Social media and adolescent engagement in deliberate self-harm

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ABSTRACT

Over the last decade the internet has become an important medium for youth to communicate with like-minded peers who they often never meet offline. At the same time, discussions of deliberate self-harm on the internet have emerged as an issue of concern. Nevertheless, there is a lack of research on how adolescent self-harmers experience their engagement with online self-harm discussion groups. This study explored how adolescent self-harmers make sense of self-harm in online discussions. I conducted an inductive thematic analysis of posts written by adolescent self-harmers in five online self-harm discussion groups. A semantic approach to thematic analysis revealed thirteen key themes that were grouped into three superordinate thematic categories. The first of these categories consists of themes centred around conceptualisations of self-harm. This category includes the themes of how self-harm is conceptualised in the analysed discussions, DSH as a negative addiction, self-harming adolescents' complex relationship with their scars, and social affiliation in the context of adolescent self-harming. The second thematic category encompasses themes regarding issues contributing to DSH for adolescent posters. This category includes DSH as a coping strategy, people offline being positioned as unhelpful, keeping DSH secret offline, a negative self-image, comorbidity with other psychological issues, social isolation/loneliness, and school-related issues. The third thematic category consists of themes focused around care and support, including both care and support online and the importance of getting help with DSH offline. Overall, from the results of this study it appears that online self-harm discussion groups have a largely positive influence, with discussions largely revolving around adolescents and older posters who used to self-harm trying to help one another with overcoming their addition to self-harming.

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CHAPTER ONE: INTRODUCTION

Historically, self-harm has not always been viewed in a negative way. There are forms of self-harm which are culturally-sanctioned (Favazza & Rosenthal, 1993). In fact, culturally sanctioned self-mutilation is one of the two categories of self-mutilation conceived by Favazza and Rosenthal (1993). The second category consists of deviant self-mutilation, which is equivalent to understandings of DSH in clinical psychology. Favazza (1996) further divided culturally sanctioned-self mutilation into two sub-categories, rituals and practices. Rituals mean mutilations that are repeated generationally, with them reflecting the beliefs, traditions, and symbolism of a society. An example consists of annual rites involving different forms of ritualised self-harm observed by Shi'a Muslims. This ritual occurs during their holy day of Ashura when the martyrdom of Imam Hussein is mourned (Zabeeh, 2005). In some schools of Shia Islam hemic flagellation rituals on this day is promoted while in Bangladesh and India cutting the body with chains or knives is practiced (Szanto, 2012) (Nelson, 2014). These rites are still engaged in by devout Shi'a Muslims today (Nelson, 2014). Meanwhile, practices involving self-harm are both historically transient and cosmetic (Favazza, 1996). They include the piercing of earlobes and other body parts. Briefly, if forms of self-harm are culturally accepted they are not viewed as maladaptive.

Today, DSH constitutes a phenomenon that is a common problem increasing in the general population, especially among adolescents (Kinahan & MacHale, 2014; Hawton, Saunders, & O'Connor, 2012; O'Loughlin & Sherwood, 2005; Kerr, Muehlenkamp, & Turner, 2010; Prinstein, et al., 2010; Teufel, Brown, & Birch, 2007). DSH has even been considered an epidemic (Plante, 2007; Whitlock, Purington, & Gershkovich, 2009). For example, a school-based study amongst adolescents in Northern Ireland found that rates of DSH were at 10% (O′Connor, Rasmussen, & Hawton, 2014). Similarly, a national inquiry in the UK found that on average two adolescent students in every classroom self-harm (Nursing Standard, 2005). These figures could be even higher, as many adolescents who engage in DSH fail to come to the attention of either medical or mental health professionals (Ross & Heath, 2002).

In regards to whether gender plays a role in tendency to engage in DSH for adolescents, there are inconsistencies in the research evidence. According to Hawton et al. (2012), DSH has consistently been found to be more common among female adolescents, although this gender

imbalance decreases with age. Similarly, in a number of community-based studies, for girls, rates of DSH were 2-8 times higher compared to those for boys (De Leo & Heller, 2004; Landstedt & Gillander Gådin, 2011; Madge et al., 2008; McMahon et al., 2010a; Ross & Heath, 2002). However, in several studies no gender-based differences in rates of DSH for adolescents were found (Gomez, Becker-Blease, & Freyd, 2015; Gratz et al., 2012; Bjärehed & Lundh, 2008; Izutsu et al., 2006; Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007). Thus, the evidence on whether gender affects tendency to engage in DSH for adolescents is far from conclusive.

Terminology and definitions related to DSH

A range of terminology and definitions have been applied to DSH over the years. Different terms used for DSH include non-suicidal self-injury (NSSI) and self-mutilation (SM; Young, Sproeber, Groschwitz, Preiss, & Plener, 2014; Prinstein et al., 2010; Ross & Heath, 2002). NSSI has recently become the standard terminology for referring to DSH (James, 2013). For this reason, throughout this thesis, the terms DSH and NSSI will be used interchangeably to refer to acts of self-harm without suicidal intent. This orientation reflects increasing moves to distinguish DSH without intent of suicide from attempted suicide (James, 2013). DSH is defined as encompassing intentional acts of harming oneself, which is typically accomplished via means of cutting, burning, or scratching oneself, according to the work of Winchel and Stanley, and Gratz (as cited in Vaughn, Salas-Wright, DeLisi, and Larson, 2015).

Several reasons for why individuals engage in DSH have been repeatedly found in the research literature. These reasons include reduction of emotional distress, expression affect, to gain a sense of control, relieve tensions, manage dissociative and depersonalisation symptoms, and influence others (Muehlenkamp, Hoff, Licht, Azure, & Hasenzahl, 2008; Walsh, 2006; Richardson et al., 2012). Because of these behaviours being the main reasons for why individuals engage in DSH, DSH has been linked with several psychological disorders, such as depressive disorders and Borderline Personality Disorder (Claes, Luyckx, & Bijttebier, 2014; James, 2013). Recently, there has been an increasing focus in regards to determining the function served by DSH for those engaging in it (James, 2013).

During the past decade ‘Alternative’ youth subcultures, may have changed the way adolescents regard DSH. These subcultures include Goths and Emos (Young et al., 2014;

James, 2013). According to Issitt (2011), in its most basic sense, the term ‘Goth’ means a group of individuals who celebrate, as well as indulge in, darker elements of sound, style, and other aesthetic avenues. Meanwhile, ‘Emo’ refers to a subculture that grew out of a particular style of music that is characterised through high emotionality, in addition to feelings of vulnerability (Bailey, 2005). Those who class themselves as Emo have a tendency to think of themselves as misunderstood, dress in a particular style and overtly express their emotions (Scott & Chur-Hansen, 2008). Often engaging in DSH is a way for them to do the latter. Controversially, those identifying with these two subcultures have been proposed to be more likely to self-harm (Young et al., 2014). According to Young et al. (2014), an underlying motivation for Alternative adolescents to engage in self-harm consists of using self-injury in order to ‘belong to a group’, as well as ‘to avoid being with people’. Thus, for them, DSH can play a role in regards to the forming of group or social identities. Additionally, Young and colleagues (2014) found that engagement in DSH has a communicative function for Alternative teenagers. This suggests that for them DSH is viewed as a valid way of soliciting help from other group members during times of psychological distress.

It is important to note that the proposal that Alternative youths, such as Goths and Emos, are more likely to self-harm is only based on a small amount of not uncontested studies and case reports (Young et al., 2014; Young, Sweeting, & West, 2006; Zdanow & Wright, 2012; Baker & Bor, 2008; Miranda, 2013; Phillipov, 2010). Therefore its validity is not without criticism. Nevertheless, the existence of these subcultures begs the question of whether DSH has become increasingly widely accepted among adolescents, and thus is now more normalised (James, 2013).

Self-harm and adolescence

In regards to conceptualising self-harm in adolescence, adolescence is a time in which, in the Western world, in contrast with the importance of parental behaviour in childhood, the behaviour of other people, such as friends, has a greater influence on the behaviour of individuals. The reason is that from a Western perspective adolescence is regarded by some researchers as the time in which individuals undergo the process of individuation from family (Liao, Huang, Huh, Pentz, & Chou, 2013; Koepke & Denissen, 2012). In the context of developmental psychology individuation means the gains in independence and in the ability to separate via internalisation of caregiving figures (Book & Berant, 2014). Thus, the issue of

peer influence, along with the related issue of independence, are regarded as being particularly important during adolescence even though they are evident throughout the entire lifespan (Drewery & Claiborne, 2009). The reason why the concept of individuation from family in adolescence is a Western concept is related to the concept of independence versus interdependence. According to Markus and Kitayama (1991) there is a distinction between an independent self-construal and an interdependent self-construal. The independent self is perceived as being a bounded, free, stable, and coherent entity, with the focus being on the individual instead of the social unit the individual is a part of. The interdependent self is viewed as a fluid, connected, and committed, and flexible being which is bound to others. While members of collectivist cultures are said to have a mainly interdependent self, members of individualist cultures are said to be more likely to have a more independent self-construal. Thus, the notion of individuation from family predominantly applies to adolescents in the Western world.

The most widely recognised model regarding individuation and identity development consists of the classic stage-model of psychosocial life-span development by Erik Erikson. Within the context of this model, identity formation is the main task for the developmental stage of adolescence (Erikson, 1968; Koepke & Denissen, 2012). Thus, the main task of the adolescent life stage is regarded as the solution of the conflict of identity synthesis versus identity confusion. An optimal outcome for this task consists of the emergence of a coherent, integrated, as well as temporarily continuous sense of self. This includes the multiple facets of the self, namely relationship roles, vocational roles, and ideology. This sense of identity is divided up into three components that correspond with different functions for sustenance of self-continuity and self-coherence (Erikson, 1974).Thus, peer influence increases in importance in adolescence as adolescents develop identities that are increasingly separate from their parents (Temple, 2012; Meeus & Dekovic, 1995).

The majority of studies investigating the motivations for engaging in DSH have given a lack of emphasis on peer influences and social contagion effects (James, 2013). For the purpose of this thesis, social contagion is defined as the spread of behaviour or affect from crowd participants to one another, with one person serving as a stimulus regarding the imitative actions of another (Marsden, 2005). It has to be noted, though, that the phenomenon of social contagion is not restricted to the crowd scenario as mass media enables social contagion as well through dispersed collectivities. Nevertheless, several recent studies on DSH have

suggested peer contagion as a possible contributing factor regarding the increase in DSH among adolescents (James, 2013; Muehlenkamp et al., 2008).

DSH and social media

Part of this peer contagion consists of the presence of DSH on social media websites. The reason for this is that using the internet, and especially social media, now have become popular ways for people to spend their time (Cha, 2013; Hübner Barcelos & Rossi, 2014; Cookingham & Ryan, 2015). Similarly, studies investigating DSH-related internet activities suggest that there is a strong adolescent audience (Duggan, Heath, Lewis, & Baxter, 2012). However, it is vital to remember that the internet and social media themselves do not necessarily create risks, such as the risk of adolescents engaging in DSH. Rather, both online and offline adolescents willingly take risks (Livingstone, 2009). Reasons include testing boundaries of parental control, and adopting the lifestyle choice of 'living dangerously'. According to Livingstone (2009) in order to grow, youths need to take risks of a social, emotional, and intellectual nature. As emphasised by Livingstone (2009), children and adolescents' online interaction involves both opportunities and risks. An example is that the establishing of online friendships can lead to contact with ill-intentioned individuals. Therefore, rather than creating risks for children, the internet serves to mediate the balance between both societal risks and opportunities. The personal risk assessment necessarily for responsible internet use merely presents a new burden for children or adolescents and parents already occupied with the fraught emotional conflicts presented by the negotiating of boundaries of dependence and independence, public and private, and tradition and change. Nevertheless, according to Livingstone (2009), adults need to remember children and adolescents' rights for full participation in their communities, including the online communities of social media websites. The author argues that young people's online interaction enables them to be part of a 'global village'. Consequently, it is vital to remember that not only have adolescents the right to communicate with their peers online the risks associated with social media, including representations of DSH, are not created through the existence of social media as growing up always involves taking risks.

Nevertheless, there is the view that online representations of DSH can serve as triggers and normalise DSH. Results of a study by Duggan et al. (2012) indicate that informal, peer driven websites featuring DSH content feature a variety of triggering content, as well as being

accessed more often compared to professionally driven websites. DSH is strongly represented on YouTube and social networking websites, as evidenced via large video view counts and group memberships. Results of a study by Lewis and Baker (2011) support the notion that online DSH content can be triggering for individuals who self-harm, as material on peer-driven NSSI websites may both normalise and reinforce DSH. Thus, it appears there could be a connection between the internet and an increase in the tendency to engage in DSH by adolescents. However, there are also alternative explanations, such as the possibility that some adolescents who do not engage in DSH themselves might engage vicariously with the self-harm of others. Consequently, the possibility of a connection between the internet and an increased tendency to engage in DSH by adolescents is not undisputed.

Conceptualising the thesis

The notion that the internet plays a role in regards to enhancing the potential for engagement in DSH in adolescents is supported by several psychological theories. These theories include cultivation theory, social contagion theory, and social learning theory. In this section I position this thesis in relation to these theories of media and social influence.

Firstly, cultivation theory involves the notion of the spread of behaviour, thoughts, or ideas from the individual to the collective. Cultivation theory is a social theory examining the long-term impacts of mass media (Cohen & Weimann, 2000). Cultivation, and along with it cultivation theory and cultivation analysis, was introduced as a macrolevel system of explanation regarding mass media by George Gerbner (Potter, 2014). Cultivation analysis investigates the contributions of television to viewers' conceptions regarding social reality (Morgan & Shanahan, 2010). According to cultivation theory, those individuals who spend the largest amounts of time watching television have a greater likelihood of perceiving the real world in ways reflecting the most recurrent and common messages of the world of fictional television (Morgan & Shanahan, 2010). Cultivation theory emphasises the importance of tracing the ways in which the media's institutional practices shape meanings regarding the mass production of messages which are then widely disseminated, thereby shaping public beliefs and knowledge over the long term (Potter, 2014). Cultivation analysis can be defined as the study of the relationships among institutional processes and message systems, as well as the public images, assumptions, and policies that they cultivate, according to the work of Gerbner (as cited in Morgan & Shanahan, 2010). It appears that, so far, no

research incorporating cultivation theory and cultivation analysis on the effects of social media, or the internet in general, on human behaviour has been undertaken. Using the internet, and especially social media, now have become popular ways for people to spend their time, time they would have in the past spent watching television. Young people have been found to spend more time online than in front of TV screens (Cha, 2013). Therefore it seems only appropriate to use cultivation theory, along with cultivation analysis, to examine the effects of social media on adolescents' tendency to self-harm.

One of the mechanisms through which cultivation is thought to work consists of social contagion. Social contagion theory supports the idea of the internet playing a role in regards to enhancing the potential for engagement in DSH in adolescents in several ways. This theory attempts to explain ways in which network structure affects developing social pressures to conform (Hartman, 1989). For this purpose, social contagion theory looks at social conditions and events that enable crowd behaviour (Locher, 2002). In this way, social contagion theory reflects the focus of social identity theory on crowds and how being part of a crowd can change individuals' behaviour (Drury & Reicher, 1999; Reicher, 1982). In regards to crowds and crowd behaviour, social identity theory argues that in crowd contexts personal identity loses saliency, with people acting in terms of the social identity associated with the particular relevant social category. While behavioural control is not lost it is governed through the values and understandings defining social identity. Thus, although crowd members continue acting in terms of self-interest these interests are now different as they are based on a collective, and thereby different, self. Through the relative anonymity to outgroups and their sanctions and simultaneous visibility to ingroup members, and the related ability to coordinate with them, crowd members are able to enact their collective understandings and values even while facing outgroup opposition. Thus social identity theory reflects the focus on crowd behaviour by social contagion theory, as social contagion is part of the process of cultivating social identities within groups.

Meanwhile, social contagion theory is mostly associated with three writers, namely Gustave LeBon, Robert Park, and Herbert Blumer. It specifies ways in which the social context individuals are embedded in affects their behaviours and attitudes (Hartman, 1989). This social context is determined through the patterns of relationships existing within a particular social structure. According to social contagion theory, behaviour, ideas, or thoughts can be transmitted from one person to an entire collective of people (Locher, 2002; Marsden, 2005). Social contagion tends to be driven via the needs of persons that are located proximate to one

another within a social structure to use one another in order to reduce uncertainty (Hartman, 1989). Proximity can be determined by physical proximity, contact, competition, or communication. Since social media offers a novel form of communication, with it being the virtual equivalent of a crowd, social contagion theory can be applied to it, and thus to online representations of DSH. This is supported by Whitlock, Powers, and Eckenrode (2006b) who argue that even though it was far from impossible for individual self-injurers to have gathered in groups before the advent of the internet, the easy access to a virtual subculture provided by the internet can serve as a reinforcer for DSH for a significantly larger number of adolescents. They also argue that the tendency for DSH to occur in epidemic-like patterns in institutional settings, including detention facilities and hospitals, implies that the behaviour could be socially contagious in other settings, and thus on the internet as well. As Brumberg (as cited in Whitlock et al., 2006b) has argued in regards to eating disorders, both discussion of self-injury techniques, as well as of the perceived benefits of DSH, could even add behaviour of a potentially lethal nature to the repertoires of established self-injurers, along with message board members who have so far not engaged in DSH, and non-participating message board viewers. Social contagion theory has in fact been applied to online representations of DSH. An example of this consists of research by Richardson et al. (2012) who argue that, while self-injury message boards and websites can be helpful in terms of providing support and information for some adolescents engaging in DSH, their content can also serve as a trigger for others. Thus, the idea of the internet playing a role in regards to enhancing the potential for engagement in DSH in adolescents is supported by social contagion theory.

Yet another mechanism through which cultivation works consists of social learning. Social learning theory, which was conceptualised by Albert Bandura, regards learning as a cognitive process that occurs in a social context, and can take place merely through observation or direct instruction, even without direct reinforcement or motor reproduction (Bandura, 1963). In addition to behavioural observation, according to social learning theory, learning also takes place via the observation of both rewards and punishment (Bandura, 1971). This process is referred to as vicarious reinforcement. Although it appears that no research exists that examines the relationship between social media use and adolescents' tendency to engage in DSH using the lens of social learning theory there is research incorporating social learning theory that examines how social media use affects other aspects of human behaviour. However, all of this research appears to be about ways in which social media aids with social learning in an educational context. An example consists of an ex post facto, causal

comparative study by Tuma (2012) to determine if there exists a statistically significant difference regarding self-reported sense of community by tourism and recreation students when an instructor's Facebook page could be accessed by one group of research participants over another during a semester. For this study, along with connectivism theories, social learning theories were used as the theoretical framework. A second example consists of a study by Rollins, Nickell, and Wei (2014) investigating salespeople's learning experiences via blogging. For this purpose the authors used netnography method to examine 200 salespeople's blogs. They drew on social learning theory, along with real salespeople's blogs, to illustrate both how and why salespeople are able to learn through reading and writing blogs. Nevertheless, even though existing research on social media using the lens of social learning theory appears to focus on an educational context, since social learning is a major part of how behaviours, including maladaptive behaviours, are acquired, social learning theory will be incorporated in this study.

The prospect of DSH having become a normalised behaviour among adolescents as a reflection of their use of social media, and thus social factors playing a role in enhancing the potential for engagement in DSH for adolescents, raises the possibility that for some adolescent self-harmers social media use could create a sub-cultural space in which DSH is contested and in some cases rendered normative. Nevertheless, there is a lack of studies that have investigated the possibility of a connection between social media use and adolescent engagement in DSH. Therefore, there is a lack of recognition of the possibility of a social media component to adolescent self-harm.

Chapter summary and aims

In this chapter I have introduced the topic of the association between social media and adolescent engagement in deliberate self-harm. As part of this previous studies investigating DSH-related internet activities, and especially their effect on adolescent self-harmers, were introduced. Theory relevant to this study also was explored, including cultivation theory, social contagion theory, and social learning theory. Lastly, as this study involves several distinct but related aims, time was taken to explore these.

The core regarding the focus of this thesis is to examine how self-harming adolescents conceptualise DSH through online self-harm discussion groups. Thus, this study aims to

investigate the social media use of adolescents who engage in DSH. Thus, it examines the ways in which social media use is connected with the efforts of adolescents to negotiate tendencies to engage in DSH. Related to this is the aim to investigate the ways in which adolescents who have previously engaged in DSH, or are currently engaging in such behaviour, make sense of DSH through social media discussions.

A part of this is examining whether and to what extent DSH is presented as normal in these discussions. This is an aspect of interest since if in online discussion groups DSH is mostly presented as normal this could potentially result in adolescents, both self-harmers and non-self-harmers, considering DSH a normalised behaviour. However, if in these groups DSH is generally not normalised but portrayed as something that should not be engaged in this could influence adolescents' opinions. This is only a tentative assertion, however, as due to this study being qualitative causal relationships cannot be established.

CHAPTER TWO: METHOD

This chapter outlines the study's methodology which is designed to ensure an in-depth exploration of the negotiation of the meaning of DSH for self-harming adolescents through online discussions. To begin with, I outline the criteria and procedure used for selecting posts for analysis. I then discuss the use of thematic analysis to examine communicational content in the various online discussion groups. Finally, I consider ethical considerations that apply to this study, along with research limitations.

Research procedure and the selection of discussion groups

Posters consisted of a variety of adolescents who participated in online discussion groups about DSH, and whose posts were analysed for this study. This research is not focused on individual posters, but rather on the content of online discussions. For the purpose of this study the term "post" may be defined as something such as a message or a picture which is published on a website or via using social media (Cambridge University Press, 2015). The exact ages and other demographic information of participants in these discussions is mostly unknown due to the largely anonymous nature of online discussion groups in general. However, it was ensured by the researcher as much as possible that all participants are indeed adolescents. This was accomplished by checking their ages where possible, and looking for age-identifying details in posts, such as posters mentioning attending high school. For the purpose of this study, the term adolescent was defined as meaning an individual aged between 13 and 19 years. Participants who had not themselves engaged in DSH or had contributed content about self-harming with suicidal extent were excluded from the study due to the study being about adolescents engaging in non-suicidal self-harming.

In order to find online discussion groups about DSH that are frequented by self-harming adolescents Google searches were conducted, as well as searches on Facebook. Because of the variable nature of the internet all searches and descriptive data collections were undertaken on July 1-July 3 2015, and compiled into an Excel spreadsheet. Searches were undertaken using several keywords, namely *self-harm, self-injury, adolescents, teenagers,* and *teens*. Even though the author made every effort possible to accurately present the research findings, the ever-changing nature of the internet leaves the study's results subject to

change. The first few online discussion groups that came up in Google and Facebook searches were chosen. The reasoning behind this was that since those are the first groups to come up in online searches they are the most likely groups to be found and thus used by self-harming adolescents wanting to talk to peers online.

A total of five online discussion groups were chosen for analysis of content for this study. This amount of different groups was chosen because it was deemed that this was a suitable amount to investigate within the time frame, and it enabled a greater balance of variety of posts to be analysed. Thus, chances of bias were reduced. Groups were chosen based on adolescent self-harmers being the primary or at the very least a major target audience, their level of accessibility to the public and on how busy and long-established discussion lists were. While a minority of groups were specifically dedicated to self-harming, especially most of those on Facebook, the majority were forums about general mental health topics, including DSH. All of the latter groups had sub-forums specifically dedicated to the topic of self-harming from the posts to be analysed were downloaded.

The participating online discussion groups ranged in size from small to large, meaning the amount of content, such as for example message board posts. The number of members registered ranged from 52 in the case of one Facebook group to 107,794 people in the case of one message board style online discussion group. In comparison, in each online discussion group there were approximately thirteen active participants in the message threads analysed for this study. Across the eight different groups analysed the posts of a total of 104 discussants were analysed. Numbers of discussants from the different groups whose posts were analysed ranged from four discussants in one of the Facebook self-harm groups to 29 discussants on the ChildLine message board. The total amount of discussants from the five Facebook groups whose posts were chosen for analysis was 43, meaning 41 percent of the total posters whose posts I analysed. Meanwhile, the total number of discussants on the three message boards chosen for analysis (VirtualTeen, ChildLine, and RecoverYourLife) was 61, or 59 percent. Thus, the number of posters from Virtual Teen, ChildLine, and RecoverYourLife were roughly balanced out compared with the amount of posters from the Facebook groups. The discussion threads analysed ranged in length from one to 38 pages. The online discussion groups were all active, with a minimum of 111 pieces of content, such as posts, being posted each month. All of them had at least one moderator or administrator who monitored group content. It was possible to identify that posters consisted of both males and females. Some of the discussions occurred on message boards and Facebook groups for

adolescents, while others are aimed at all age groups with some individuals posting on them being adolescents. Groups not specifically targeted at adolescents were included for this study because online searches failed to find an amount of groups deemed sufficient by me. Additionally, groups not specifically targeted at adolescents were found to have a large proportion of adolescent users, as well as generally featuring higher amounts of posts compared with groups targeted solely at adolescents.

All of the participating online discussion groups are international and English-speaking. As Aoeatora/New Zealand is a country with a relatively small population there was a lack of local online self-harm discussion groups. As English is used in a variety of countries posters' locations are not easy to distinguish. Most of these groups are hosted from the United States but all are accessible to adolescents from across the world. Therefore participants are likely to be from a variety of countries and cultural backgrounds, with the majority of them being from Western countries and cultural backgrounds. This is apparent from their posts and the information they chose to provide on their online profiles. Nevertheless, as the posts analysed for this study are anonymous it is impossible to tell for certain which countries or cultural backgrounds posters are from.

The largest online discussion group used in this study, virtualteen.org, is dedicated to topics relevant to the lives of adolescents who make up the website's target audience (Virtual Teen, 2015b). Subforums are dedicated to these topic areas, such as issues related to mental health, puberty, help and advice for dating, sexuality, education, as well as lifestyle topics such as sports, fashion, and cooking. There is a subforum called "Cutting and Self Harm", from which I chose threads and posts to be analysed for this study. According to Virtual Teen's rules images of self-harm or possible triggers of any form are prohibited. Another online discussion group chosen for this study consists of the message board section on ChildLine.co.uk. ChildLine is a free of charge 24-hour counselling service for both children and adolescents up to their 19th birthday in the UK (NSPCC, 2015). It is provided by the National Society for the Prevention of Cruelty to Children. ChileLine's message board section includes subforums dedicated to topics such as sex and relationships, gender and sexual identity, health and wellbeing, life issues, emotions, abuse, and harmful behaviour. The latter category includes a subforum dedicated to self-harm from which content analysed for this study was selected. RecoverYourLife, one of the largest self-Harm support communities on the internet, is a further online discussion group from which posts were selected for analysis (RecoverYourLife, 2012). According to the website's rules,

RecoverYourLife does not condone any types of pro-activity or encourages anyone to self-harm, and a few rules exist to ensure this. The website's aim is described as offering community and support with getting through self-harm. RecoverYourLife is aimed at all age groups. Additionally to these three online discussion groups five public self-harm groups on Facebook were also chosen for this study. All of them, while being aimed at all age groups, appear to have a large amount of adolescent posters, judging from the ages provided by posters. Again, due to the anonymous nature of the online discussion groups it is impossible to prove posters' ages. Moreover, the number of members of the different Facebook groups ranges from ten to 56 members. Thus, online discussion groups of a variety of sizes were chosen for this study.

In total 55 discussions encompassing 369 pieces of content were selected and downloaded for analysis. 26 of these threads were from Virtual Teen, ChildLine, and RecoverYourLife, while 29 were from the selected Facebook groups. Thus, the amount of threads and posts from Virtual Teen, ChildLine, and RecoverYourLife were roughly balanced out compared with the amount of posts and threads from the Facebook groups. As Facebook is a tool used by a lot of adolescents to communicate today, including adolescents' posts from self-harm groups on Facebook is just as relevant as posts from self-harm message boards. This variety allows for a broader picture to be developed.

I selected conversation threads that were currently active. The reason behind this decision was that by the time this thesis is completed they will still be more relevant than older conversation threads. For the selection of content from online discussion groups for adolescents, threads and their respective messages were chosen via a random selection process. This was done in order to avoid cherry-picking of threads as much as possible. For each of these online discussion groups, all threads were assigned a number. Numbers were then randomly generated by an online number generator. Threads corresponding to the generated numbers made up the data set. However, certain posts were excluded from the study to ensure that the research questions were answered. Posts by family members and friends of adolescents engaging in DSH were not analysed, since this study's focus is on experiences of self-harming adolescents.

This method of sampling could not be used for online discussion groups that were frequented by self-harming adolescents but aimed at all age groups. The reason is that in the case of the latter groups not all content was created by adolescents. Therefore, an effort was made to

ensure that only threads by adolescents and threads by adults looking back retrospectively at their adolescence were chosen for analysis. All chosen pieces of content were immediately downloaded onto the researcher's computer. Time and date of download were noted for each piece.

Analysis

Thematic analysis was used to examine communicational content in the various online discussion groups. This method of data analysis was chosen because it allows for in-depth exploration of the association between social media, in the form of online self-harm discussion groups, and adolescent engagement in deliberate self-harm. That because thematic analysis is free of the requirement to progress from text analysis to adhering to the ideological or theoretical principles of any specific approach, as for instance is the case in grounded theory (Weiten, 2010).

Thematic analysis is used in qualitative research (Daly, Kellehear, & Gliksman, 1998). It focuses on the examination of themes within data. Thematic analysis is a strategy for data reduction and analysis involving the segmentation, categorisation, summarisation, and reconstruction of data in a way which captures the vital concepts within a data set (Flick, 2013). Additionally, thematic analysis involves identifying both explicit and implicit ideas within data, rather than simply counting words or phrases in a text (Guest, MacQueen, & Namey, 2012). The primary process regarding the development of themes within the raw data consists of coding (Boyatzis, 1998). This is achieved by recognising important moments within the data, as well as encoding it prior to interpretation. Most researchers view TA as a very useful method for capturing intricacies of meaning within a set of data (Guest, MacQueen, & Namey, 2012). Thus, the use of TA enabled the identification of an in-depth description of patterns within the data.

Primarily inductive thematic analysis is used, rather than deductive thematic analysis. The reasoning behind this is that this method of analysis prevents the researcher as much as possible from starting out with preconceived notions regarding what the final themes ought to look like (Braun & Clarke, 2006). Thus, inductive TA avoids the rigidity, as well as the premature closure, that are among the risks of a deductive approach to TA (Mills, Durepos, & Wiebe, 2010). The idea behind inductive TA is to let theory emerge via the analysis of data (Braun & Clarke, 2006). Therefore inductive TA is data-driven. The emergent themes can

still be related back to other relevant literature. Therefore there is still ample room for theory but at the same time theory is prevented from drowning out themes that do not fit with it.

This study used a semantic approach to TA. The concept of a semantic approach to TA was developed by Braun and Clarke (2006). This means that the analytic aim is to organise content in order to demonstrate patterns in the data. These patterns can then be related back to already existing theory or be used to develop new concepts. This is in contrast to a latent approach, which strives to identify underlying constructs and ideas that influenced or produced the overt content of the data.

In regards to ontology and epistemology, this study used critical realism. Critical realism acknowledges the ways in which individuals make meaning regarding their experiences, as well as, in turn, the specific ways the broader social context affects those meanings (Braun & Clarke, 2006). It involves a stratified view of the nature of reality, meaning that the real stratification of being is regarded as separate from our knowledge of being. Simultaneously, focus is retained on both material and other limits of "reality". Critical realism involves recognising that multiple modes and levels of engagement exist between knower and known (Peters, Pressey, Vanharanta, & Johnston, 2013). Thus, it divides ontology into levels of the real, meaning the mechanism generating phenomena at the level of the actual, the actual, meaning events that occur, and the empirical, meaning our experience of those events. This enables critical realists to distance themselves from the postmodern view of all of reality being reducible to nothing more than language. Thus, critical realism allows for both a constructionist epistemology and a realist ontology.

The analysis identifies key themes, both as distant entities and how they are related to each other. The extent to which key themes are reflected in the current psychological self-harm literature is also considered. The themes did not just come from the data by themselves. They were imposed by me on the data in order to make sense of the conversations in the online discussion groups that chosen for analysis in this study. The thematic analysis undertaken for this study involved adhering to the step-by-step guide for doing thematic analysis suggested by Braun and Clarke (2006). The first of these steps was to thoroughly familiarise myself with the posts that made up my dataset. This involved immersion, meaning repeated reading of the data, along with reading the data in an active way, involving searching for meanings, patterns etc.

This was followed by the second step suggested by Braun and Clarke (2006), namely generating initial codes from the posts, and involved organising them into meaningful groups. The coding was heavily influenced by the themes being more data-driven than theory-driven, and by the aim being the coding of the entire data set rather than coding being used to identify only particular, limited features of the data set. I worked systematically through the entire set of posts, giving full and equal attention to each post, and identified interesting aspects within the data items that formed the basis for repeated patterns, e.g. themes, across the data set. Coding was done manually by me by printing out the selected posts, writing notes on the texts, and using highlighters to indicate potential patterns. I carefully ensured that all posts were coded, before being collated together within each code.

When all of the selected posts were initially coded and collated, and I had a long list of different codes I had identified across my data set, I searched for themes. This is the third step suggested by Braun and Clarke (2006). This phase refocused the analysis at a broader level of themes, instead of codes. It involved grouping the different codes into potential themes, as well as collating all relevant coded data extracts within the themes that were identified. This phase ended with a collection of candidate themes, sub-themes, as well as all extracts of data which had been coded in relation to them. When I had devised a set of candidate themes the fourth step of thematic analysis, as suggested by the authors, began. It involved refinement of those themes. This phase involved two levels regarding reviewing and defining my themes. Level one involved a review at the level of the coded data extracts. This meant reading the collated extracts for each particular theme, and considering whether they appeared to form a coherent pattern. Meanwhile, level two involved considering the validity of the individual themes in relation to the entirety of posts, forming the data set. However, it also involved determining whether my candidate thematic map accurately reflects the meanings that are evident in the overall data set. I also re-read my entire data set with two goals in mind. The first was, as discussed, an ascertaining of whether the themes work in relation with the data set. The second goal was to code any additional data found within themes that was missed in earlier stages of coding.

When I had a satisfactory thematic map of my data the fifth step of thematic analysis, as suggested by Braun and Clarke (2006), began. At this point, I defined and further refined the themes that I presented for my analysis, as well as analysing the data within them. Defining and refining means identifying the essence of what each particular theme is about, as well as the themes overall and determining which aspects of the data are captured by the different

themes. For each individual theme I conducted and wrote a detailed analysis. Along with identifying the story told by each theme I considered how it fits into the broader overall story told about my data in relation to the research questions. This ensured that the themes did not overlap too much. Thus, I considered the themes themselves, as well as each theme in relation to the others. Part of refinement included identifying whether or not a theme contained any subthemes.

As soon as I had a set of fully worked-out themes the sixth step, as suggested by Braun and Clarke (2006), began. It involved both the final analysis and the write-up of the report. The aim here was to tell a complicated story of my data in a way that will hopefully convince the reader of both the merit and validity of my analysis. This involved providing sufficient evidence regarding the themes within the data, meaning enough data extracts to demonstrate the prevalence of each theme.

Thus, all six steps of thematic analysis outlined by Braun and Clarke (2006) were used for this study. This ensured an in-depth exploration of the association between social media, in the form of online self-harm discussion groups, and adolescent engagement in deliberate self-harm as much as possible.

Ethical considerations

In regards to this study, several ethical issues exist which are covered in this section. These relate to privacy and confidentiality, as well as DSH being a sensitive topic, especially since this study focuses on adolescents

In regards to the analysis of peer-created online content about DSH in social media discussion groups, one ethical issue regarding risks to participants is related to the fact that analysing peer-created online content about DSH by adolescents by its very nature involves involuntary participation of the research participants (Coolican, 2009). Individual producers of content to be analysed were completely unaware of the study's existence. In the case of the thematic analysis of peer-created DSH content on social media discussion groups consent cannot be obtained. The reason is that obtaining consent from discussion group participants would disrupt the natural flow of conversation. The main ethical issue regarding involuntary participation is that people's lives can be invaded by such acts (Coolican, 2009; Kraut et al., 2003). However, this issue is likely not to be prevalent in the case of this study as only

anonymised excerpts from participants' posts will be accessible to the public via being included in this thesis. Identifying information, such as email addresses, partially disguised pseudonyms, or other distinguishing personal information, such as posters' locations are not included in this thesis.

Because the researcher needed to gain access to private social media discussion groups, such as Facebook groups some level of invasion of participants' privacy was necessary for this study. Nevertheless, posters' identifying details, such as names, schools, or locations, were only seen by the researcher and posters to these fora. In contrast, other social media discussion groups about DSH targeted at adolescents are accessible to the general public. Therefore the issue of invasion of participants' privacy does not apply to them. Thus, completely unobtrusive observation is made in this case. Similarly, it has been argued that scientists can record online communication without the consent or knowledge or participants since this constitutes unobtrusive observation of unidentifiable individuals in a public place (Herring, 1996).

Another ethical issue regarding risks to participants in regards to the analysis of peer-created online content about DSH in social media discussion groups concerns participants' anonymity, and thus confidentiality, and privacy. Since DSH is a very sensitive issue uttermost care needs to be taken care to preserve participants' anonymity. Additionally, as all of the research participants will be adolescents due to the research topic involving self-harming during adolescence the fact that the research participants are vulnerable individuals needs to be considered. For these reasons posted names and online usernames used by discussants were kept anonymous. In the case of the majority of discussants whose posts were chosen for analysis for this study only their usernames, not their real names, are known to me. Similarly, other potentially identifying details like participants' location are anonymous. The original list of participants is held only by me.

Limitations

As with all research, this study is not free of limitations. Firstly, it is vital to recognise that I do not assume that all the accounts collected from international English-speaking online discussion groups are completely applicable adolescent self-harmers in Aotearoa/-New Zealand. Aotearoa/New Zealand is a country with a unique culture. It is shaped by European,

especially British, customs, along with Maori and Polynesian traditions. Thus, New Zealand culture shows some vital cultural differences in comparison with other English-speaking Western cultures.

The anonymity of online discussion groups could mean that some participants might not be adolescents. With online research there is always the risk that participants could lie about their ages (Wright, 2005). However, in the case of this study this issue was mitigated in several ways to a relatively high degree. For one, posts from a relatively large number of different posters, 104 in total, were chosen for analysis. This large number of discussants lowers the risk that too many of them could be lying about being adolescents. In the case of Virtual Teen, ChildLine, and RecoverYourLife the majority of posters provided their ages on their profiles. In the case of the Facebook groups, it was generally possible to find out age-related clues from accessing posters' Facebook profiles. The most frequent example was posters providing the name of their high school, as well as their years of high school attendance, on their profiles. Schools usually have control of their Facebook pages and can vet the people claiming to attend a particular school against the actual school roll. In addition to posters across the different discussion groups generally providing their ages in their online profiles several clues regarding their ages were found in the posts themselves. For example, there was frequent mention of posters attending high school, and being worried about issues of confidentiality regarding their DSH (Attard & Coulson, 2012). One such frequently-mentioned issue was discussants expressing concern that their parents could potentially find out about their self-harming from other adults, such as mental health professionals or teachers. Also, virtually all of the online discussion groups shared the membership requirement of their members having to be over a certain age. This minimum age was thirteen in the case of Facebook and Virtual Teen, and eleven for ChildLine. Because of the minimum age for ChildLine being eleven, while this study is focused on adolescents aged between thirteen and nineteen years of age, care was taken to only include posts by discussants aged thirteen and up as much as possible. RecoverYourLife was the only discussion group to lack a minimum age requirement. Thus, the risk of participants lying about being adolescents affecting the study was mitigated in as many ways as realistically possible.

Nevertheless, while every effort possible was made to ensure that the posts used for this study were posted by self-harming adolescents, due to the anonymity of online discussion groups, there is no way to guarantee that every single post actually was posted by an adolescent self-harmer. Thus, a handful of posts could potentially have originated from individuals who are

either not adolescents or do not self-harm. Discussants could also have deliberately lied about factors related to their engagement in DSH. However, they do not need to have deliberately lied in order for distortion of factors related to their self-harm to occur. Instead, they simply could lack insight into what drives their behaviours related to DSH. Additionally, the details provided by posters regarding their self-harm were made through self-reports that relied on retrospective recall, and cannot be verified via other means (Murray & Fox, 2006).

Further, there is no way of knowing how accurate posters' representations of their lives, and factors related to their self-harming truly are. That is unavoidable in the case of research focused on participants' accounts, and especially with the anonymity of the internet added in. Another reason for this is partly because points of view of people close to discussants offline, such as their parents and friends, on discussants' behaviour and factors related to their DSH are missing.

The particular online self-harm discussion groups chosen for this study could differ in some ways from other such groups. I cannot be certain that this study did not simply involve tapping into the cultures of the particular groups chosen instead of general norms, as well as benefits, of online self-harm groups (Murray & Fox, 2006). The groups chosen happened to consist mainly of people who shared the common goal of wanting to reach a stage where they would be able to stop self-harming, which involved them having developed norms, rules, and 'etiquette' in line with this aim. In contrast, other groups might encourage an entirely different set of both values and behaviours.

Another limitation of this study is that there was not enough time to analyse every single post by an adolescent self-harmer from every single online self-harm discussion group out there. This means that there is a potential risk that even though data collection finished when theme saturation was achieved some issues could still have been overlooked (Attard & Coulson, 2012; Duggan et al., 2012).

There are also several potential limitation in regards to the use of thematic analysis. Unlike biographical approaches, such as narrative approaches, with thematic analysis the researcher is not able to retain a sense of both continuity and contradiction via any one individual account (Braun & Clarke, 2006). These contradictions, as well as consistencies, across individual accounts could be revealing. Thematic analysis also involves the risk of ending up declaring the obvious but failing to rise above the mundane. Another limitation of thematic analysis is that, in contrast to other qualitative analytic methods, there is a lack of an ability to

retain a sense of contradiction and continuity via any one individual account, with these consistencies and contradictions across individual accounts potentially being revealing. Unlike other qualitative analytic methods thematic analysis fails to allow for the making of claims regarding language use and the fine-grained functionality of talk.

Online research also involves several limitations. These are associated with the potential of sampling bias (Kraut et al., 2003; Weiten, 2010). Even though the population of internet users keeps growing not everyone has online access (Weiten, 2010). Web users tend to be brighter, as well as more affluent compared to nonusers. They also have a greater likelihood of being white, young, and to have children (Kraut et al., 2003). Some evidence also exists for them differing in psychological characteristics compared to non-web users (Kraut et al., 2003). Thus, users have been suggested to be more extroverted and stressed than non-users (Kraut, Fussell, Brennan, & Siegel, 2002). Thus, several limitations involving sampling bias are associated with online research. Overall, this study is not free of limitations.

CHAPTER THREE: ANALYSIS OF THEMES

Online self-harm discussion groups, including message boards and Facebook groups, provide a venue for active and former self-harmers to make sense of their own self-harm. This includes the various ways in which social media is associated with the efforts of adolescents to negotiate tendencies to engage in DSH. Several ways in which self-harming adolescents conceptualise DSH through online self-harm discussion groups are evident from my analysis of their online posts. These various ways are encapsulated by the themes generated by the thematic analysis used in this study. This chapter presents the results from the analysis in the form of these themes.

Thirteen themes, each with their respective subthemes, were identified from the research corpus. These themes encompass the key issues related to links between online discussion groups and adolescent engagement in deliberate self-harm. Each of these themes and the subthemes related to them make up answers to the original research questions, namely what the nature of a social media component is in regards to adolescent self-harm.

Themes gathered for this thesis from the online discussions can broadly be divided into three major thematic categories. The first consists of themes centred around defining self-harm. These include the themes of how self-harm is conceptualised in the analysed posts, DSH as an addiction, the framing of DSH as something negative, self-harming adolescents not minding their scars, and social affiliation in the context of adolescent self-harming. The second major thematic category encompasses themes around contributing issues regarding DSH. These entail the themes of and DSH as a coping strategy, people offline being unhelpful, keeping DSH secret from people offline, a negative self-image, comorbidity with other psychological issues, social isolation/loneliness, and school-related issues. The third major thematic category consists of themes focused around care and support. It includes theme of care and support online and the theme of the importance of getting help with DSH offline. Each theme making up the three major thematic categories will be discussed with regard to what it tells us about the posters' experiences, and how these are linked with the self-harm literature and the theoretical framework presented earlier.

Themes around conceptualising self-harm

There is considerable variation regarding definitions of self-harm and related terms such as DSH, NSSI, and self-mutilation. In this section I address this variation and consider the differences and similarities regarding conceptualisations of self-harm and related understandings as expressed by online discussants. Understandings of self-harm in the analysed data encompass both similar and different conceptualisations of the term compared with the ways in which the term self-harm is defined in the literature. Discussants place considerable emphasis on understanding DSH as an addiction. A further theme making up part of this section consists of the framing of DSH as something negative. This understanding is common to both the online discussions analysed and scholarly literature on self-harm. I also talk about how self-harming adolescents not minding their scars is an important element of their understandings. The scars are metonyms for the act and reminders of one's own behaviour. Lastly, I also consider the role played by social affiliation in the context of adolescent self-harming.

Conceptualisations of self-harm

In the various posts self-harming adolescent posters conceptualise self-harm in a variety of ways. Posters' conceptualisations span cutting, to mental self-harm and even includes crying. Their conceptualisations both overlap and differ from each other and definitions of self-harm in the psychological literature.

Firstly, self-harm is framed in the posts in several ways that are in accordance with self-harm definitions in the literature. For one, throughout the posts self-harm is presented as a destructive cycle which is addictive, involving strong urges:

> *I'm not saying you are too weak to fight through this on your own and I don't want to discourage you, but I'm gonna tell you it's more than hard to stop self-harming without any help. The only way I got out of this addiction was to hand my razors over to my parents and tell my friends about it. That way I could call a friend at any time to distract me if the urges were becoming unbearable. (Virtual Teen, 2015f)*

This poster clearly frames self-harming as an addiction here. In doing so she also emphasises how difficult it is to stop self-harming without help from others like parents and friends. She

also conceptualises the urge to self-harm as "unbearable", thus reinforcing the addiction conceptualisation of self-harm. The account also invokes the involvement of supporters or sponsors as a means of regulating one's actions in order to manage the addition.

Self-harm being conceptualised as an addiction is in accordance with the literature since, as determined by Sandman and Hetrick (1995), individuals experience an increase in opioid production after an episode of self-harm (Brown & Kimball, 2013). In combination with conditioning biochemical processes, this subconscious physiological process may potentially induce dependency, along with making the self-harming behaviour addictive (Sandman & Hetrick, 1995). Thus, there might potentially be parallels between the physiology of self-harm and that of heroin addiction. The strongest link between self-harm and the opiate system consists of the finding that opiate receptor blockers may potentially both attenuate and eliminate this behaviour. Nevertheless, although there are discussions regarding self-harm as an addictive behaviour, the literature connecting DSH and the opiate system is currently sparse (Brown & Kimball, 2013). However, DSH is also considered to be addictive by other authors. For example, NSSI has been conceptualised as an addictive, repetitive coping strategy (Richardson et al., 2012; Nafisi & Stanley, 2007; Plante, 2007). Thus, a solid foundation for self-harm being defined as addictive exists in the psychological literature.

Like other addictions, self-harm is presented as involving the gradual moving on to more dangerous methods of self-harm, as illustrated by this post. Milder forms of cutting are presented as gateway activities that lead to more intense forms of self-harm:

> *I was battling cancer at the time. I don't really count it as my first time cutting because I didn't do it again for several months. I was just having a horrible day in general. I was listening to airplanes by BoB. I saw my red pencil sharpener on my nightstand. I unscrewed it and made a small cut on my hand. I was texting my friend. I never thought I would move on to much more dangerous self-harm habits.* (Virtual Teen, 2004)

This poster talks about how for her dealing with cancer was related to the first time she self-harmed. However, she doesn't count this occurrence of cutting her hand with a pencil sharpener as her first time cutting for the simple reason that she did not cut again for several months. She describes listening to music and texting her friend during this first incident of self-harming. She also mentions that at the time of this first instance she didn't realise that she would eventually move on to more dangerous types of self-harming. Thus, even though

the poster did not self-harm again for several months since she ended up self-harming again, and eventually even moved on to more intense forms of DSH, this first time of self-harming created an urge to self-harm which became a habit. Then, this habit eventually reinforced the DSH for her. Thus, this is an example of self-harm as a kind of addiction.

There is also a consensus among discussants that self-harm is bad and "fucked-up" (Virtual Teen, 2014a). This framing is also common in the scholarly literature, which continuously portrays self-harm in a negative way (Lundh, Wångby-Lundh, & Bjärehed, 2011; Nock & Prinstein, 2004). An example of this consists of the definitions of self-harm by Young et al. (2006) as a maladaptive coping strategy aimed at relieving negative emotions such as anxiety, anger, guilt, or frustration. Virtually the same definition is used for NSSI by Sornberger, Smith, Toste, & Heath (2013) who define it as a maladaptive coping strategy used to deal with emotional difficulties. Part of self-harm being considered as negative in the psychological literature consists of psychological self-harm definitions continuously emphasising the negative consequences associated with it, such as significant scarring, infection of wounds, life-threatening injury, and even accidental death (Richardson et al., 2012; Nafisi & Stanley, 2007; Plante, 2007). Thus, the negative conceptualisation of self-harm in the posts analysed is in accordance with the literature.

A variety of different behaviours are counted as types of self-harm in the posts. Mostly, cutting and "more dangerous self-harm habits" were classed among them (Virtual Teen, 2004). The carving of words was included in some posts. Examples of words carved into skin by posters include self-depreciating terms, such as "worthless", "stupid", "ugly", "fuck up", "slut". Generally, posters tend to carve negative words into their flesh. Other examples include "death" and "hate". Terms expressing their struggles in life linked with self-harm also appear in this context. These include "help me" and "why". Additionally, in several posts behaviours like scratching, digging of nails into hands, and pinching to the point where it can cause harm you and leave damage on the body were mentioned as examples of types of self-harm. An example of the latter is this: "I would say to a degree it (pinching) is self-harm, but more a coping method which is totally ok, if you are pinching yourself to the point where it can harm you and leave damage on your body, then that isn't good (ChildLine, 2015d)." These methods of self-harming are similar to the methods of self-harming mentioned in psychological literature on the topic. The latter include cutting, scratching, burning, carving symbols or words into one's skin, interfering with wound healing, needle-sticking, and banging body parts (Gomez et al., 2015; Phillips et al., 2013; Vaughn et al., 2015; Brown & Kimball, 2013).

Additionally, in accordance with the definitions of self-harm in the literature that include coping with negative emotions as a reason for self-harming, self-harm is regarded in some posts as a natural response for people who have run out of ways to cope. One post even argues that self-harming is giving into the mirage of worth, which was created by people to make others feel bad, and letting it control you.

> *The idea that you are somehow inferior to those around you is absurd and it is completely a mirage created by people who want to make you feel bad. Society has created this world around you that makes you feel this way. It is not your fault. Self-harming is merely giving into this mirage, letting it control you. (Virtual Teen, 2015e)*

Thus, there is some sense of society being blamed for people self-harming. This, however, is somewhat at odds with the literature. This is because the literature fails to consider self-harm at any level other than the individual level and sometimes the relational level, such as peer influence (Brown & Kimball, 2013; Lundh et al., 2011; James, 2013; Duggan et al., 2012). Thus, the literature lacks the addressing of society as being a potential factor associated with self-harming. Participants' accounts, such as the one above, conceptualise self-harm as an addictive response to pressures in society. In the process, discussants are able to externalise their self-harm and in doing so situate themselves as victims of circumstance.

Some discussants also moved beyond physical self-harm to present mental self-harm as an important form of self-harm: "I stopped cutting a long time ago, but mental self-harm is more fun (Virtual Teen, 2014a)." In this post, the poster describes mental self-harm as having replaced cutting for them because the former is more fun for him than the latter. Further, behaviour such as crying was also included in discussant conceptualisations of self-harm. This is in contrast to the literature, which defines self-harm as intentional self-induced harming of one's own body resulting in tissue damage (Lundh et al., 2011; Nock & Prinstein, 2004; Remaschi, Cecchini, & Meringolo, 2015; Lewis, Heath, St Denis, & Noble, 2011; Claes et al., 2014).

An example of mental self-harm is hurting with words via individuals writing words on themselves with pen:

> *When I started I carved words into myself (arms/stomach/legs) but after a while I just cut lines because it was quicker. I also had a habit of getting drunk and covering myself in offensive writing in black marker pen, and in college would just cover paper in what I wanted to write on myself but I hadn't heard of anyone else doing this until*

> *today. I don't think it is that weird - I saw the choice between writing words and cutting symbols/words as the same choice burning myself or cutting myself, sometimes I just wanted to hurt with words.* (Virtual Teen, 2014a)

In this post, the discussant writes about writing offensive content on himself with marker pen, in addition to carving words into himself. He mentions that he views the choice between writing words on himself with pen and carving words into his skin as the same choice between burning or cutting himself. Thus, he recognises writing with a pen on oneself as being a type of self-harming as much as cutting or burning oneself are.

There are tensions between abnormal thoughts and self-harm as a form of release across the posts. Cutting, for example, is presented as being related to abnormal thoughts where cutting provides a way of overcoming or responding to these thoughts. Through these accounts discussants work to obtain a sense of separation between themselves, their abnormal thoughts and self-harm behaviour:

> *Many people get like that, feeling like cutting is a part of you, makes you normal among other things. But you need try to get past that stage. Know that cutting yourself is because you have thoughts in your head that are not normal, and cutting is the only way to get out of it. The one way that stopped me doing it was people finding out and I felt embarrassed, stupid, abnormal - quite the opposite of how I felt immediately after cutting* (Virtual Teen, 2004).

The threat of having self-harm seen by others as representing who the person is motivates some to end their DSH. They do not want people to find out and then see them as synonymous with DSH and therefore abnormal. Such labelling would cause this discussant to feel abnormal, which was the opposite from what he felt immediately after cutting.

In contrast, and as part of the complexity of discussants working to give coherence and meaning to their DSH, other posts respond by questioning the link between self, DSH and discovery by other people: "From what you wrote it sounds like you feel that something is wrong with who you are because you self-harm? It's a part of yourself that you're wanting to hide from (RecoverYourLife, 2015d)?" This discussant tries to draw out the original poster in terms of the link between self and DSH. In doing so they suggest that self-harming can be seen as part of the self-harmer that they want to hide from. Such exchanges reflect some of the value in people engaging in deliberate self-harm finding spaces in which they can engage in trying to make sense of their

actions. This discussion moves out beyond the existing scholarly engagements with DSH in that in the literature there is no discussion of whether self-harm is or is not regarded as a part of the person engaged in such behaviour or the implications of labelling in terms of imposing a social identity on a person, which may challenge their own felt identity. The literature simply defines self-harm as being the intentional act of harming one's body to cope with negative emotions (Young et al., 2006; Brown & Kimball, 2013; Lundh et al., 2011). It does not consider whether or not the engagement in this act is or is not viewed as part of the individual engaging in it by the individual in question.

To recap, DSH is conceptualised by discussants in various ways , including DSH being an addiction, a serious matter, an escalating activity where one gradually moves on to more dangerous forms of harm. DSH is presented as an abnormal activity that includes both physical and psychological forms. Discussants present DSH as involving a variety of different behaviours, some sense of society being blamed for people self-harming, mental self-harm, self-harm being portrayed as both abnormal and normalised, and DSH being mentioned both as being and not being a part of those engaging in it. Conceptualisations of DSH in posts in some respects resemble scholarly definitions as well as providing richer and more varied understandings of DSH. Below, some of the prominent ways in which discussants understand DSH are explored in more detail, including DSH as an addition, negative aspects of DSH, and the importance of scars.

DSH as an addiction

As noted above, from the posts in the different online discussion groups emerged the theme of DSH as an addiction. The function of this framing is exhibited by several posts, such as this example: "I know that it feels like cutting would be a relief, and it may well be in the short term, but in the long term it doesn't solve anything and then you wind up with a self-harm problem/addiction (RecoverYourLife, 2015c)." This participant refers to a strong urge to self-harm as a means of gaining relief in the short term. DSH is presented here in a similar fashion to someone with a substance misuse issue who feels the urge to drink alcohol but knows that this is not good for them in the long term .Giving in to the urge is presented as a short term way of managing concerns in one's life, but as also increasing the urge to self-harm. As noted by a poster in one of the discussion groups:

> *I started cutting a couple weeks back, only because it cleared my mind, and I just scraped with a maths compass, however, the last time I did it, I used a razor from a sharpener, and it didn't hurt, it just bled. I felt bad after, but I've been so close to doing it again. It's been 4 days since I've cut. And I've had to fight the urge every second. (Virtual Teen, 2015g)*

This poster writes about starting cutting to clear his mind by scraping with a math compass, before moving on to using a razor from a sharpener. He voices feeling bad after using a more severe method of self-harming but simultaneously experiencing a sense of addiction. This sense of addiction is expressed by him stating that he has been very close to self-harming with a razor he has sharpened again. He reports having to fight the urge to self-harm again. Thus, a key element in the construction of DSH as an addition is the threat of losing control regarding the intensity of release associated with self-harming.

The notion that for self-harmers there can be a strong urge to self-harm that makes it difficult for them to stop engaging in DSH is echoed by another poster:

> *I want you to know that there's no reason to say sorry, you haven't let anyone down and you haven't done anything wrong. Its hard to ignore the urge to self harm. I think you need to get help for how you're feeling, does anyone know about how youre feeling? Its important that you get help as soon as possible because self harm just gets worse and worse. Sorry if this makes no sense my heads a bit jumbled at the moment.* (Virtual Teen, 2015f)

This post is a response in a discussion thread started by another poster who talked about his issues with relapsing regarding self-harming. This poster considers ignoring the urge to self-harm as "hard". Thus, he acknowledges the existence of urges, a vital part of addiction.

Another poster states that self-harm is an addiction for her in an even clearer way:

> *The first time i ever cut I was in the 7th grade. (about 3 years ago) It was dumb I was depressed and I didn't know what to do, I wanted to be 'happy' again. I don't know why but i grabbed the knife that was on the counter and made a line. There wasn't any blood and I don't know why I did it but I could feel something again. I wasn't so numb. But then everything just went down from there, a downward spiral, people call it. Cutting became an addiction, where it felt like i needed it to feel somewhat normal.*

I'm supposed to try stopping it, but I don't know if I can anymore..I've used it for two long. (Virtual Teen, 2004)

In this post the discussant states that she initially started self-harming because she hoped it would make her feel happy again. She considers herself dumb when she self-harmed for the first time, so clearly regrets it. She then mentions a downward spiral in which self-harming, in the form of cutting, became an addiction for her. What is especially noteworthy is that she conceptualises cutting, and therefore self-harming, as an addiction. During the addiction stage she felt she needed to cut to feel somewhat normal. Now she appears to be getting used to the idea of stopping self-harming but doesn't know if she can anymore because she has been cutting for so long. As she clearly became so used to self-harming as a way of feeling something again over the lengthy period of three years that she doesn't know if she can stop self-harming her case she appears to be addicted to self-harming.

These extracts exemplify how DSH is often conceptualised as an addiction throughout the posts analysed for this study. This construction is anchored in discussant references to experiencing strong urges to self-harm, and not knowing whether they can ever succeed in trying to stop self-harming. A related, but distinct, theme to the addiction theme consists of an emphasis on negative aspects of DSH, besides the danger of addiction. In the following section, this emphasis on negative aspects of DSH is explored.

Emphasis on negative aspects of DSH

Another prominent dimension of posts to the online discussion groups consists of an emphasis on negative aspects of DSH. These negative aspects are in terms of their physical and mental health and people around them. Throughout the posts across the discussion groups DSH is conceptualised as something people should not do despite impulses to engage in it because it is a negative and harmful activity. Below is a typical short post invoking this construction as participants offer their support in response to the reported actions of particular posters: "cutting yourself is bad news and advise you to seek help, friends or family or maybe doctor. all the best (Virtual Teen, 2015g)." By talking about cutting as "bad news" and advising others to seek help, the poster conceptualises it as something harmful that is to be stopped. Similarly, another poster frames DSH as a problem: "See I don't want family involved... its not their problem and I dont want them worrying about me, as im worthless (Virtual Teen, 2015e)." Here a poster resists the

assertion by others that it is important to seek help from family by stating that he does not want to worry them. He also presents himself as not worthy of their concern and in doing so associates his actions with who he is. Here we may be presented with some insight into why many posters resist equating themselves with their DSH behaviour. Such an association of self with DSH comes with a negative assessment.

One's DSH was also understood in relation to the negative effects it has on people close to self-harmers. These people include self-harmers' family members and friends. The negative effects on people close to self-harmers are emphasised by some posters. An example consists of this post: "Not only does this have an effect on you, but on the people around you who care. If you won't stop cutting for you, then at least try for the other people (Virtual Teen, 2004)." This discussant proposes that self-harmers should care about the effect their DSH has on others, such as family and friends, if they don't care about the effect it has on themselves. He proposes that self-harmers should at least stop self-harming for those who care about them if they can't do it for themselves. Thus, the emphasis is put away from the self-harming individual. Instead, it is given to his or her social environment, namely the people close to self-harmers in their offline lives.

A related aspect of the negative effect DSH has that is related to the reactions of non-self-harmers to self-harming consists of the negative stigma surrounding DSH. An example consists of the following quote emphasising how a self-harming poster felt about himself when people found out about his self-harming: "The one way that stopped me doing it was people finding out and I felt embarrassed, stupid, abnormal - quite the opposite of how I felt immediately after cutting (Virtual Teen, 2004)." This quote describes the poster's emotional state after others in his offline life found out that he self-harms. He mentions feeling embarrassed, stupid, and abnormal, and that these emotions were very different from the emotions he felt right after self-harming. Thus, he describes how the stigma about his self-harming experienced by others was transferred to him. This was accomplished in the form of him feeling similar negative emotions than the people who found out about his self-harm. Thus, he names the negative stigma around self-harming being the one thing that stopped him from continuing with engaging in DSH.

This emphasis on DSH as a negative and highly problematic practice is complicated by the association of DSH with release from urges. Below a poster invokes this framing as well as relativizing the relief that comes with DSH as a short term gain: "I know that it feels like cutting

would be a relief, and it may well be in the short term, but in the long term it doesn't solve anything and then you wind up with a self-harm problem/addiction as well as depression (RecoverYourLife, 2015c)!" Along with framing DSH as a problem this post also conceptualises it as only being a short-term relief for issues such as depression. The poster asserts that in the long term DSH does not solve any of the issues self-harmers have in their lives, and instead leads to an addiction.

DSH was repeatedly framed as a negative way of coping with other issues that only offers short-term relief whilst placing one at greater risk of long term problems: "you dont have to hurt yourself to feel better its not worth it I promise (Facebook, 2014)." This poster asserts that self-harm is not worth engaging in because one does not need to hurt oneself in order to feel better. Thus, he communicates that there are more effective ways to reach the goal of feeling better.

From the extracts explored in this section I have shown that another prominent dimension of posts to the online discussion groups consists of an emphasis of negative aspects of DSH across the different discussion groups. These negative aspects of DSH are shown as including the negative framing of DSH, the negative effects it has on people close to self-harmers, and the negative stigma surrounding DSH. These elements are highly congruent with the framing of DSH as an addiction in the previous section. However, self-harming is not only represented in the forms of its negative aspects, as the following section shows, self-harming adolescents conceive of their scars in a positive manner.

Self-harming adolescents have complex relationships with their scars

The visible signs of self-harm are something that is often assumed to be hidden by youth engaged in DSH. Yet, self-harming adolescents' comments on the discussion lists partially contradict such assumptions. These posters being simultaneously concerned and unconcerned about their scars was another noticeable theme in regards to the online discussion group posts. Self-harming adolescents report accepting and, in some cases, even embracing their scars, with the exception of when they are around their families. In the process they provide an embodied account that raises tensions around the signs of their DSH:

> *I don't bother hiding them anymore, apart from around my family, but when I'm in college or about the town I happily have my sleeves rolled up, I don't care who sees. So long as its not my family. At this point I'm almost proud of them, weird thing to*

> *ALMOST be proud, but I somehow am, but at times it does embarrassed me a little.* (Virtual Teen, 2014a)

In this quote a poster talks about not caring who sees her scars, as long as her family does not see them. Thus, she differentiates her family from everyone else. Unfortunately, she does not state her reasons for this differentiation. She states that she is almost proud of her scars but at the same time a bit embarrassed. This quote means that the poster to some extent accepts her scars but differentiates with whom she is comfortable exposing them and with whom she is not. She acknowledges the scars being part of who she is around some people, but not around others.

Along similar lines, other posters present themselves as being proud of words or symbols carved into their skin, and wanting to preserve these artefacts of their self-harm practices: "I don't carve words but I used to carve designs. I like pretty things, so if I have scars I like them to look perfect and pretty. I stopped because it go to hard to make excuses for how I got them. I know it sounds really messed up... (Virtual Teen, 2014a)". This poster reports not making any effort to hide her scars with clothing. She presents the pretty designs carved into her flesh as somewhat desirable to here. This discussant also raises absent negative reactions from others in terms of her finding it hard to make excuses for how she got these marks on her skin. Stopping her own self-harm is associated with difficulties with explaining the marks to others. There is also an aspect of learning that comes through such accounts where one comes to anticipate and respond to the likely reactions of others to the signs of self-harm that mark their bodies.

Issues around participants not being concerned by the marks of self-harm also include posters stating that their scars from self-harming are a part of them. This connection between self-harm and self is particularly apparent in talk about the representational function of scars in remembering what particular marks mean to them. These posters' embracing the signs of their self-harm is in stark contrast with the extracts in previous sections where posters work to maintain some distance between self and self-harm by conceptualising their self-harm as negative, harmful, and not worth engaging in. This apparent oxymoron is best explained by posters who do not mind their scars having accepted and sometimes even embraced parts of themselves they perceive as negative, such as DSH. This includes scars representing memories for self-harming individuals, as stated in the words of one poster:

> *as for scars, i don't mind. i deserve them. i don't ever regret cutting, so why should i be ashamed of these scars? each cut means something different, has a different*

> *emotion and situation behind it. each one holds a memory. as awful as the memory may be, it's a part of who i am and the scar just accentuates the memory.* (Virtual Teen, 2004)

This poster voices not being ashamed of her scars because she doesn't regret cutting due to the scars holding different meanings for her. Each scar has a meaning attached to a particular emotion or situation. Thus, each scar holds a memory. No matter how negative these memories may be she still accepts them as part of who she is now. Thus, she acknowledges that negative experiences have shaped her personality, and made her who she is now. Here we see some similarities to scarification as a means of remembering or mourning a loved one after death. That is because memories are key to both situations. A similar function exists for tattoos. Tattoos often are inked because of the meanings their designs hold for those receiving them. Just like with scars from self-harming these meanings are often attached to a particular emotion or situation. This emotion or situation may be regarded as positive, negative, or neither by the person deciding to get a tattoo.

So far, there has been a lack of research comparing motivations for tattooing and DSH. Some of the little research that does exist suggests that college students who self-harm are motivated by a need to alleviate emotional pain while students who tattoo are motivated by self-expression (Aizenman & Jensen, 2007). Similarly, Straker (2006) also found that some people refer to their scars as being like an autobiographical memory, as mementos inscribed on the body. Thus, there might potentially be a shared motivation of aesthetic self-expression for self-harm and tattooing. Moreover, while not being explicitly linked with DSH, tattooing has been linked with risk-taking behaviours, including a high rate regarding self-reported prior suicide attempts, disordered eating behaviours, and drug use (Hicinbothem, Gonsalves, & Lester, 2006). Additionally, Anderson and Sansone (2003) described the case of a 19-year old male who used the process of tattooing, along with its associated physical pain, to acutely regulate negative emotional states. Thus, overall what little research findings there are comparing motivations for tattooing and DSH are relatively conflicting.

Similarly, the idea of self-harming individuals having conflicting views regarding their scars overall lacks research, although it was mentioned by Chandler (2014). Most of the participants in the study by Chandler (2014) stated that they did not mind their scars. Participants stated that they sometimes feel comfortable or confident with their scars. However, they also simultaneously indicated anxiety and concern regarding what others

could think on seeing their scars. Thus, the theme of self-harmers, and therefore also self-harming adolescents having a complex relationship with their scars lacks research, and therefore only is reflected to a small extent in the self-harm literature.

Social contagion or social [dis]affiliation

Overall, some mention of instances of social affiliation was found in the analysed posts. This includes how self-harming adolescents come to understand their DSH in relation to the actions of others. In doing so, they differentiate themselves from self-harming peers. This happens a lot with marginalised groups. They appeal to a stereotype of a homeless person or self-harmer and then differentiate themselves as somehow better or more genuine. While, several posters mention having friends that self-harm this alone is not evidence of social contagion. An alternative explanation could, for example, be that adolescents who self-harm gravitate to one another and may be trying to dissuade each other from self-harming. Thus, overall, there is a notable lack of straight examples of social contagion in the posts analysed. Therefore social contagion overall failed to constitute a theme. The posts analysed did not include any persuasive discourse to portray self-harm as something positive and worthy of engaging in. Similarly, there were no posts in which discussants stated that examples of DSH in other discussants' posts affected their own self-harming. However, one post stands out as featuring some level of social contagion regarding offline peers of adolescent posters, and can be positioned as part of the dynamics of social affiliation through DSH. In this post, a poster mentions that when he cut in front of a friend at school it caused his friend to try out cutting himself:

> *however today I feel quite bad about it because it happened again, in college, and for some reason it made one of my friends curious so he tried cutting, fucking stupid thing of him to do, he did it out of curiosity? What the actual fuck? However he just described it as extremely painful and unpleasant so I don't think he'll do it again, but OK was sure to bitch slap him and shout at him first. Made me feel horrible that I ended up making someone hurt themselves. (Virtual Teen, 2014a)*

Here the poster voices his guilt as he feels he is responsible for his friend trying out self-harming. He also emphasises that he communicated to his friend that self-harming is 'bad' and that he should never self-harm again. This post shows concern for others and a desire to

not influence others to engage in DSH. Thus, once again self-harming in portrayed in a negative way. However, what is especially notable about this post is that its poster connects his friend trying out self-harming in the form of cutting with witnessing him engaging in it. Thus, the excerpt raises some of the complexities around ideas of copying or social contagion as one type of social affiliation.

Some other posts, while not explicitly featuring copying or contagion, also feature elements of social affiliation, and notably the opposite of it, namely social disaffiliation, in regards to adolescents' engagement in DSH. This includes some posts in which posters mention that they either currently have offline friends who also self-harm or had such friends in the past. Here we have an example of the former. This poster states that, while this was the first friend he told that he engages in DSH, she is unable to help him because self-harms herself and cannot help herself, let alone him:

> *The first girl I told also self-harms and is depressed. She doesn't think she can help me cause she can't help herself. I just think she needs time. She still looks out for me though. She might just need time. To figure herself out you know? She's very troubled.* (Virtual Teen, 2014a)

The emphasis here is on the poster's friend being unable to help him overcome self-harming because she cannot help herself. The poster portrays his friend in positive ways, including emphasising that she looks out for him and may just need time to help herself first before helping him. Thus, one issue associated with peer support for self-harmers is pointed out, namely the possibility that self-harmers cannot always help and support each other with overcoming self-harm because their own mental health issues are too much for them to deal with to be able to help others. Additionally, the poster having an offline friend who self-harms as well by itself is not enough to indicate the presence of any elements of contagion. Instead, this appears to be just an example of adolescents who self-harm gravitating to one another, and trying to dissuade each other from self-harming. Thus, this post is about affiliation and negotiation rather than learning to harm one's self by observing and copying others.

In contrast, another post, while also showcasing self-harming adolescents gravitating to offline peers similarly engaging in DSH, indicates disaffiliation rather than affiliation:

> *When I was younger and had first started cutting I would carve words into my shoulders and legs. I went through a phase where I was hanging out with a girl who cut herself too but she did it for attention. She would cut things like "Marilyn Manson" into her skin and random crap just so she could show people. So I cut a heart. I quickly realize that was stupid and stopped hanging out with her. I still have the faint scar of "Ugly" in my shoulder from when I was 14. It was a phase I quickly graduated from.* (Virtual Teen, 2014a)

Here we have an example of a female adolescent having in the past been friends offline with another self-harming adolescent girl, and eventually resisting this social influence via disaffiliation. However, the extent to which her former friend's DSH was a factor in her own self-harm is not apparent from the post. Therefore social contagion cannot be implied from this post. Instead, this account seems to be more about differentiation from another self-harmer. The poser achieves this in two ways. Firstly, she emphasises that she is no longer friends with her offline peer. Secondly, she differentiates her own reasons for DSH via portraying the friend's reasons as more negative by labelling her as an attention seeker who uses self-harm as one way to get attention. The poster also portrays herself as someone engaging in DSH for 'nobler' reasons than her friend by stating that she quickly realised cutting words into her skin like her friend to get attention was "stupid". The other, represented by the poster's former friend, is presented as more superficial and seeking attention whereas the self, represented by the poster, is presented as more serious having 'graduated' from self-harming.

Thus, in terms of these accounts social dimensions of DSH are more varied and complex than a straight social contagion argument suggests. This includes both social affiliation and disaffiliation, with there being only one post involving some level of contagion. Thus, social contagion by itself overall is not a theme in the data. This theme and the already mentioned related but still distinct themes of how self-harm is defined, DSH as an addiction, an overall emphasis on negative aspects of DSH, and self-harming adolescents not minding their scars, make up a group of themes. These themes are centred around defining self-harm. Another group of themes revolves around contributing issues regarding DSH, rather than defining the term itself. I will talk about this group in the following sections.

Themes around contributing issues regarding DSH

Several themes that contribute to self-harming are mentioned in the posts analysed. The first of these is DSH being used as a coping strategy by posters to deal with a variety of issues in their lives. This theme partially overlaps with the other themes in this section. One of these other themes is people offline being unhelpful in self-harming adolescents' attempted recoveries. Other themes include adolescent self-harmers keeping DSH secret from people offline and struggling with negative images of themselves. Further themes revolve around the comorbidity of DSH with other psychological issues, as well as with social isolation/loneliness, and school-related issues, and DSH being used as a maladaptive coping strategy. As these themes all overlap with one another to some extent, while still being distinct themes, they will all be explored in this section. Thus, all of these issues are explored in more detail in the subsections below.

DSH as a coping strategy

An important issue to emerge across the posts was the use of DSH as a coping strategy to deal with various pressures in adolescent posters' lives. This issue is exhibited in several different ways. Firstly, DSH is mentioned in several posts as calming, relaxing, and clearing the mind:

> *cutting really makes me feel... better, yanno? it calms me down. it hurts, so in order to make it not hurt my brain slows down and doesn't receive the physical pain, which means that it's also not receiving the mental pain and it's really relaxing. i realize that 'in the long run' it doesn't help... but i know how to do this and not hurt myself. i may be obscenely morbid, but even so, i don't want to die and i won't let myself get seriously wounded.* (Virtual Teen, 2004)

What is notable about this post is the poster's emphasis on a link between her self-harm in the form of cutting and a sense of relaxation and a temporary forgetting of issues in her life due to the physical pain from the self-harm. She realises that DSH is not a long-term solution for her issues but subsequently states she will continue self-harming because she knows how to do it without seriously injuring herself. DSH is connected with temporary coping with negative emotions in this post. The idea of using DSH to cope with negative emotions is repeatedly mentioned in the literature. Self-harm is conceptualised by several authors as a

mechanism for coping with emotions and regulating them, which is supported by high levels of negative affect reported by self-harming individuals (Laye-Gindhu & Schonert-Reichl, 2005; Nixon, Cloutier, & Aggarwal, 2002; Suyemoto, 1998).

Meanwhile, several other posters state that they perceive self-harming, such as cutting, as helping with the specific negative emotion of anger:

> *Something terrible happened to me, i just couldn't believe it, so I started cutting, that was the only way to get rid of my anger, but after few months, I just realized that it was stupid, so I stopped Nothing but a scar was there... I do not recommend it to anyone, but it's the only way to get rid of anger...* (Virtual Teen, 2004)

This poster writes about self-harming in the form of cutting because she saw it as the only way to cope with her anger resulting from a negative life event. Even though she now regrets self-harming, thinking with hindsight that it was "stupid", she still feels that it is the only way to cope with anger. There is also mention in the literature of self-harm functioning as a maladaptive coping strategy aimed at relieving anger, and other negative emotions, such as anxiety, guilt or frustration (Young et al., 2006).

Likewise, other posters proposed that they use DSH to cope with life events and negative feelings: "Ive been feeling bad over the past couple of weeks, and over the past 4-5 days I have started SH again to cope with it. I haven't SH for almost 2 years now... but ive hit rock bottom again, and I don't know what to do (Virtual Teen, 2015e)." Here, yet again, we have an emphasis on the idea of using self-harm as a way to cope with negative emotions. What is particularly interesting about this post is that this poster was able to overcome DSH for a lengthy period of time before starting to self-harm again because she has hit 'rock bottom'. This suggests that for her DSH is the only way of coping with negative emotions, or at least the only way she knows.

Another poster proposed using cutting as a way to distance herself from painful issues in her life.

> *I was 19 when I started cutting, Ashley. I don't know exactly what you're going through, but I know when I was 19 I was dealing with all sorts of issues (being away at college, not having any good friends at college, break-up with my bf of 5 years, etc). It was all very painful and it seemed like cutting was the only way to distance myself from all of it. (RecoverYourLife, 2015c)*

For this poster self-harm in the form of cutting was the only way she felt she could distance herself from the various issues she was dealing with as a nineteen-year old adolescent, and which she describes as very painful. These issues included social isolation, and the ending of a long-term romantic relationship. She describes these issues as being very painful for her.

What is noticeable about the literature on DSH as a maladaptive coping strategy is that while the theme of DSH being used as a coping mechanism is repeatedly mentioned the sources are all somewhat outdated.

Nevertheless, along with the related themes of people offline being unhelpful in self-harming adolescents' attempted recoveries, adolescent self-harmers struggling with negative images of themselves, keeping DSH secret from people offline, comorbidity of DSH with other psychological issues, as well as with social isolation/loneliness and school-related issues DSH being used as a coping strategy is a notable theme in the data analysed. This theme partially overlaps with the next theme in this section, people offline being perceived as unhelpful by self-harming adolescents.

People offline being unhelpful

A recurring theme that is woven throughout the posters' efforts to conceptualise their DSH which raises issues such as pride and memory, is how other people offline are often unhelpful regarding posters' self-harm and attempts at recovery. In this context, posters refer to parents and other adults, such as teachers and counsellors. This is in contrast with the earlier mentions of parents helping adolescent self-harmers recover. This shows that parents of self-harming adolescents have the potential of being both helpful and unhelpful in regards to their children's attempts to overcome self-harming. Accounts of a lack of support from people offline are anchored in references to such people interfering with the posters efforts to control their own recovery from DSH. An example offered by one poster consists of a reference to counsellors asserting that self-harmers of are simply seeking attention. This account emerged in the context of the poster thanking other forum members for encouraging her to seek help with their DSH:

> *Thank you all for the support. I have tried talking to someone, a counselor at my college, but I decided not to go back due to the fact that they told me I was just seeking attention and that I needed to relax. However, that also was not a very good*

> *counselor, but it's one of three that is at my school and it was hard enough to go to the one. (RecoverYourLife, 2015c)*

This poster refers to her efforts having tried to talk to a counsellor at her college who she describes as having been unhelpful in her recovery. According to this discussant, the counsellor told her that she is self-harming to seek attention and needs to relax. She perceived this as very unhelpful advice for her recovery, and thus states that she feels the counsellor is not a good counsellor. The counsellor is portrayed as being dismissive of the reasons why this young woman is engaging in DSH. Since this counsellor is one of only three at her school, and she feels it was already difficult to get an appointment with her, this discussant feels that she is struggling to get any helpful counselling to overcome her self-harm.

Another poster replies to the extract above by stating that she is critical of the advice generally offered by counsellors:

> *I'm glad you said that isn't a good counsellor, because that is disgraceful behaviour. It's awful how many are like that. I say this from the point of view of having studied counselling for a few years and only stopped because I finally stopped denying how serious my own issues still are. There was even other people on my course that I'm amazed got so far because they will make terrible counsellors! (RecoverYourLife, 2015c)*

In this extract we can see how some counsellors are portrayed as tending to be unhelpful and are displaced as experts on DSH. Instead, such discussants position themselves as the 'experts' who actually know why people engage in DSH. This discussant achieves this rhetorical positioning by emphasising her own experience of having studied counselling for a few years as well as having first-hand experience of DSH. She achieves this by emphasising her own experience of having studied counselling for a few years. However, the discussant does not state that no good counsellors exist. This post could also be interpreted as that since, in the discussant's opinion there are a lot of unhelpful counsellors, this makes it important to find the right one. Thus, there are two, not necessarily conflicting ways this post could be interpreted. In considering such posts, we also need to remember that these are subjective accounts of the efficacy of councillors.

The issue of having one's self harm reduced to attention seeking was a prominent one in posts that is not just associated with councillors. Below, another poster mentions that her

parents think she self-harms to get attention: "I've only recently told my mum as she had noticed them (scars) already, but she thinks it's a cry for help and that I'm attention seeking. Tell me what to do how do I convince my mum and what are good alternatives?? Please help I don't know what to do (ChildLine, 2015b)!!" Here the poster talks about being at a loss in terms of what to do because her mother views the reasons for her self-harming to be merely a cry for attention. The discussant asks other posters for help on how to convince her mother that she is self-harming for other reasons. Again, it is not possible to know whether her portrayal of her mother's reaction to her self-harming is accurate since we lack the mother's point of view, as well as the points of view of outsiders.

Losing friends and falling out with people, as well as toxic friendships, are also issues presented as central to experiences of self-harming. An example of this consists of posters mentioning that friends pressure them to see their scars even when they have stated that they do not want to show these marks, as illustrated by the following quote:

> *He (my best friend)'s been pushing me to see my scars. When we change, I make him turn around. Lately, he's put more pressure on me. He says he can see me in the mirror. I don't care if I'm naked in-front of him but I care about the scars. The scars - old and new - are personal to me. They're private. They're the only thing I get to myself and that's very important to me. (ChildLine, 2015a)*

This quote reveals the poster's resistance to showing his scars to his best friend. The reason given for this is that his scars are very personal and private to him. This quote shows how when outed as a self-harmer one negotiates what one has done with friends who may be inquisitive. Therefore this extract differs from those examples where posters are proud of their scars. Being private about one's scars could be a different step in the self-harm career or a distinct position adopted within the language game or discursive field that is collectively constructed around DSH (Billig, 1997). When moving on the self-harming individual may potentially not want the memories, represented by the scars, in the same way as he or she becomes more estranged from the scars.

There was a lot of talk on the lists about how people in life are unhelpful and as a result people engaging in DSH struggle with getting help to overcome their DSH. Particular emphasis was put on how some posters felt that their parents prevent them from obtaining help:

> *It will be at school again, mostly due to the fact that counseling at the school is free. I don't think you can actually set up an apt. Until school starts though. I mostly draw to try and help it usually distracts me. Other than that I can't really do much. My parents are basically like prison guards always keeping watch on me and making sure I have a valid reason to leave the house. If they knew anything about this they would probably make me transfer to a community college in town and just make things worse. They're idea of fixing the problem just creates a bigger one. (RecoverYourLife, 2015c)*

This extract invokes several issues around parental efforts to help when they do not understand DSH. Firstly, the poster talks about their parents being like prison guards who only let her leave the house for what they regard as valid reasons. This means that the poster lacks ways to overcome self-harming, like distractions other than drawing. According to the poster, her parents' attempts of controlling her contribute to her not telling them about her issues with self-harming. She presents herself as feeling that if her parents knew they would make her self-harming issues worse by transferring her to a different school. The poster stating that her parents' idea of fixing her self-harming problem would merely increase the extent of it highlights the limited ability of those who do not have personal experience of DSH to help self-harmers. This extract also mentions the poster having a lack of financial means for counselling, which limits her options for accessing professional assistance.

The emphasis on the limited ability of those who lack personal experience of DSH to help self-harmers in the previous extract is consistent with posts from other discussants. Another issue related to this was the lack of informed people to talk to for support offline. This includes people close to posters' in their real lives, such as family members and friends, not caring about them engaging in DSH: "I did tell my friend about my self harm problems today, but he didnt gve a shit, or thats what it seemed like. So I'm kinda lost (Virtual Teen, 2014a)." Here we see how the poster connects feeling lost with his friend appearing not to care that he self-harms. There is of course no way of knowing the friend's perspective but the poster's perception is important here. This quote illustrates the importance adolescent self-harmers attach to receiving support from peers in their offline lives. It also highlights their perceptions of the limited ability of non-self-harming peers to help. Part of this issue is, as suggested by several posters, that DSH can be difficult to understand for people who have never self-harmed: "I know how hard it is to talk about SH, people just can't understand that but that doesn't mean they will walk away from you (Virtual Teen, 2015e)."

Some posters have not told anyone offline that they are self-harming. For several posters not having anyone to talk to about self-harming in their offline lives is associated with them talking to other self-harmers in online discussion groups: "I'm on here hoping I could talk to someone my age going through the same thing. I just recently started cutting, I have been depressed for almost six months now, it has slowly gotten worse every day (RecoverYourLife, 2015c)." This quote highlights the importance adolescent self-harmers attach to receiving support from other adolescents going through issues with self-harm. Thus, it shows how vital peer support is for self-harming adolescents in order to a successful recovery to occur. In a sense, the lists are spaces for peer support. Peer support has been identified as a vital source of support, including benefits in one's personal life (Drew, Pike, Pooley, Young, & Breen, 2000). These benefits include the providing of information and assistance. Thus, according to Firmin, Luther, Lysaker, & Salyers (2015), for some psychological conditions peer support is much more desirable and effective compared to professional help. In a sense, the online self-harm discussion groups are spaces for peer support.

In contrast, other posters mention that they struggle to ask for help. This means they are caught in a catch-22. They need help but do not feel able to ask for it. They know there is a problem but cannot admit to themselves or to others that there is a problem. This struggle is exhibited by the example of one poster stating that asking others for help makes him feel vulnerable:

> *Yeah that's where I'm stuck. my dad's long gone so he's out. And I desperately don't want to tell my mum because I don't want to upset her and also I am so shy and un-trusting of people like I hardly tell anyone anything about myself so its really hard for me to even take that first step. And I feel stupid when I do talk even to by best friend about something like that. Even this is strange to me like it makes me feel vulnerable to ask for help or even just talk about anything deep :(. (RecoverYourLife, 2015b)*

This quote illustrates the poster's feeling of being incapable of asking anyone for help even though he wants to talk to people about his self-harming issue. He is worried about upsetting his mother. Additionally, he appears to have some issues with social anxiety, which prevent him from taking the first step of telling people about his behaviour, even his best friend.

Another poster is also caught in the catch-22 of wanting to tell someone that she is cutting but being hesitant about going ahead: "I need help. I can't decide whether or not to tell anyone I know about the fact that I am cutting. I really want to but I'm afraid that people will look down on me when they learn

(Virtual Teen, 2014b)." While she realises that she needs help with her DSH she feels that she cannot decide whether to tell anyone about. The reason is that she is afraid people could look down on her because of her self-harm. As in order to get offline help with her DSH she would need to talk to someone, be it a mental health professional, or a friend or family member, about it, being afraid of taking this step effectively prevents her from getting help.

Similarly, for one poster their insecurity and anxiety interfere with getting psychological help with their DSH: "I'm just very insecure and have a lot of anxiety, so going to see someone terrifies me, especially now that I have had a past bad experience (with a counsellor) (RecoverYourLife, 2015c)." This poster invokes past negative experience with seeing a counsellor as being linked to their anxiety about getting counselling support to overcome her issues with DSH. She presents her experience of counselling as negative, and now an impediment to her accessing another counsellor.

There is also some other support in the literature for the theme of people offline being unhelpful. For example, the notion that self-harmers are accused of attention-seeking in some posts is reflected in the literature. Some research suggests that health professionals sometimes perceive self-harming as attention-seeking (Tindale, 2007; Sandy, 2013; Murray & Fox, 2006). Moreover, a study found that 41 per cent of adults in Scotland think of self-harming adolescents as attention-seeking, while 34 per cent think they are manipulative (Paediatric Nursing, 2006; Murray & Fox, 2006). Furthermore, Baker and Fortune (2008) state that people offline may be unhelpful or even threatening for individuals who engage in DSH as they may lack vital knowledge shared by the members of online self-harm discussion groups. Additionally, in a study by Murray and Fox (2006) about the effects of internet self-harm discussion groups on self-harming behaviour respondents described that one factor in them using discussion groups was that their family members and friends felt uncomfortable talking about their self-harm, and that they did not know other self-harmers in their offline lives. This means that the idea reflected in various posts that DSH can be difficult to understand for outsiders is supported by the literature. The literature offers some support for the theme of people offline being unhelpful. A result of not wanting unhelpful support can be to keep DSH secret from people offline. I discuss this issue in the next section.

Keeping DSH secret from people offline

Another notable theme consists of keeping one's self-harming secret from people offline. Embarrassment about DSH, and a resulting fear of people finding out, are frequently mentioned as underlying reasons. This includes worry and fear about telling parents:

> *I didn't tell my family that I cut, summer is here and I'll have to change into short sleeve soon but I have no idea what I'm gonna say to my mother, she will freak out when she finds out, what should i tell her ? she will never look at me the same way she used to, and so scared and I'm crying all the time, I have two big scars and a few small ones, does anyone have a way to get rid of the small scars at least, within 20 days ? Please answer me.* (Facebook, 2013)

This poster's account of worrying about her mother's reaction if she was to find out about her DSH, and her preconception that this reaction will be negative expresses her drive to keep her self-harm secret from her parents. She describes this fear as stunning her into silence. Additionally, this fear encompasses the idea that her mother might have a different perception of her as a person. By asking others for tips on how to achieve her goal of hiding her scars from her family she further expresses this drive to keep her DSH a secret. The advice offered to her in the online discussion was to accept her self-harm as part of herself that she will not be able to forever hide from her family. She was also advised that telling her mother herself would mean less of a shock for her mother compared to her finding out about her daughter's self-harm by accident. As part of this she was told that a loving mother would understand and be supportive. This advice ties back to the themes of self-harming adolescents no minding their scars and the importance of obtaining help with DSH offline. Thus, there is some overlap between these themes.

Meanwhile, keeping DSH secret from people offline is often achieved by lying about self-harming and the resulting scars to people offline:

> *A teacher saw my cuts, and apparently reported it to my head of school who came to talk to me. The teacher remains anonymous, but to the point: I lied. I told him it was just an accident, and I don't think he believed me. But I just straight up looked him in the eye and lied, and now I feel terrible. (Virtual Teen, 2015c)*

What is interesting about this quote is that the discussant expresses his wish to keep his DSH secret as overriding any wish to get help with overcoming self-harming. He also states that he

experiences a sense of guilt for lying about self-harming. This suggests that he feels he did the wrong thing by lying about engaging in DSH, and therefore hiding his self-harming from people offline, in this case his teacher and head of school.

Fear of people offline, such as parents, seeing scars from self-harming is central to efforts to keep DSH secret. Posters express worry and fear about people's reactions if they were to find out about their self-harm. One poster also mentioned that she has not told her family about her self-harming because she does not want them to worry:

> *I don't want to go A & E as im scared. very scared, people will judge, not just my family but the people who know me, who I work with and probs the people at A&E. I had about 8 cuts until last night when venting to a friend on skype, when I lost it, and went a little overboard and cut myself up alot, about 20 times. See I don't want family involved... its not their problem and I dont want them worrying about me, as im worthless. (Virtual Teen, 2015e)*

This quote reveals the intensity of the poster's fear of people offline judging him for self-harming. These people include his family, co-workers, and bosses at work. It even extends to the people at A&E. The discussant states that he does not want family involved so that they are not burdened with worry about something he perceives to not be their problem and about him. Thus, he positions self-harm as a personal issue. It is an issue also related to a sense of worthlessness and not deserving the concern of others.

Fear of being judged is also a central factor regarding another poster hesitating to tell people offline about the fact that she is cutting:

> *I need help. I can't decide whether or not to tell anyone I know about the fact that I am cutting. I really want to but I'm afraid that people will look down on me when they learn. I'm so scared about it that I don't want to post this. I guess I'm more afraid about the fact that someone will try to stop me but I don't want to stop. But if I don't tell anyone then I'll be keeping a secret that could potentially ruin a relationship that I would rather keep intact. What should I do? Please, HELP.* (Virtual Teen, 2014b)

This poster cannot decide whether she should tell anyone offline about the fact that she is self-harming, in the form of cutting. While she wants to tell people she is afraid that people might look down on her for self-harming. Thus, she expresses a worry that people could judge her for self-harming. Nevertheless, fear of negative judgement is only one reason why

she is hesitating to tell people offline. Another reason for her is that someone could try to stop her from self-harming even though she doesn't want to stop. She also acknowledges that by not telling people she is cutting she could potentially ruin an important relationship that she wants to keep intact. She expresses feeling helpless because she cannot decide whether to tell people offline. Still, what she shares with the previous poster is that both discussants mention a fear of being judged by people offline as a vital reason for keeping their self-harm secret. Thus, overall this appears to be a central factor in posters keeping their DSH secret from people offline.

There is limited research on the extent to which self-harming adolescents, as well as self-harming adults, keep their self-harm secret from people close to them offline. The issue of adolescents concealing DSH from others was mentioned by Austin and Kortum (2004). They regarded concealment as crucially important to them. The authors argued that by hiding self-harm from peering eyes adolescents can increase their ability to self-harm more often without others' interrupting them. Similarly, Selekman and Beyebach (2013) suggested that a high likelihood exists that self-harmers of all age groups may deceive or lie to conceal their DSH. The issue of hidden self-harm is also addressed by Turp (2003) who examined the nature of self-harm and challenged the belief of behaviour being only self-harming if it is of a dramatic and obvious nature, such as cutting. Thus, she considers a wide variety of self-injurious activities that an individual may engage in, while no one else may be aware of their DSH. Turp (2003) also mentions that self-harmers may not tell mental health professionals straight away about their self-harm as part of the presenting problem. The reason, the author suggests, is that it can take time for the client to dare to share this aspect of their mental distress. The author states that these hidden forms of self-harm are no different compared with the more obvious forms, except potentially in terms of their intensity. Nevertheless, they are very similar regarding the underlying states of mind they reveal. However, all of the literature mentioning the theme of keeping DSH secret from people offline consists of accounts by therapists treating clients affected by DSH. Thus, there is a considerable lack of studies investigating the extent to which self-harming adolescents, as well as self-harming adults, keep their self-harm secret from people close to them offline.

A negative self-image

Throughout the posts a noticeable feature is a consistently negative self-image displayed by posters. A major part of it consists of posters being obsessed with the way they look because they are unhappy with their own bodies. When considered in the context of posts where people report being proud of their scares, negative self-assessments raise the diversity of experiences and positions being actively negotiated online. Posts often invoke issues around physical appearance in the form of feeling ugly and fat:

> *I'd do words on my thigh or stomach. People would call me ugly, slut, etc and it'd find its way there as is begin believing it too.* (Virtual Teen, 2014a)
>
> *As for the topic, i write fat and die...* (Virtual Teen, 2014a)

These posters talk about cutting words insulting themselves into their skin. This talk occurs as part of a threat on cutting words into one's flesh. The choice of words is interesting, as posters commonly mention carving words insulting themselves, such as "ugly", "slut", and "fat". Thus, there is a link between the choice of words users carve into their flesh and their self-harming. Physical and psychological forms of DSH are combined in such acts.

Other negative feelings posters exhibit about themselves consist of feeling insecure, and deserving of their scars from DSH: "As for scars, i don't mind. I deserve them (Virtual Teen, 2004)." By stating that she feels deserving of her scars this poster indicates her negative image of herself, and even self-hatred. Presenting a justification for not minding one's scars because one 'deserves them' suggests a lack of caring about the appearance of her skin and potentially about herself. It is also associated with feeling angry at with one's self for giving into to the impulse to self-harm or addition. It is also associated with feelings of self-pity:

> *I'm lost, and the demons are winning. They've managed to make me forget about the imaginary friend I created to help me fight them. I'm drowning in so much self-pity, depression and resentment of life and everything, as well as stress from school, that it feels like my good side is dying, and it's screaming for me to help it, to save it but I just CAN'T*
>
> *I FUCKING CAN'T DO IT (Virtual Teen, 2015c)*

Here we see a poster expressing feeling lost in the impulse to self-harm. He connects his sense of feeling lost with self-pity and the good side of him dying. He describes the sense that

his good side is dying as involving a struggle to save what is left of it, a struggle which he is ultimately losing. Thus, he expresses his self-image as being negative and overwhelming.

The idea of a negative self-image being associated with self-harming is supported by the literature. For example, low self-esteem is mentioned as a risk factor for self-harm in several psychological studies (Phillips et al., 2013; Fliege, Lee, Grimm, & Klapp, 2009). Hawton, Rodham, Evans, and Weatherall (2002) also found low self-esteem as a factor associated with self-harm, albeit only for female adolescents. Additionally, self-harming adolescents have been found to have a higher tendency towards a coping style involving self-blame compared with non-self-harmers (De Leo & Heller, 2004). Thus, there is support for the idea of a negative self-image being associated with self-harming in the literature. In addition to a negative self-image, there are other psychological issues associated with self-harm, such as depression and social isolation, in the posts analysed. These will be explored in the following sub-section.

Comorbidity with other psychological issues: depression and social isolation

Through these online discussions, issues of comorbidity of DSH with other psychological issues, as well as with social isolation and loneliness can be read into the online discussions. Particularly prominent were links between DSH and depression that emerged through the posts. In several posts DSH is mentioned as helping with depression or feeling upset: "I know I shouldn't have done my arm in the first place, I was in a bad place mh wise and couldn't care about consequences. Just very down now and depression isn't helping the urges (RecoverYourLife, 2015a)." Worth noting here is that the poster describes himself as being in a bad place in terms of his mental health being linked with an increase in his urges and severity of self-harming. As the reason for the latter he states a relationship between his issues with depression and not caring about consequences of engaging in DSH. He also mentions that when he is not in such a bad place with depression anymore he does not engage in and regrets self-harming.

There are also several cases of DSH being linked with sleeping issues and anxiety: "I'm tired because of flashbacks (it prevents me from sleeping) and that's what leads to my anxiety and stress which leads to me self-harming (ChildLine, 2015b)." For this poster flashbacks are connected with sleeping issues. These are in turn linked with her experiencing anxiety and stress. Meanwhile, she associated her anxiety and stress with her engagement in self-harming.

Likewise, in the literature, self-harm has repeatedly been connected with depression and anxiety. For example, Fliege et al. (2009) state that both self-harming adolescents and adults experience more negative emotions, such as depression, anxiety, and aggressiveness, compared with individuals who do not self-harm. Moreover, in a study by Klonsky, Oltmanns, and Turkheimer (2003) self-harmers reported more symptoms of depression and anxiety. Similarly, Andover, Pepper, Ryabchenko, Orrico, and Gibb (2005) found that self-mutilators reported a significantly higher amount of symptoms of depression and anxiety compared with a control group. Thus, DSH has often been linked with both depression and anxiety.

Additionally, comorbidity of DSH with an eating disorder and bipolar depression also emerged from the participant discussions: "I have cut for four years, I'm currently trying to stop although it's very hard. I have a eating disorder and sleeping disorder and have bipolar depression. I do not advise anyone to cut if they have not first started its not good, please don't (Virtual Teen, 2004)." This poster mentions comorbidity of DSH with several other psychological issues. These consist of an eating disorder, a sleeping disorder, and bipolar disorder. She does not mention, though, whether she has been diagnosed with any of these by a mental health professional. Likewise, in the literature eating disorders are mentioned as linked with DSH. For example, eating disorders are among a number of frequently reported co-occurring diagnoses for DSH, according to (Fliege et al., 2009). Similarly, Truglia et al. (2006) linked DSH and eating disorders. Additionally, Whitlock, Eckenrode, and Silverman (2006a) found that self-harming university students were more likely to report one characteristic of an eating disorder. Thus, the literature offers a high level of support for the idea of a link between DSH and eating disorders.

The literature also offers some support for a relationship between sleep problems and self-harm in adolescents. The findings of a study undertaken in Norway by Hysing, Sivertsen, Stormark, and O'Connor (2015) highlight a strong link between sleep problems and self-harm. However, the findings of a study by Sansone, Edwards, and Forbis (2010) partially indicate the opposite. They found that among adult outpatients in a primary care clinic, poor sleepers failed to have a significantly greater amount of different self-harm behaviour compared with normal sleepers. However, they also found that poor sleepers have a significantly higher rate of the specific self-harming behaviour of head-banging. Nevertheless, we need to remember that since this study was undertaken with a sample of

adult outpatients in a primary care clinic the findings cannot necessarily be generalised to adolescent self-harmers, a rather different population group.

However, there is a lack of research on the possibility and extent of a relationship between bipolar disorder and DSH for both adolescents and adults. Not a single study was found investigating this issue. However, individuals with mood disorders have been found to be at a higher risk regarding self-harm than other psychiatric groups (Pope, Xie, Sharma, & Campbell, 2013). In contrast, in a study by Tuisku et al. (2006) no association was found between mood disorders and self-harm. However, in a follow-up study to their original study the authors found a link between mood disorders and self-harm (Tuisku, Pelkonen, Kiviruusu, Karlsson, & Marttunen, 2012). Thus, the results of the few studies there are point towards a relationship between mood disorders and DSH.

Similarly posters evoke links between their DSH and social isolation or their lack of friends, and associated feelings of loneliness. Part of the theme of social isolation/loneliness consists of losing friends or falling out with friends. There are five cases of this in the discussions analysed.

> *I dont have any friends that would come with me to A&E if I went, I lost 98% of my friends when i decided to do an apprenticeship instead of going to college, and now I only see 2 friends, 1 who lives a couple of houses down and 1 thats about 15mins away (Whos now on holiday, and stood me up last week. Yeah it made me feel horrible.). (Virtual Teen, 2015e)*

Worth noting here is the extent to which this poster appears to be emotionally affected by his social isolation from losing the majority of his friends and one of his few remaining friends standing him up. The existence of a relationship between his social isolation and his DSH is not spelled out here. However, since his social isolation clearly affects him the possibility of such a relationship exists.

Another example of social isolation/loneliness consists of an adolescent stating in a forum post that his offline peers do not know how to help him with his issues with DSH, and therefore stop talking to him:

> *Yeah, I remember how that goes. I try to appear relatively sane to people unless I have a reason not to. Which, of course, means their eyes pop out of their head when they realize what is actually going on. They're always like "You seem so well-*

> *adjusted." Really? I don't feel well adjusted. This also means that no one really knows how to help me when I have problems, so a lot of times, they just stop talking to me for a while.* (Virtual Teen, 2014a)

This poster adopts the subject position of a person who has some kinds of issues, although from his post alone it is unclear what kinds of issues they are. He then discusses how people react when they notice them because he or she does not appear on the surface to be affected by mental health issues. This is then linked by him to his social isolation as people do not know how to help him when he has problems associated with his potential mental health issues. Thus, the poster connects his mental health issues, including DSH, with his social isolation.

A relationship between social isolation and self-harm has been established by several studies. Self-loathing has been indicated to play a part in this relationship. The finding of an association between a negative self-image and DSH in adolescents has already been discussed in a previous section of this thesis. A negative self-image, in the form of self-loathing, along with mental health issues, such as depression, compacts social isolation. This has been found to be the case by Christoffersen, Møhl, DePanfilis, and Vammen (2015). The authors found there to be a high correlation between low self-esteem, low social support in childhood, and DSH in Danish young adults. They also suggested a relationship between traumatic life events, such as psychiatric disturbances, including depression and anxiety, and DSH in young adults. They also found social support to be a partial mediator for NSSI. Similarly, Rotolone and Martin (2012) found that individuals engaging in DSH reported significantly lower levels regarding perceived social support, social connectedness, and self-esteem compared to non-self-harmers. The authors also suggested that attempting to cope with the mental health issue of anxiety is a factor in adolescent DSH. Additionally, findings of a study by Claes, Houben, Vandereycken, Bijttebier, and Muehlenkamp (2010) indicate that adolescent self-harmers perceive themselves as having lower levels of social skills. The self-harming adolescents in this sample also had more friends engaging in DSH, something the authors found to be related to having low self-esteem. They suggested that either adolescents affected by low self-esteem could be more attracted to self-injuring peers, or that adolescents with low self-esteem could be more vulnerable to copy NSSI from peers in order to deal with issues in their lives or to gain a particular identity in their peer group. Thus, support from the academic literature exists for the complex notion of social isolation being compacted by mental health issues and self-loathing.

Furthermore, other studies also support the notion of a relationship between social isolation and self-harm. For example, Adler and Adler (2005) report self-harming adolescents as describing themselves as loners or feeling more lonely compared to non-self-harming adolescents. Moreover, a theory was proposed by Nock (2008) that individuals engaging in DSH may feel the need to use this extreme manner of communicating because they lack available support. Additionally, Wu, Chang, Huang, Liu, and Stewart (2013) found limited social networks to be linked with self-harm in Asian societies in a case-control study in Taiwan. This is not the only study to connect limited social networks with DSH. This association was also established by Kaba et al. (2014) who found self-harm in jail inmates to be significantly associated with being in solitary confinement at least once. The link between limited social networks and self-harm is further strengthened by Haw & Hawton (2011) who suggest that DSH patients who live alone may lack supportive social networks, thus being affected by social isolation, and therefore may be at increased risk of repetition of DSH, as well as suicide. Thus, an association of social isolation and self-harm has been established via several studies.

School-related issues

The lives of adolescents are marked by spending a lot of their time at school, with increasing emphasis being put on academic achievements, especially during middle and later adolescence. Many adolescents have to deal with negative aspects of the school environment. These issues include bullying and stress related to academic performance. Both were also an important feature of the online conversations:

> *I know that no one wants to hear me whine... but I have been clean for almost 3 weeks... but my boyfriend is being a total ass, school is getting harder, the bullies won't stop and my family isn't good at being there for me.... I feel like I need to cut... I need a release.... I want to escape reality for a while....* (Facebook, 2013)

In this excerpt the school-related issues of academic stress and bullying are clearly connected with the poster's need to cut. She states that she feels the need to self-harm to obtain a release and temporarily escape reality. Her reality she wants to escape from clearly includes academic stress and bullying.

Most studies on the association between school-related issues and self-harm focus on school bullying victimisation rather than on academic factors, such as school stress. Thus, bullying specifically has been found to be associated with DSH in adolescence (O′Connor et al., 2014). Similarly, school bullying victimisation has been associated with self-harm in various studies (McMahon, Reulbach, Keeley, Perry, & Arensman, 2010b; Jantzer, Haffner, Parzer, Resch, & Kaess, 2015; Fisher et al., 2012). Thus, there is a significant amount of support in the literature for a relationship between school bullying victimisation and self-harm as a particular school-related issue linked with self-harm.

An example of stress related to academic performance from the discussion groups consists of this excerpt:

> *Worst of all, the cuts are obvious, and I love the scratch them from time to time. It gives me a little pain, which I enjoy. Even the act of rubbing them gives a small but pleasurable sting.*
>
> *Sorry, I feel like I've let you down, and my brain is just melting, I'm losing control it feels like. It's just loneliness. I feel alone, and to top it off the pressure of homework that I didn't do over the holidays has built up. (Virtual Teen, 2015f)*

What is notable about this excerpt is that the poster connects his pressure from homework he did not do building up with losing control in regards to self-harming. He describes this sense of losing control as feeling like his brain is melting: "A teacher saw my cuts … I'm scared though. My life is going downhill; grades are slipping, friends are drifting away, and I just can't seem to get control back anymore (Virtual Teen, 2015c)." In this post a sense of losing control related to the poster's self-harming is connected not only with the poster feeling his life is going downhill in general but also with his issue with poor academic performance being part of it.

Links between academic stress and DSH in adolescence were identified by Hawton, et al. (2003), who also identified a reduction in the frequencies of adolescent DSH during school holiday periods. Due to the high prevalence of study-related problems reported by adolescents, they connected educational stresses with a higher prevalence of DSH during term time. The authors also found the largest amount of DSH episodes occurring on Mondays while the least occurred on Saturdays. They connected this pattern with the idea of study-related stress being a contributory factor in DSH. This seemed especially likely to them due to the excess of cases on Monday not being found in August and September, school holiday

periods in the UK where the study took place. Similar to academic stress not liking school work has also been linked with DSH in adolescents (Kidger et al., 2015). Not liking school work is one of the factors in dropping out of school. It is not surprising that a relationship between self-harm and school dropout was found as well (Remaschi et al., 2015). However, compared with the larger amounts of research on the relationship between bullying and DSH there is a relative lack of research on the relationship between school-related factors other than bullying, such as academic stress and poor academic performance. Nevertheless, associations between school-related factors and DSH were investigated by several authors. Consequently, the literature offers some support for the idea of school-related factors being a factor in adolescent DSH.

This theme and the already mentioned related but still distinct themes of people offline being unhelpful in self-harming adolescents' attempted recoveries, adolescent self-harmers struggling with negative images of themselves, keeping DSH secret from people offline, comorbidity of DSH with other psychological issues, as well as with social isolation/loneliness and school-related issues, make up a group of themes. These themes are all focused on contributing issues regarding DSH. Another group of themes deals with the important role the online discussion groups play in relation to providing care and support for posters using DSH to cope with these contributing issues. I will look at this group in the following sections.

Themes around care and support

One of the most important functions the online self-harm groups to emerge across the various sites analysed for this thesis was the function of these spaces as venues for posters to provide each other with care and support. As having a lack of people to talk to offline is a major factor driving the posters online to the discussion groups in search of care and support the related theme of the importance of getting help with DSH offline will also be explored in this section. As these two themes show care and support online as well as offline are vital for the recovery of self-harming adolescents.

Care and support online

Across the different discussion groups care and support stands out as a major motivation for engaging with others in these spaces. In the context of this thesis care and support means posters in online discussion groups expressing concern for the wellbeing of other posters and trying to help each other with managing their DSH. Part of this consists of posters telling other posters they did the right thing by posting, thereby encouraging them to manage their urges to self-harm: "Hi there Milly, Well done for posting here and asking for some help and advice-That is what the boards are there for (ChildLine, 2015b)." In this post the original poster of a thread is praised for posting and asking for help and advice to overcome her issues with DSH. This way she is encouraged to keep using the forum. What is especially notable is the warm tone used to signal support.

Care and support in the online groups also involves giving advice, which throughout the posts analysed mainly consists of suggesting coping strategies and alternatives to self-harming. Part of this also involves the exploring of the underlying causes for posters' DSH. Expressing worry about triggering other posters to self-harm also is repeatedly found:

> *When I'm self-harming...I do a lot of different things usually I prefer burning myself over cutting...when I cut I sometimes carve words or sometimes symbols but usually I don't cut deep enough to make the permanent scars. I have one permanent scar, it's my mother's name and I wanted this one to stay...otherwise I wouldn't want these words on my skin forever. I hope I didn't trigger anyone.* (Virtual Teen, 2014a)

While this poster does not shy back from listing the different methods of self-harm he engages in he also expresses hope that this list did not trigger other posters. Therefore he exhibits concern for the wellbeing of his fellow posters.

Care and support also includes posters telling each other to stay strong and not give in to the urge to self-harm. Posters also praise each other for making progress with stopping engagement in DSH. Overall there is a strong theme of posters exhibiting care for and support of other users' overcoming of DSH.

In expressing care and concern through offering advice and wisdom posters form an online community. This is reflected in the sense of community posters exhibit towards each other in facing and coping with the urge to DSH. In the context of this thesis online community means a sense of we are in this together. Community has been defined as including notions

such as members' sense of solidarity, significance, and security (Sonn & Fisher, 1996). Thus, definitions of community have moved away from an exclusive focus on geographical settings. It is now common for people to attain their identities, as well as experience feelings of belonging in communities which are not located within particular geographical areas. Consequently, communities can consist of networks of relationships that are non-territorially based and provide tangible support, friendship, and esteem (Heller et al., 1984; Sonn & Fisher, 1996). Similarly, psychological sense of community was defined by McMillan and Chavis (1986) as shared emotional connection, integration, fulfilment of needs, and influence. According to them psychological sense of community is a feeling members have of belonging, that members matter to each other and the group, as well as a shared faith that needs of members will be met via their commitment to be together.

In the online discussion groups analysed for this thesis part of this sense of community consists of posters telling other posters they did the right thing by posting, thereby encouraging them to share their concerns and efforts to keep themselves well. Another part of this consists of posters telling other posters that they can always talk to them if they need to.

Another subtheme of care and support consists of the focus on recovery exhibited throughout the posts analysed. A major part of the support posters give to other posters regarding overcoming their self-harming entails a focus on recovery from DSH. Thus, posters show a focus on both their own recovery and that of other posters towards whom they are displaying care and support. An example of this consists of an individual telling a fellow poster that to stop DSH you need to want to stop it, thus giving advice on overcoming DSH: "Oh, and the most important thing? You have to want to stop (Virtual Teen, 2015a)." Another example consists of posts exploring ways of helping with stopping DSH. A significant aspect of this subtheme consists of a focus on recovery by focusing on overcoming underlying issues in posters' lives associated with their self-harm. An example of this consists of a post including tips on how a fellow poster who is currently self-harming can deal with bullying that is linked with their issues with DSH. Additionally, another notable aspect consists of posts praising fellow posters for making progress with stopping to self-harm.

Many posts relate to asking for advice. These online discussion groups are frequented by self-harming adolescents who commonly use them to gain advice on overcoming self-harming. This quote serves as an example: "I've only recently told my mum as she had noticed them already, but she thinks it's a cry for help and that I'm attention seeking. Tell me what to do how do I convince my mum and

what are good alternatives?? Please help I don't know what to do (ChildLine, 2015b)!!" Here we can see that since this poster has had a lack of success in getting help with overcoming her issues with DSH in her offline environment she resorts to using an online self-harm discussion group in order to get this advice. As part of this she asks other posters how convince to her mother, a major part of her offline environment that her self-harming is not a cry for help or engaged in to seek attention. Her strong need for care and support is emphasised by her asking the other posters to please help her because she lacks any idea of what to do to overcome DSH. Advice on one of the forums from which data was analysed for this thesis was even stated as having been very helpful for a past self-harmer when she was struggling with stopping DSH.

The emphasis placed on care and support online is supported by studies such as that conducted by Murray and Fox (2006). These authors found that a primary reason provided by their respondents for becoming a member of internet self-harm discussion groups was to receive support. Online relationships identified by Murray and Fox (2006) also continued beyond the discussion groups and for some included regular communication via private e-mail. A sizeable number of respondents stated that concerns for the group led them to private e-mail communication while a similar amount of respondents viewed private e-mail as an effective method for receiving of providing of instrumental support. Similar findings were established by Baker & Fortune (2008), who conducted a qualitative study using discourse analysis to explore the accounts of young adults engaging in self-harming and suicidal behaviours who use websites dedicated to these topics. They found that participants constructed these websites as sources of understanding and empathy, as communities, as well as a way of coping with psychological and social distress. The authors suggested that users of these websites are given access to vital, social valued identities, such as belonging to a community, being understood, and coping with their issues. There were similar findings in a study by Whitlock et al. (2006b), which examined messages posted on internet self-injury discussion groups. The authors found that such online interactions provide vital social support for otherwise socially isolated adolescents engaging in DSH. Nevertheless, there is still a considerable lack of empirical research, and thus psychological literature, on the topic of internet self-harm discussion groups (Murray & Fox, 2006; Baker & Fortune, 2008; Whitlock et al., 2006b).

The importance of getting help with DSH offline

While care and support is reflected as being an important part of the online communities formed by online self-harm discussion groups in these groups the importance of getting help with DSH offline is also emphasised. This includes encouraging other posters to ask for help offline:

> *I think you definitely need to see a professional about how you're feeling right now. I'm not saying you are too weak to fight through this on your own and I don't want to discourage you, but I'm gonna tell you it's more than hard to stop self-harming without any help.*
>
> *The only way I got out of this addiction was to hand my razors over to my parents and tell my friends about it. That way I could call a friend at any time to distract me if the urges were becoming unbearable. (Virtual Teen, 2015f)*

Here the discussant emphasises the extent of the difficulties of stopping self-harming without any offline help. She conceptualises this offline help as involving parents, friends, and mental health professionals. As part of this she emphasises the importance of the poster she is replying to seeing a mental health professional for help with overcoming his self-harming. She further reinforces the importance of offline help for overcoming DSH by stating that the only way she overcame her addiction to self-harming was to hand her razor over to her parents. She was also aided in her efforts by being able to call a friend whenever her urges to self-harm became unbearable in order to distract herself from the desire to hurt herself.

The importance of seeing a mental health professional is also raised in various other posts:

> *I do want to reiterate what everyone else has said though- even though giving it a go with a different counsellor is definitely the hardest option right now, it's also the best one! Maybe you could see one of the other counsellors at school or if you would feel more comfortable having a fresh start and going somewhere different, you could see your GP to be referred to a counsellor or therapist? (RecoverYourLife, 2015c)*

This poster emphasises that seeing a counsellor is the most effective way to overcome DSH. She gives tips about finding a good counsellor to the poster she is replying to in her post. A counsellor is the most frequent type of mental health professional mentioned. Some posters

also mention that they are already seeing a mental health professional. Relatedly, the importance of getting medical help in order to overcome DSH is also raised:

> *I had a similar thing happen, my a teacher seeing cuts but a teacher seeing about 2 pages of my French book saying kill me and other suicidal thoughts. My head of year came to me asking about it he had a photo copy of it I was so upset with the fact he had a copy of it. He asked me what was wrong I just looked him in the eyes and lied saying I was bored. I end up just putting up with life for about 5 more years then got medical help. It's wasn't easy asking for help but It does help please get help. (Virtual Teen, 2015c)*

The discussant emphasises the importance of getting offline help, including medical help. This poster emphasises that the difficulties involved with asking for offline help are worth it for its importance for overcoming DSH. By stating he put up with the underlying issues connected with self-harming for him for five more years before getting help he indicates a wish for having got help earlier. He communicated to other posters not to put off getting help like he did.

As part of emphasising the importance of getting help offline posters also emphasise how vital talking to people close to you offline about DSH is. Frequently users emphasise that talking to family, mainly parents, can help: "I'm sorry to hear things have been so hard for you recently. It's very difficult to go through this alone, do you think you could try to open up to your mom about how much you're struggling at the moment (RecoverYourLife, 2015a)?" This poster highlights the difficulties is dealing with DSH alone. By alone he clearly means without offline help.

Posters also mention opening up to their best friend about their engagement in DSH. There are various other examples of this theme. One of these consists of encouraging other posters to tell people offline: "People don't turn their backs that easily on someone they love, so telling a friend doesn't mean you'll lose him. I know how hard it is to talk about SH, people just can't understand that but that doesn't mean they will walk away from you (Virtual Teen, 2015e)."

One way in which posters encourage other posters is by emphasising that "people do care": "Talk to someone, or find a better way to vent. People do care. Because if you keep going you might end up hurting yourself permanently (Virtual Teen, 2015d)." This poster emphasises the importance of getting offline help by stating that if the poster he is replying to keeps self-harming he could hurt himself permanently.

Other mentions of this theme include posts highlighting the importance of talking to an adult about self-harming, and encouragement to talk about feelings that are related to posters' self-harming at first to people offline instead of DSH itself. Other posts emphasise that parents' reactions may not be as negative as other posters who have not told their parents about their current self-harming may think. Examples of this are posters telling other posters that their parents will love them despite their self-harming, and that the shock of their child hiding self-harm from them is most likely to freak out parents, rather than the self-harm itself.

Another related subtheme consists of friends and family being important sources of support for posters. This is in contrast to the earlier theme of people offline being unhelpful in regards to posters' issues with self-harm and attempts at recovery. The fact that both themes were gathered from analysed posts indicates that people offline can be both helpful and harmful in regards to discussants' self-harm and attempts at recovery. Thus family and friends can be a great source of support but also a great source of problems in self-harming adolescents' lives. A significant part of the former consists of posters mentioning that they are happy to see their friends because friendships are sources of strength and support from them. Therefore seeing their friends at least temporarily decreases their urge to self-harm. "Thanks guys, but I'm seeing friends today so that might help. I'm not telling them though, I'm just hoping they care enough to notice (Virtual Teen, 2015f)." What is noticeable about this excerpt is that even though its author is not planning to tell his friends that he self-harms he reckons merely seeing his friends will help him with his self-harm issues. What is especially interesting, however, is that he still hopes that his friends notices that he self-harms because to him them noticing shows that they care about him as a person. Thus, this quote shows the importance of offline support in two ways, firstly by having a positive distraction from DSH in the form of company from friends, and friends caring about one enough to notice it and therefore be a source of help with overcoming DSH itself. With this subtheme, there is a lot of overlap with the previous subtheme of the importance of talking to people close to you offline about DSH.

Again, there is a lack of research on the extent to which being a member of an online self-harm discussion group affects likelihood of getting help with DSH offline. The reason for this is that, as already mentioned, a lack of empirical research, and thus psychological literature, exists on the general topic of internet self-harm discussion groups (Murray & Fox, 2006; Baker & Fortune, 2008; Whitlock et al., 2006b). Furthermore, the research on this topic that does exist does not focus on whether being a member of an online self-harm discussion group

affects likelihood of getting offline help with DSH. Instead it focuses on online care and support between members of such groups.

However, there is a considerable amount of literature on the importance of getting offline help with DSH from mental health professionals for affected individuals, including self-harming adolescents. For example, empirically supported treatments aimed at self-harming adolescents have been found to be effective (Greydanus & Pratt, 2015). Cognitive behaviour therapy and dialectic behaviour therapy are mentioned as particularly effective forms of treatment for DSH (Moorey, 2010; Lindgren & Hällgren Graneheim, 2015; Gibson, Booth, Davenport, Keogh, & Owens, 2014).

Social support from family members and friends has similarly been identified as an important factor for recovering from DSH by several studies. For example, young adults who engaged in DSH were found to have significantly lower levels of friend support compared with individuals not engaging in DSH in a study by Heath, Ross, Toste, Charlebois, & Nedecheva (2009). Similarly, Wu et al. (2013) found social support to be vital for self-harm management. Additionally, social support and social networks potentially modify help-seeking behaviour prior to DSH, as suggested by Wu et al. (2011). The authors established this in a study investigating help-seeking behaviour, as well as correlates of this, prior to self-harm within an East Asian setting. Moreover, offline social support specifically was suggested to be a partial mediator for DSH by Christoffersen et al. (2015). The authors conducted an epidemiological investigation of a Danish national sample regarding the effects of offline social support on DSH. However, social support, defined in terms of the level of quality of perceived support gained from social relationships, including offline social relationships, has received less research compared with other etiological factors in relation to DSH (Wu et al., 2013). Thus, in comparison with the overall larger amounts of research on the importance of getting offline help with DSH from mental health professionals for affected individuals, including empirically supported self-harm treatments, less research has been undertaken to investigate social support by family members and friends as a factor in relation to DSH. Consequently, there is a relative of empirical research, and thus psychological literature, on the topic of the importance of getting help with DSH offline, which was emphasised as a theme in the analysed posts.

Chapter discussion

In this chapter I have explored three different major categories of themes in relation to social media use of adolescents who engage in DSH. As part of this I have considered how well represented the themes making up these three groups are in the literature.

The first of these three major thematic categories consists of themes centred around conceptualising self-harm. This category includes several themes. It opens with an exploration of the different ways in which self-harm was conceptualised in the online discussion group posts. This major thematic category continues with DSH being framed as an addiction by posters, while framing of DSH as something negative is a further theme in this category. This negative conceptualisation of DSH is in contrast with another theme, self-harming adolescents not minding their scars. Apart from considering DSH an addition and as something negative DSH posters also conceptualise it as being a serious, escalating matter, an abnormal activity, involving a variety of different behaviours that are both physical and psychological, as being partly to blame on society, both abnormal and normalised, and both being and not being part of those engaging in it. These conceptualisations of DSH in posts in some respects resemble scholarly definitions, as well as providing richer and more varied understandings of DSH

Next, I explore the second major thematic category which consists of themes involving contributing issues regarding DSH for adolescents. This starts with people offline being conceptualised as unhelpful in regards of adolescent self-harmers' attempts to stop engaging in DSH. Then, there is secrecy, in the form of keeping their self-harm secret from people offline. This second major thematic category continues with self-harming adolescents displaying a negative self-image. Posters also display comorbidity of their self-harm with other psychological issues, social isolation and loneliness, as well as with school-related issues. They portray their self-harm as a coping strategy used to deal with a variety of issues in their lives. The literature offers support for some of the themes in this group. These include the theme of people offline being unhelpful, the idea of a negative self-image being associated with self-harming, the comorbidity of DSH with several psychological issues, including depression, anxiety, eating disorders, and sleep issues, as well as with social isolation, and with several school-related factors, most notably bullying, and the idea of DSH being a maladaptive coping strategy. In contrast, there is a lack of literature supporting the theme of adolescent self-harmers keeping their self-harm secret from people offline.

Similarly, there is a lack of support in the literature for the comorbidity of DSH with bipolar depression.

The third major thematic category consists of themes focused around care and support. Part of this is care and support online among adolescent posters in the different online self-harm discussion groups analysed for this study. A second theme in this group consists of importance of getting help with DSH offline. There is some support in the literature for both online self-harm discussion groups offering care and support to members and the importance of getting help with DSH offline for adolescents. However, there is a lack of research on the extent to which being a member of an online self-harm discussion group affects likelihood of getting help with DSH offline.

After presenting an analysis of a range of themes in relation to the literature in this chapter the next one will consider more general issues related to research into DSH. It will also examine the contribution made by this thesis to the existing cannon of research literature on DSH in adolescents. These issues, along with their implications, are suggested by the thirteen themes, divided into three major thematic categories, discussed in this chapter.

CHAPTER FOUR: THESIS DISCUSSION

Today, the internet serves as a popular medium for self-harming adolescents to talk to one another about their engagement in DSH. This is partly because the internet offers the benefit of relative anonymity while in adolescents' offline lives. In contrast, talking about their self-harm offline to peers and adults alike comes with the risk of being stigmatised. Thus, examining these discourses can reveal vital information on the different ways in which adolescents conceptualise DSH. Nevertheless, there is a relative gap in the literature regarding how self-harming adolescents conceptualise DSH through online self-harm discussion groups. Therefore this study was aimed at shedding some light on this important topic.

This chapter serves the purpose of considering more general issues related to the research into DSH. It also examines the contribution made by this thesis to the existing cannon of research literature on DSH in adolescents. All of this is accomplished in several ways. The first of these ways involves summarising the main findings, including the thirteen themes gathered from the thematic analysis divided into three main thematic categories. The study's findings are also related to both previous research and existing theory. Then, their clinical implications are gauged. The issue of generalisation as it applies to qualitative research also is considered, and areas of future research highlighted by the study's findings are mapped out.

This thesis examined how self-harming adolescents conceptualise DSH through online self-harm discussion groups. I explored the different ways in which adolescent posters make sense of their own self-harming through online discussions. I also investigated the ways in which social media is associated with the efforts of adolescents to negotiate tendencies to engage in DSH. A related aim was to investigate the possible ways in which the increased awareness of DSH among adolescents due to being exposed to it via representations of DSH in social media could potentially have influenced their views on the topic. This means whether online representations of DSH could be associated with adolescent posters considering DSH a normalised behaviour or whether this exposure could alternatively be linked with them becoming more aware of the negative aspects of self-harm. The latter would mean that social media could potentially be used to reduce self-harm.

Summary of main findings

From the study's results it becomes apparent that self-harming adolescents conceptualise self-harm in a variety of ways, including the framing of DSH as an addiction and something negative that needs to be overcome. The former emphasises the struggle involved in overcoming DSH, while the latter suggests that engagement with online self-harm discussion groups do not glorify DSH. Instead of glorifying DSH these groups are a facilitative environment for try to understand self-harming adolescents' motives for engaging in DSH and supporting them in order to help them move forward and overcome DSH. Moreover, the addiction theme reflects the contradictory ways in which DSH is frame in the online discussion group posts analysed for this study. On one hand DSH is presented as a negative addiction, on the other hand it is also presented as a way of managing life pressures and in a sense asserting dominion over one's body and self. It is an urge to be managed as well as a means of relieving stress. Thus, adolescent self-harmers in the online self-harm discussion groups explored DSH as a negative short-term coping strategy to better deal with a variety of issues in their lives.

In their posts, self-harming adolescents also emphasised not minding their scars. Thus, they appear to acknowledge their scars as a part of themselves. This indicates that they accept memories of negative life events associated with the scars as part of themselves. According to the study's findings, social affiliation also plays a role in the context of adolescent self-harming. This is because some posts mention adolescent self-harmers either currently being friends or having been friends in the past offline with fellow self-harming adolescents. Along with affiliation, disaffiliation is also apparent in the posts. This is because there is some mention of self-harming adolescents differentiating themselves from other adolescent self-harmers. Moreover, the study's findings also suggest that adolescent self-harmers view people offline, including mental health professionals and teachers, as well as family and friends, as having the potential for being both unhelpful and helpful in regards to their self-harming and their attempts to overcome it. This indicates that they may be reluctant to approach people offline for help with overcoming their self-harm. Additionally, the findings suggest that self-harming adolescents tend to keep their engagement in DSH secret from people offline, and to have a negative self-image. The former indicates that it may be difficult self-harming adolescents to open up to people offline. This, in turn, would mean that it is difficult for self-harming adolescents to obtain the help they need in order for successful recovery from DSH.

There is a comorbidity of DSH with other psychological issues, such as depression, anxiety, sleeping issues, eating disorders, and bipolar disorder, as well as with social isolation and loneliness, and school related issues. This suggests that, along with struggles with social isolation and loneliness mentioned by posters, comorbidity of DSH with other psychological issues could make it more difficult for adolescent self-harmers to overcome self-harming, due to them facing multiple issues at once in their lives.

My results indicate that the nature of the relationship between DSH and social media use is mainly positive rather than negative. This means that online self-harm discussion groups mainly have a positive function on self-harming adolescents because in these groups DSH is largely portrayed as something negative that needs to be overcome. Thus, these social media depictions of DSH, in the form of online self-harm discussion groups, raise awareness of the negative aspects of DSH for self-harming adolescents. Therefore social media challenges tendencies to self-harm in adolescence. This goes against assumptions in the psychological literature relating to social contagion. The reason is that recent psychological self-harm literature in the form of studies suggests that engagement in DSH can be a socialised behaviour (James, 2013; Heilbron & Prinstein, 2008; Heath et al., 2009). This means that adolescents may have a greater likelihood of engaging in DSH if either close friends or other peers self-harm (Heilbron & Prinstein, 2008). An area of research supporting the notion that DSH could be socially influenced consists of the study of social contagion effects (Heath et al., 2009). Contagion has been noted in both self-harming adolescents and adults (Heath et al., 2009; Fennig, Carlson, & Fennig, 1995). This study largely failing to find an association of self-harm with contagion in adolescents suggests that engagement in DSH is not socialised behaviour either online or offline.

Furthermore, the study's results suggests that adolescents who have, or are currently, engaged in DSH are somewhat positively influenced by representations of DSH in social media, in the form of online self-harm discussion groups. That is because rather than normalise DSH social media representations of it have the potential of enabling adolescents to become more aware of the negative aspects of self-harm. Since people engaged in these groups either have self-harmed themselves or are currently self-harming. Therefore they know the implications and consequences of self-harming first-hand. Thus, in many ways these groups function as an online counselling service provided by adolescent self-harmers for each other. That is, if this kind of counselling works. Whether it really works cannot be substantiated in terms of from

my study. Nevertheless, posts reporting back in terms of taking on board messages from the discussion groups suggest some positive influence.

Similarities and differences with previous research

The findings of this study show both vital similarities and vital differences compared with previous research undertaken on the link between social media and DSH, and DSH in general. Firstly, the study's findings show several key similarities with previous research in regards to conceptualisations of DSH. DSH has repeatedly been conceptualised as an addiction in previous research (Sandman & Hetrick, 1995; Brown & Kimball, 2013; Richardson et al., 2012; Nafisi & Stanley, 2007; Plante, 2007). Similarly, the negative conceptualisation of self-harm in the posts analysed is in accordance with the literature (Lundh et al., 2011; Nock, 2008; Young et al., 2006; Sornberger et al., 2013; Richardson et al., 2012; Nafisi & Stanley, 2007; Plante, 2007). Methods of self-harming mentioned in the posts also are similar to the methods of self-harming mentioned in psychological literature on the topic. Methods mentioned in both posts and literature include cutting, scratching, burning, carving symbols or words into one's skin, and interfering with wound healing (Gomez et al., 2015; Phillips et al., 2013; Vaughn et al., 2015; Brown & Kimball, 2013). Thus, the literature offers some support for the ways in which DSH is conceptualised in the posts analysed for this study. This means that the conceptualisations of DSH in the posts largely conform to the definitions of DSH in the literature. Thus, there appears to be reasonable evidence in the literature for the ways DSH is conceptualised in the posts.

Additionally, the study's findings show several vital similarities with previous research in regards to issues contributing to DSH for adolescent self-harmers. Thus, in line with definitions of self-harm in the literature that include coping with negative emotions as a reason for self-harming DSH is framed as a coping strategy for dealing with difficult emotions in the posts (Young et al., 2006; Sornberger et al., 2013). Moreover, the literature offers some level of support for the idea of people offline being unhelpful reflected in the posts (Tindale, 2007; Murray & Fox, 2006; Paediatric Nursing, 2006; Baker & Fortune, 2008). These people include medical professionals, mental health professionals, teachers, family, and friends of adolescent self-harmers. Additionally, the idea of a negative self-image, including low self-esteem and a coping style involving self-blame, being associated with self-harming is supported by the literature (Phillips et al., 2013; Hawton, et al., 2003; De

Leo & Heller, 2004). Similarly, the comorbidity of self-harm with other psychological issues, as well as social isolation and loneliness, and school-related issues is reflected in the literature. Psychological issues linked with DSH in the posts include depression, anxiety, eating disorders, and sleep issues. The first of these psychological issues, self-harm has often been connected with depression and anxiety in the literature (Fliege et al., 2009; Klonsky et al., 2003; Andover et al., 2005). Additionally, in the literature eating disorders are mentioned as linked with DSH (Fliege et al, 2009; Truglia et al., 2006; Whitlock, et al., 2006b). The literature also offers some support for a relationship between sleep problems and self-harm in adolescents (Hysing et al., 2015; Sansone et al., 2010). Additionally, a relationship between social isolation and self-harm has been established by several studies (Adler & Adler, 2005; Nock & Prinstein, 2004; Wu et al., 2013; Kaba, et al., 2014; Haw & Hawton, 2011). An association between school-related issues and self-harm has also been found by a variety of studies. However, most of these studies focus on the link between school bullying victimisation and self-harm, rather than other school-related issues, such as academic stress and academic underperformance. Thus, it appears that there is reasonable evidence for an association of school bullying victimisation and self-harm. Overall, issues contributing to DSH for adolescent self-harmers that are evident in the posts are largely reflected in the literature.

The study's findings also show several vital similarities with previous research in regards to care and support. Thus, the vital finding in this study that care and support for members are important functions of online self-harm discussion groups is reflected in the literature. This emphasis placed on care and support online is supported by various studies (Murray & Fox, 2006; Baker & Fortune, 2008; Whitlock et al., 2006b). Consequently, both the study's findings and the literature highlight the importance of care and support online for overcoming self-harm, particularly for adolescents. Overall, the findings of this study involve a number of similarities with previous research, and thus the literature on DSH in adolescence.

Nevertheless, the findings of this study show several vital differences compared with previous research undertaken on the link between social media and DSH, and DSH in general. For one, the literature overall lacks research on how self-harming adolescents conceptualise self-harm. The findings of this study show that the self-harm conceptualisations of adolescents self-harmers differ in some ways from the official definitions in the literature. For example, in the posts analysed for this study self-harm was framed as including mental self-harm, such as writing words on one's body with marker pen

and crying. In contrast, the literature tends to define self-harm as intentional self-induced harming of one's own body resulting in tissue damage (Lundh et al., 2011; Nock & Prinstein, 2004; Remaschi et al., 2015; Lewis et al., 2011; Claes et al., 2014). Additionally, in the posts there is some sense of society being associated with individuals engaging in DSH. This focus on the societal level is largely missing from the literature.

Moreover, while the posts reveal a tendency for self-harming adolescents to keep their self-harm secret from people offline, such as friends and family, there is a lack of research on the extent to which self-harming adolescents, as well as self-harming adults, keep their self-harm secret from people close to them offline. Additionally, there is a lack of research on the possibility of a relationship between bipolar disorder and DSH for both adolescents and adults, while there was mention in the posts of bipolar disorder being associated with DSH for self-harming adolescents. Similarly, there is a relative lack of literature investigating the possibility of a link between sleeping issues and DSH. There also is a relative lack of research on the relationship between school-related factors other than bullying, such as academic stress and poor academic performance, which were mentioned in the posts. Additionally, there exists a lack of research on the extent to which being a member of an online self-harm discussion group affects likelihood of getting help with DSH offline. Thus, the findings of this study involve a number of differences compared with previous research, and thus the literature on DSH in adolescence.

Relating my findings to existing theory

It can be argued that social contagion theory has some minor relevance to understanding the positive and pro-social online behaviour of adolescents in the discussions analysed. According to social contagion theory the social context individuals are embedded in affects their behaviours and attitudes. This appears to somewhat occur in the posts but mainly not in the way predicted. Rather, the main way in which social contagion occurs to a minor extent in the posts analysed is through posters holding the shared view that DSH is something negative that needs to be overcome. Thus, instead of online DSH content on peer-driven online self-harm discussion groups being triggering for adolescent self-harmers via as material on peer-driven NSSI websites normalising and reinforcing DSH it appears that such content actually discourages adolescent self-harmers from continuing and increasing engagement in DSH. Thus, online self-harm discussion groups could potentially help them stop self-harming.

Consequently, rather than normalise DSH social media representations of it have the potential of enabling adolescents to become more aware of the negative aspects of self-harm.

Cultivation theory is also relevant to this study's findings. The reason is because the notion inherent in it of the spread of behaviour, thoughts, or ideas from the individual to the collective is apparent in the posts analysed. This is because due to the posters overall holding the shared view of DSH being something negative that needs to be overcome, and communicating this view to other posters in a persuasive manner, there is a possibility of this view spreading from individual posters to the collective of posters of the different online self-harm discussion groups analysed. There is a lack of opposing views, including lack of a view of self-harm being positive and worthwhile. Thus, the primary proposition of cultivation theory, namely that the more time individuals spend engaging with media and 'living' in the media world, the greater the likelihood of them believing social reality depicted in media, could potentially applies here (Cohen & Weimann, 2000). Originally, this primary proposition was about the television world and social reality portrayed on television. However, with the internet having largely replaced television as the main form of media consumed, this idea applies to the online discussion groups analysed for this thesis. For many of the posters whose posts were analysed the discussion groups are their main venue for talking about their self-harming. Due to them having a lack of people to talk to offline about this, the online discussion groups become their world in which they live.

Additionally, online discussion groups today are a vital means of communication via the creation of social networks where individual posters congregate electronically in order to share advice and ideas (Ridings & Wasko, 2010). Thus, the relationships among users of online discussion groups can result in the formation of persistent social structures known as social networks. The recent rapid growth regarding membership of online discussion groups in general suggests that participation in such groups provides vital benefits for members (Constant, Sproull, & Kiesler, 1996; Wellman, 1997; Wellman & Gulia, 1999). These benefits include both social and informational support for the individuals participating (Constant et al., 1996; Wellman, 1997; Wellman & Gulia, 1999; Sproull & Arriaga, 2007). Thus, online discussion groups provide virtual spaces for globally distributed people to interact around a shared purpose (Rheingold, 2000; Sproull & Arriaga, 2007). Briefly, online discussion groups analysed for this thesis appear to function as social support forums via which adolescents can discuss their feedback in a group setting despite feeling that they do

not have adequate offline support. These discussions appear to be places where feelings of being understood and taken seriously can be cultivated.

Another theory relevant to this study's findings consists of social learning theory. The reason is that from reading online posts people can be encouraged by model behaviours mentioned in them (Rollins et al., 2014). This is because social learning theory involves the prediction that learning from models may increase one's expectations regarding task performance (Manz & Sims, 1981). Therefore adolescent self-harmers could learn to perceive DSH as something negative to be overcome from engaging with content in the online self-harm discussion groups analysed for this study. This could be the reason why the overall consensus in the posts analysed is that DSH is something negative and addictive, which needs to be overcome rather than continued with. In this way, peer-created online content on DSH may help self-harming adolescents with overcoming self-harming. People also can find social media use, such as writing forum posts or posting in Facebook groups, empowering because it allows them to express themselves (Rollins et al., 2014). Thus, self-expression through posting in online self-harm discussion groups may have a positive function for adolescent self-harmers. Thus, this could be another way in which online self-harm discussion groups could help self-harming adolescents overcome self-harming. Yet another way in which these groups could help self-harming adolescents via social learning is that by being on these sites they are learning from those out there what not to do in some ways. This could include, for example, being motivated to get help offline from reading accounts of other adolescents who did not get help offline eventually having their self-harming spiral out of control. However, these are all tentative assertions as due to this study being qualitative it does not deal with cause-and-effect-relationships.

Clinical implications

The results of this study have several potentially vital implications in the clinical area. All of these revolve around taking adolescent understandings and views into account when working with them. This may potentially make self-harming adolescent clients more receptive to treatments.

The first of these implications is that self-harm conceptualisations by adolescent self-harmers ought to be taken into account more by clinicians than they currently are. This includes the

idea that plans for clinical treatment in the future should potentially include views of DSH as an addiction and as something negative that needs to be overcome, as well as the recognition of the idea of self-harming adolescents having complex views of their scars.

Firstly, the ways in which self-harming adolescents conceptualise self-harm in the discussion analysed differ to some extent from official clinical definitions of self-harm. This means that self-harm conceptualisations by adolescent self-harmers need to be taken into account by clinicians in order for better understanding of the ways in which adolescents self-harmers conceptualise self-harm. Further, the posts overwhelmingly conceptualise DSH as an addiction and correspondingly clinical treatments could focus on this way of viewing self-harm. Treatments of adolescent, and possibly adult, self-harm could use similar methods to treatments for types of addiction more established in the literature, such as interventions for drug and alcohol addiction. Because adolescent self-harmers appear to experience DSH as an addiction, interventions with the aim of overcoming addiction could potentially be more effective than other types of treatments for DSH.

Similarly, as in the posts DSH is framed mainly in a negative way, as something that needs to be overcome clinicians could use this information in treatments. Thus, instead of assuming that adolescents view self-harm as 'cool' or 'trendy', they could potentially already be on the same page with their adolescent clients by communicating to them a shared understanding of self-harm as something negative that needs to be overcome. As, it is important for effective treatment that clients feel understood and not looked down on, especially in the case of adolescent clients, this knowledge could help clinicians gain the trust of self-harming clients. This could make clients more receptive to treatment.

Moreover, the finding that self-harming adolescent tend to not mind their scars could help clinicians gain more understanding and acceptance of ways in which self-harming adolescents view their scars. Again, this knowledge could potentially help clinicians gain the trust of self-harming adolescent clients and thus make them more receptive to treatment.

A key issue is that, according to the findings of this study, DSH is often used as a coping strategy by adolescent self-harmers to deal with issues in their lives in the short-term, treatments for DSH need to be aimed at tackling the underlying issues. These issues include self-harming adolescents perceiving people offline as being unhelpful and keeping DSH secret from them, a negative self-image, as well as comorbidity with other psychological issues, social isolation/loneliness, and school-related issues. Thus, if these underlying issues

are resolved or at least improved, interventions aimed at helping adolescents overcome self-harm are more likely to be successful.

Another potential clinical implication is that clinical interventions could be aimed at challenging the view of people offline as unhelpful by self-harming adolescents as part of effective treatment. Additionally, treatments for DSH may need to be aimed at tackling several related issues mentioned below. Social media could also potentially be used clinically to reduce self-harm in adolescents. Clinical interventions could also focus on making school counselling a safe place for adolescents dealing with self-harm.

From the posts analysed it appears that people offline, such as friends and family of self-harming adolescents, are viewed as unhelpful by many discussants on these lists. If this is found to be the case in future research, clinical interventions could be aimed at challenging this view as part of effective treatment. The reason is that if self-harming adolescents are able to overcome this view they could be more likely to start opening up to family and friends about their self-harm. Having offline support networks could help them stop self-harming. However, self-harming adolescents' wishes of keeping DSH secret from people offline also need to be recognised as much as possible. Thus, their wishes for confidentiality need to be respected unless doing so could cause serious harm for them. This is a particularly difficult issue in regards to DSH as engaging self-harming often has the potential of resulting in serious injuries or even death. Still, care needs to be taken to respect adolescent self-harmers' wishes for confidentiality as much as possible. Thus, they need to be supported in choosing not to tell friends or teachers about their self-harm as much as possible.

The finding that in the posts a negative self-image is associated with self-harming also has implications for clinical practice. Clinical work with adolescents engaged in DSH could involve improving the self-image of self-harming adolescents, including confidence and self-esteem. Similarly, due to the finding of comorbidity of self-harm with other psychological issues treatments could focus on simultaneously treating several psychological issues. Treatments aimed at helping adolescent self-harmers could also include aiding them with overcoming issues of social isolation and loneliness. School-related issues could be tackled as well. For example, help with academic issues, including academic stress, could be included as part of self-harm treatments. Likewise, if there actually is a link between school bullying victimisation and self-harm, schools need to prioritise the implementing of anti-bullying interventions and policies (McMahon et al., 2010b). Many interventions have already been

found to directly decrease bullying in schools, especially those involving multiple disciplines, mentoring programmes, a whole-school approach, and increased social worker involvement in the school environment (Vreeman & Carroll, 2007).

Moreover, as another finding in this study was that there is generally a lack of people to talk to for support offline for adolescent self-harmers interventions could also focus on making school counselling a safe place for adolescents dealing with self-harm. This would mean school counsellors providing an atmosphere of safety, trust, support, and understanding that encourages self-harming adolescents to talk about their self-harm issues. This type of intervention could also be used by teachers, in addition to school counsellors.

Correspondingly, since it was found in the study that care and support online are a major feature of online self-harm discussion groups practitioners ought to have a more positive view of online discussion groups. Thus, social media could potentially be used to reduce self-harm in adolescents. This could include making online discussion groups part of treatments for DSH in adolescence. Thus, self-harming adolescents could be encouraged by clinicians to use online discussion groups pre-approved by them as part of clinical interventions.

Generalisation and future research

In the case of qualitative methodology the issue of generalisation is controversial (Kvale, 1996; Polit & Tatano Beck, 2010). Generalisation is associated with the application of results from a sample to a population in quantitative studies (Kvale, 1996). Since the assumption of representativeness fails to be fulfilled in qualitative studies, this kind of generalisation is impossible. Moreover, it is not always wanted. The reason is that the goal of the majority for qualitative studies, instead of generalising, is to develop a rich, contextualised understanding regarding some aspect of human experience via the intensive study of particular cases (Polit & Tatano Beck, 2010). Rather, other kinds of generalisation, including analytic generalisation and case-to-case transfer, are proposed (Firestone, 1993; Mason, 2002).

To avoid the issues associated with generalisation in qualitative research it has been proposed that qualitative researchers talk about transferability instead of generalisation (Bergström, 2010). Transferability relates to questions about whether findings from a particular study can be used to make statements about other people in similar situations. In this study it is argued that its findings are transferable, as well as interesting, in regards to adolescent self-harmers,

other than those whose posts were analysed for it. Even though their posts might not entirely represent the general experiences and views of all self-harming adolescents, they still make a statement regarding ways in which DSH might be experienced by adolescents. Thus, the ideas and concepts developed via this present study may be useful for further research.

There is still a considerable lack of empirical research, and thus psychological literature, on the topic of internet self-harm discussion groups (Murray & Fox, 2006; Baker & Fortune, 2008; Whitlock et al., 2006b). Therefore, given the pervasiveness of social media in young people's lives, more research on this topic is generally needed. Most studies on this topic focus on negative effects of internet self-harm discussion groups, such as graphic images and descriptions of self-harm being potential triggers for self-harmers. There especially is a lack of studies focusing on positive effects of internet self-harm discussion groups, such as care and support online. As the internet today, and especially social media websites, have a major influence on adolescents due to the amount of time spent online by them, more research in this area would be of interest.

Future studies could also benefit from looking more closely into ways in which self-harming adolescents, and self-harmers of all age groups, conceptualise self-harm both to themselves and each other. As part of this the question of the extent to which adolescent self-harmers, and self-harmers in general, consider society to be a factor in their self-harming could be addressed. An example of this is pressures society puts on adolescents. The reason is that if societal aspects play a part in DSH in adolescence exposure to these factors by self-harming adolescents, and adolescents at risk of self-harming in the future, could be decreased or eliminated as much as possible. Additionally, by increasing understanding of how self-harming adolescents, and self-harming individuals in general, conceptualise self-harm clinicians could find better focal points regarding interventions. Thus, treatments could be better tailored to the specific needs of adolescent self-harmers. The same would also apply to other age groups. The study makes a strong case for looking at the positive aspects and social implications of the social learning that takes place in a positive environment for self-harm, which these groups ultimately are. This includes what the implications of being in a community of probably current or ex-self-harmers are for adolescent self-harmers. That could be explored in a case study.

Additionally, while there is some research on DSH as an addiction the literature connecting DSH and the opiate system is currently sparse. Thus, more research is needed in order for

improved understanding on the specifics of the connection of DSH and the opiate system. This could then inform clinical treatments of DSH.

Moreover, even though there is some research examining how self-harming adolescents view their scars, there is not much research in this area. Knowledge and understanding of the ways in which adolescent self-harmers conceptualise their scars offers insight into their reasons for self-harming. As for effective treatment of DSH in adolescents, and all age groups in general, knowledge and understanding regarding the factors involved in their self-harm is necessary further research on how self-harming adolescents view their scars is recommended.

Research about how helpful people offline are for self-harming adolescents' recovery, and the extent to which self-harming adolescents keep their self-harm secret from people close to them offline, is similarly existent but relatively sparse. Social support, defined in terms of the level of quality of perceived support gained from social relationships, has received less research compared with other etiological factors in relation to DSH (Wu et al., 2013). The reason why social support is a vital research topic is that the importance of effective support networks cannot be underestimated in order for successful recovery from DSH to occur. Therefore more research in this area would be needed to gain more insight into the extent to which offline support networks are in existence and effective for adolescent self-harmers.

While there is a decent amount of research on the comorbidity of DSH with other psychological issues there is a lack of research on the nature and extent of comorbidity of DSH with bipolar disorder. As there was some mention of DSH as being comorbid with this psychological disorder more research to investigate this link further is needed.

There is a growing literature on the relationship between school-related issues and DSH. However, most of it focuses on school bullying victimisation rather than on academic factors, such as school stress and poor academic performance. In order to get a fuller picture of the exact nature and extent of the link between school-related issues and DSH, and especially how and how much academic pressure on adolescents are related to DSH, further research is needed.

This study also lacked a focus on how DSH is viewed by self-harming adolescents from different cultures, genders, and socioeconomic backgrounds. Future research could focus on this topic in regards to the engagement with online self-harm discussion groups by self-

harming adolescents. As culture, gender, and socioeconomic background shape our views of the world to a considerable extent these factors cannot be ignored.

Concluding remarks

In conclusion, I cannot definitely say that there is an association between social media use and adolescent engagement in DSH due to this study being an analysis of social media posts. Nevertheless, I can say that, given the quality of the posts analysed for this study and the in-depth sort of discussions that take place in online self-harm discussion groups they are likely to be related. The posts from the online self-harm discussion groups analysed for this study allow for a good but not complete picture of how social media use and self-harm are related. From the analysis of the posts some positive rather than negative aspects of online self-harm discussion groups have become apparent. This includes the talk across the online discussion groups analysed being focused on portraying self-harm as undesirable, and on overcoming it. This pattern indicates that social learning is at work as the discussion threads analysed often featured a focus on trying to persuade fellow posters to stop self-harming, and helping them find ways to achieve this aim. Consequently, social learning plays a major role in regards to the social interaction of the posters in the online self-harm discussion groups analysed for this study. Self-harm is conceptualised by adolescent self-harmers in a variety of ways, involving both similarities and differences with clinical definitions. A major trend in the posts analysed is the framing of DSH as an addiction. This includes conceiving of DSH as something negative that needs to be overcome. This addiction lens also involves viewing DSH a short-term strategy with a great risk of turning into an addiction. Thus, DSH appears to be used by posters to cope with a variety of issues they face in their lives. These issues include a comorbidity of DSH with other psychological issues, such as depression, anxiety, sleeping issues, eating disorders, and bipolar disorder, as well as with social isolation and loneliness, and school related issues. The posts also indicate that self-harming adolescents have a complex relationship with their scars. This involves the interesting contrast of not minding one's scars but simultaneously making an effort to hide them from others, like friends and family, along with their engagement in DSH. The latter is somewhat linked with self-harming adolescents appearing to have a negative self-image. Social affiliation with other self-harming adolescents offline also appears to be part of the experience of being an adolescent self-harmer. Additionally, self-harming adolescents view people offline, including mental

health professionals and teachers, as well as family and friends, as unhelpful in regards to their self-harming and their attempts to overcome it.

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APPENDICES

Appendix I: Consent letter for online discussion groups

To whom it may concern,

I am conducting research on the relationship between self-harm among adolescents and online discussion and social media websites for my Master's Thesis in Psychology. This research consists of a study that aims to explore the conversations in an online environment among adolescents engaging in deliberate self-harm (DSH) and to understand the role of social media as a mechanism for engaging/facilitating DSH or as a means for coping with it. The study itself consists of an analysis of posts on different online discussion groups and social media websites for common themes. For this I would be interested in analysing posts on your message board. I realise of course that I would need your consent for this.

This study is not about pathologising individuals engaging in self-harm. Instead, its aim is to give them a voice by find out how they construct self-harm. Thus, this study is about how adolescents engaging in self-harm make sense of their behaviour rather than judging them by merely using theory. The reasoning behind this approach is that any good therapeutic approach looks at the clients' constructions of reality, meaning their ways of framing it. As part of the study participants' identities would be completely anonymised.

Yours sincerely,

Katrin Waite

Masters Candidate

School of Psychology

Massey University, New Zealand

Appendix II: Research ethics: Low risk notification form

MASSEY UNIVERSITY
ALBANY

12 June 2015

Katrin Waite
1 Inca Place, Redhill
Papakura 2110
Auckland

Dear Katrin

Re: The association between social media and adolescent engagement in deliberate self-harm

Thank you for your Low Risk Notification which was received on 21 May 2015.

Your project has been recorded on the Low Risk Database which is reported in the Annual Report of the Massey University Human Ethics Committees.

You are reminded that staff researchers and supervisors are fully responsible for ensuring that the information in the low risk notification has met the requirements and guidelines for submission of a low risk notification.

The low risk notification for this project is valid for a maximum of three years.

Please notify me if situations subsequently occur which cause you to reconsider your initial ethical analysis that it is safe to proceed without approval by one of the University's Human Ethics Committees.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

A reminder to include the following statement on all public documents:

> *"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.*
>
> *If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Dr Brian Finch, Director (Research Ethics), telephone 06 356 9099, extn 86015, e-mail humanethics@massey.ac.nz".*

Please note that if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to provide a full application to one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

Yours sincerely

Brian T Finch (Dr)
Chair, Human Ethics Chairs' Committee and
Director (Research Ethics)

cc Dr Richard Fletcher, School of Psychology, **Albany Campus**
Dr Darrin Hodgetts, School of Psychology, **Albany Campus**
Professor James Liu, School of Psychology, **Albany Campus**

Massey University Human Ethics Committee
Accredited by the Health Research Council