groups remains limited. Therefore, the aim of this exploratory study was to examine the experiences of self-harm in people from early adulthood to late middle age to gain greater insight and understanding in this underexplored area.

The demographic profile of participants echoed the patterns identified in many studies as most participants were female, started to self-harm in early adolescent and cutting was the most common method used (O'Connor, Rasmussen & Hawton, 2014; Townsend et al., 2016). Yet the sustained length of time participants had self-harmed illustrates that the assumption self-harm often spontaneously ends, as people enter into early adulthood, is not always the case (Moran et al., 2011). As found in the Arnold (1995) and Outside the Box (2008) studies the findings from this research demonstrate that self-harm can remain a feature of people's lives for substantial periods of time. The assumed rarity of self-harm in people in early adulthood to late middle age might be because they have stopped, or alternatively the stigma and shame associated might affect reporting even more so (Babiker & Arnold, 1997; Chandler, Myers & Platt, 2011).

In recent years self-harm has gained greater attention and awareness, aided by the voicing of personal experience accounts by high-profile figures (Hilton, 2016). At the same time there has been an unprecedented expansion of online self-harm websites and interactive forums for those with direct experience to come together for support and raise awareness (Adler & Adler, 2011). Despite this those who self-harm continue to experience stigma and judgement from others (Lloyd et al., 2018), namely as self-harm falls outside the realms of acceptable behaviour, it is thus constructed as pathological by others and hence is heavily stigmatised (Shaw, 2002). Parker and Aggleton (2003) argue that stigma operates across three levels from the structural, to the social and then the internal. At the structural level stereotypes are upheld and enacted, for example with the pervading myths that people who self-harm are deemed to be manipulative and attention seeking. These stereotypes and labels are then emphasised between people through the process of social stigma, as it is still not uncommon for treatments and local anaesthetic to be withheld when stitching self-harm wounds (Pembroke, 2006c; Taylor et al., 2009). Yet it is at the internal level where these perceived negative structural and social attitudes are most keenly felt, as shame and guilt are common responses expressed by many that self-harm (Babiker & Arnold, 1997; Warm, Murray & Fox, 2002; Sheehy et al., 2019). However, the findings from this study indicate that a double stigma was experienced by participants, as not only did their self-harm transgress the realms of acceptable behaviour, but also through not fitting the assumed typical age of someone who self-harms, namely an adolescent, feelings of shame and guilt were intensified. In response, many participants chose to keep their self-harm hidden to maintain the impression that it was a thing of the past, but this brought distinct tensions for participants particularly in the navigation of their working lives.

With their adult status, most participants were in paid employment, which raised fears around work colleagues finding out about their self-harm, through seeing their scars. This led one

participant to self-harm on an area of her body that was less visible to colleagues through fears around being unfairly judged, whilst other participants expressed concerns around the potential impact on their future career development. Fearing colleagues' reactions and responses to their self-harm participants preferred to try and keep their self-harm hidden and concealed, rather than risk potential judgement and misunderstanding. Yet the effectiveness of strategies of secrecy to avoid negative stigmatising reactions is not, as Verhaeghe and Bracke (2011) argue, always guaranteed. Instead, such strategies that attempt to minimise or conceal can have a detrimental effect, in compounding feelings of isolation, shame and loneliness, rather than leading towards help-seeking and a reduction of self-harm (Straiton et al., 2013).

The findings from this study revealed that although most participants had seen a reduction in the frequency of their self-harm many experienced an increase in the severity of harm. This contrasts with the study undertaken by West, Newton and Barton-Breck (2013) that explored how 25 adults evaluated their experience of self-harm over their lives, as many had ceased to use it as a coping strategy or others found themselves self-harming less frequently. However, the study by Woodley et al. (2020), which explored how adults of a self-harm support group risk managed their self-harm, found the longer people self-harm they often become more skilled at damage limitation. Nonetheless, risks remained as a smaller number of participants illustrated that there were times when a more impulsive form of self-harm occurred, and this was associated with greater risk and severity of injury. It is unclear if participants in this study experienced an increase in the severity of their self-harm due to greater impulsivity occurring over time or whether the addictive nature of self-harm had led to an increased intensity and escalation to receive the same initial benefits (Brown & Kimball, 2013; Wadman et al., 2017). Either way the risks associated with an escalation in self-harm over time and the potential for life threatening injuries cannot be ignored.

Overwhelmingly there is a reluctance to seek help in people who self-harm across all ages, with stigma primarily affecting help-seeking (Long, 2018; Troya et al., 2019a). Lloyd, Blazely and Phillips (2018) argue that it is perceived stigma that prevents people who engage in self-harm from seeking help. However, the double stigma participants experienced, through being an adult who self-harms, meant feelings of shame and guilt were intensified, as even though the severity of harm had increased for most participants few were receiving any formal support for their self-harm. Ogden and Bennett (2015) suggest that help-seeking is instigated in adults who self-harm when it no longer offers the effective management of the private self. The findings from this study illustrate that this is not always such a straightforward process as a small number of participants had sought formal help for their self-harm, but found they were unable to access support through not meeting the inclusion criteria of being female and under the age of 25 years. This is not altogether surprising as often formal programmes of support are aimed at younger people, with an upper limit of 25 years (Outside the Box, 2008), whilst in the voluntary sector organisations often struggle to secure funding to provide services beyond this age limit, as hope and possibility of change are largely associated with youth (Boyce, 2016). Nonetheless, the lack of formal support participants reported receiving for their self-harm is alarming considering the increase in the severity of their harm and the potential relationship this has with an elevated risk of suicide among older adults (Dennis & Owens, 2012).

Despite receiving limited formal support for their self-harm, over the years most participants had experienced periods of time when they did not self-harm. A variety of different mechanisms were identified as supporting people in this, thus reflecting the complex and

individual reasons as to why someone self-harms, and how a variety of approaches are needed to help people to stop (Pembroke, 2006b; Dargan, 2013). Very often it was informal supportive, non-judgemental friendships and relationships that were identified as being crucial to helping participants to lessen their self-harm. The importance of peers providing support to each other has been identified as having a positive effect in helping those that self-harm to lessen and in some cases stop (Smith & Clarke, 2003; Corcoran, Mewse, & Babiker, 2007; Boyce, Munn-Giddings & Secker, 2018). The findings from this study highlight how the loss and ending of these important friendships and relationships in adulthood can be keenly felt by adults who self-harm, primarily as such supportive relationships were not easily replaced due to the shame and guilt participants experienced in disclosing their self-harm as they aged.

In conclusion, self-harm has gained greater attention and awareness in recent years, yet it remains an area where misconceptions prevail, particularly in relation to age as the assumption that self-harm primarily only affects those in adolescence persists. As a result, very little is known about the experiences of self-harm in adults. This paper provides evidence around the role of self-harm in adults and its potential for escalation in severity. Furthermore, it draws attention to the double stigma that adults who self-harm often experience and the subsequent effect on help-seeking and disclosing their self-harm to others. Finally, it raises concerns over the lack of formal support adults received for their self-harm and the potential relationship with an elevated risk of suicide in older adults.

Limitations of the study

There are several limitations to this study that need to be acknowledged. Firstly, this was a small-scale exploratory online study which recruited participants from one user-led online forum. As a result, it is not possible to generalise the findings to all adults that self-harm from the ages of 25 to 60 years. Further research is thus needed that recruits' adults from a variety of different online platforms and community-based venues to increase the diversity of the sample. Secondly, in utilising an online survey methodology this meant it was not possible to prompt participants to elaborate on their answers or ask additional questions that were salient to them. Future research could utilise a more interactive approach through online synchronous interviews or a large-scale survey where the themes identified in this study could be mapped across a wider population. Finally, only a small sample of men were recruited into the study, hence further research is needed that specifically targets early adulthood to late middle-aged men who self-harm, as their experiences continue to remain hidden.

Implications for practice

It is recommended that greater recognition is needed at a public health level that challenges the assumption that self-harm largely affects adolescents. The double stigma adults that self-harm face and the resulting intensified feelings of shame and guilt need to be addressed, particularly in relation to help-seeking. In educating both the public and services that self-harm can affect people of all ages access to support needs to be widened to include those who do not fit societal assumptions around the typical profile of someone who self-harms.

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