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Self-harm as a means to manage the public and private selves: A qualitative study of help seeking by adults

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Abstract

Adults ($n = 25$) completed online free text boxes about their self-harming behaviour. Thematic analysis identified three dominant themes: 'managing the private self', 'managing the public self' and 'moving on'. Transcending these themes was the notion of thresholds of change. Self-harm enables people to manage both their private and public selves. When thresholds of change are surpassed, the public self communicates a need for help. Self-harm exists within a precarious balance of well-being and can be a form of self-care. Help seeking is instigated when this balance is disrupted and continued if it offers a better form of self-management than the individual's own self-harming behaviour.

Keywords

experiences, function, help seeking, qualitative, self-harm

Introduction

Self-harm can be broadly defined as 'self-poisoning or self-injury, irrespective of the apparent purpose of the act' (National Institute for Clinical Excellence (NICE), 2004: 3). Research has explored self-harm in terms of its prevalence, the problem of help seeking and the possible causes of self-harming behaviour. These areas will now be considered.

In terms of its prevalence, many studies focus on self-harm among adolescents. Madge et al. (2008) evaluated the prevalence of self-harm in 14- to 17-year-olds from seven European countries found an average overall prevalence of 13.5 per cent of females and 4.3 per cent of males reporting self-harming in their lifetime. In addition, several studies indicate that self-harm usually occurs for the first time during adolescence (Muehlenkamp et al., 2012). Self-harm, however, also occurs in adulthood. For example, Outside the Box (2008) identified durations of self-harm up to 25 years which inevitably enter into the adult years, and it has been estimated that between 4 per cent (Briere and Gil, 1998) and 5.9 per cent of the US population have engaged in self-harm within their lifetime (Klonsky, 2007). Furthermore, a study comprising 17 countries found that an average of 2.7 per cent of the adult population reported at least one episode of self-harm (Nock et al., 2008) and a study of one Accident and Emergency (A&E) department in Oxford, UK, reported that 1165 individuals with self-harm incidents attended a total of 1588 times within a year. Of these, only 5.8 per cent of them were under 16 years old, 56.7 per cent were 16–34 years, 34.6 per cent were 35–64 years and 2.9 per cent were 65 years or older (Hawton et al., 2011). In addition, NICE (2004) reported that self-harm resulted in approximately 150,000 attendances to A&E departments across England and Wales.

Although providing some insight into prevalence, these figures are, however, misleading. Self-harm is often a very private act, with many people not seeking medical assistance and, therefore, being beyond these data. In fact, a study in New Zealand concluded that only one-fifth of those who self-harmed sought help (Nada-Raja et al., 2003), and Madge et al. (2008) suggested that only one-tenth of those who self-harm seek medical attention. To address the problem of help seeking, some studies have explored the quality of the care received. For example, Horrocks et al. (2005) explored patients' satisfaction

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with their care, and Harris (2000) highlighted the gap between patients' views of their own behaviour and their beliefs about the views of those who try to help them. In contrast, the barriers to help seeking have also been explored. For example, Cigularov et al. (2008) explored barriers to help seeking after a school-based education intervention and identified issues including a feeling of being unable to discuss problems with adults, self-over-confidence, a fear of hospitalisation and a lack of closeness to school adults. Similarly, Freedenthal and Stiffman (2007) highlighted factors such as embarrassment, a belief that there was not a problem, a belief that nobody could help and self-reliance. Furthermore, Young et al. (2007) explored differences between those who sought help versus those who did not and concluded that those from a manual labour background were more likely to attend A&E, whereas those who were unemployed made greater use of psychiatric, A&E and social services. In contrast, however, Freedenthal and Stiffman (2007) concluded that although structural issues such as money or service availability may be key to help seeking, they were only rarely cited in their study as causes to not seek help. This may be because such structural factors largely operate beyond our awareness.

There is also a wealth of research addressing the causes of self-harm. In the main, this has focused on potential risk factors and has highlighted the impact of issues across the lifespan. For example, Linehan (1993) indicated that early childhood experiences were key to the development of self-harm, and Gratz (2003) emphasised the impact of physical, emotional or sexual abuse, as well as neglect, separation and loss. Additionally, an early insecure attachment may also increase the likeliness of self-harming behaviour (Adshead, 2010). Self-harm may also be triggered by adult experiences, and research indicates that traumatic experiences such as rape or assault can also increase the likelihood of an individual engaging in self-harming behaviours in later life (Long et al., 2013). In contrast, some studies have called for a move away from risk and aetiological factors towards an emphasis on reasons and the individual's own perspective (Barton-Breck and Heyman, 2012; Chandler, 2014; Harris, 2000). For example, Adshead (2010) takes a more psycho-analytical approach and argues that self-harm can be read as a form of communication which is used to express self-hatred and rage. Similarly, Klonsky (2009) and Barton-Breck and Heyman (2012) concluded that participants' reasons for self-harm involved affect regulation, the need for emotional release and self-punishment, and Chandler (2014) highlighted a key role for regaining control. Similarly, Long et al. (2013) emphasised the psychological damage caused by life events and trauma, and in a large-scale quantitative study, the most commonly cited reasons for self-harm were 'feeling the body is real', 'getting rid of anger', 'stopping guilt' and 'distraction from memories' (Briere and Gil, 1998).

Self-harm can, therefore, affect people of all ages, not just adolescents. Many people who self-harm, however, do not seek help, and some research has addressed this problem with a particular emphasis on the quality of the care received and possible barriers to help seeking. There are also several possible causes for self-harm, and some recent research has addressed the individual's experiences of their behaviour with a focus on their own explanatory frameworks and the potential function of their behaviour. To date, however, no research has explored the ways in which the function of self-harm and an individual's reasons for their behaviour may affect whether or not they seek help. Therefore, this study aimed to explore how people who self-harm make sense of their behaviour and the implications of these explanatory frameworks for help seeking. To this end, this study used a qualitative methodology as a means to access the individual's own experiences but rather than utilising interviews, anonymous textual accounts were obtained as a means to encourage openness that may be more forthcoming if the participants were confident that they cannot be identified in any way. Finally, this study focused on adults, as prevalence studies highlighted the frequency of this problem among this population.

Method

Design

This study used a qualitative design involving anonymous text boxes to encourage engagement from those who may not wish to take part in more intrusive forms of research. The inclusion criterion was aged over 18 years who reported self-harming behaviour as adults (18+ years).

Participants

A total of 34 participants started to complete the text boxes. However, three did not meet the inclusion criteria, and seven had either written minimal answers (i.e. 'yes' and 'not much') or did not complete all sections. Accordingly, data were analysed from 25 participants. Of these, the majority were females (2 males and 23 females) and came from the United Kingdom ($n=14$), the United States ($n=7$), Ireland ($n=1$), Dubai ($n=1$), Australia ($n=1$) and Canada ($n=1$). They were aged between 19 and 45 years (mean age: 29 years) and had been self-harming for between 6 months and 32 years (mean length of time: 10.5 years). The mean age of onset was 17 years (ranging from 12 to 36 years), and the majority considered themselves as currently ($n=20$) self-harming. The majority had also received professional help ($n=22$), but often this was not directly for their self-harm behaviour but as a result of other problems such as a suicide attempt, addictions or an eating problem. The majority of participants described cutting themselves ($n=20$), but some also mentioned starvation ($n=2$), alcohol use ($n=1$),

Table 1. Participant demographics.

Name	Age	Sex	Age of onset	Years self-harming	Sought help?	Professional help?	Country	Still self-harming?
Amelia	36	F	27	9	No	No	US	Yes
Rosie	25	F	23	2	No	No	UK	Yes
Olivia	30	F	25	3	Yes	Yes	US	No
Helen	19	F	16	4	Yes	Yes	UK	Yes
Hannah	24	F	16	7	Yes	Yes	Ireland	No
Robert	24	M	13	11	Yes	Yes	UK	Yes
Liz	27	F	15	12	Yes	Yes	UK	Yes
Louise	33	F	13	20	Yes	Yes	UK	Yes
Josie	26	F	15	7	Yes	Yes	US	No
Kate	32	F	15	17	Yes	Yes	US	Yes
Annabelle	43	F	16	27	Yes	Yes	US	Yes
Christine	20	F	12	8	Yes	Yes	US	No
Samantha	36	F	15	16	Yes	Yes	UK	Yes
Lucy	24	F	15	4	Yes	Yes	UK	No
Vicky	24	F	13	11	Yes	Yes	UK	Yes
John	29	M	28	6 m	No	No	UK	Yes
Jill	19	F	11	9	Yes	Yes	Dubai	No
Jan	40	F	14/22/40	4/14 m	Yes	Yes	UK	Yes
Mary	21	F	14	7	Yes	Yes	Australia	Yes
Lynne	41	F	14	27	Yes	Yes	UK	Yes
Jaz	19	F	13	6	Yes	Yes	UK	Yes
Frieda	23	F	12	9	Yes	Yes	US	Yes
Rachel	45	F	13	32	Yes	Yes	UK	Yes
Ali	43	F	36	7	Yes	Yes	UK	Yes
Lisa	20	F	11	9	Yes	Yes	UK	Yes

making themselves sick ($n=1$), chain smoking ($n=1$), scratching themselves ($n=1$), biting themselves ($n=1$), drug use ($n=2$), body piercing ($n=1$), digging their nails into their hands ($n=1$), hitting themselves ($n=1$) and banging their head ($n=1$). The participants' details can be found in Table 1. All participants have been given pseudonyms.

Procedure

Favourable ethical approval was granted by the University Ethics Committee. Initial messages were sent to administrators of self-harm support groups and pages on Facebook requesting permission to post a recruitment message on their wall. Participants chose to take part by clicking a link which took them to an information page, where they gave their consent and answered the survey anonymously. The survey consisted of the following questions: (1) 'Can you tell me about your self-harming? When did it start? How does it make you feel?'; (2) 'Have you ever sought help? (e.g. Friend, family member, website, doctor, counsellor?) If so, who have you sought help from? Why did you choose them? Was there anything that helped you decide to'; (3) 'Can you describe your experiences of seeking help and whether it was helpful? What were your expectations and were they met?' and (4) 'If you have NEVER sought help from anyone can you describe why this is?' Participants were also asked for their age, country of residence and whether they considered themselves to be still self-harming. Data collection was ended when it was felt that sufficiently rich data had been obtained for analysis.

Data analysis

Participants' free text responses were analysed using Thematic Analysis which enables flexibility and allows the researcher to actively engage in the data (Braun and Clarke, 2006). In addition, this approach emphasises participant's own personal experience and can generate unanticipated ideas. The texts were read and re-read by both authors to ensure familiarity with the data. For each response, a coding sheet was used which contained all possible themes and sub-themes. Relevant quotes from each response were placed under each theme on the coding sheet. With continuous reference to each response, comparisons were made across the various themes. This analysis process involved close discussion between authors and all codes, and themes and sub-themes were discussed and changed as a result of this discussion. (Note that spelling and grammatical errors have been edited at times to keep the flow of the passages.)

Results and discussion

Three dominant themes were identified from the data: (1) managing the private self, (2) managing the public self and (3) moving on. Transcending these was a fourth overarching theme of thresholds for change. These themes will now be described, illustrated with exemplar quotes and discussed in the context of existing literature. The final conclusion will then explore the findings within a framework of theories relating to the self and the importance of equilibrium.

Theme 1: managing the private self

It was clear that all participants used self-harming as a means to regulate their emotions. Participants described using self-harm in the following ways: (1) to validate their distress, (2) a self-punishment, (3) to regain control, (4) as a relief and release of overwhelming emotions and (5) as self-care.

Validating distress. Self-harm was seen as grounding, and many felt that by causing harm to the external self, they could become anchored to the present reality. Such physical pain was, therefore, not only a distraction from their emotional pain but also a means to validate their emotional distress. Olivia illustrated exactly this:

> When I felt the worst, when I was completely numb and disconnected from the world around me, cutting made me feel a physical pain that reminded me I was alive. It gave me something to focus on that was outside of my head and thoughts.

Similarly, Helen described welcoming anything that would make her feel alive:

> The way I hurt myself is by starving myself, at the beginning not because I saw myself as fat, but I felt the hunger as a way of giving me new pain, a pain that I was not already feeling. It made me feel real, that I could feel emotion.

Self-punishment. For many, emotional distress was exacerbated by self-hatred, and they used self-harm to punish themselves. Some described how the treatment from others had made them believe that they deserved pain. As Jaz said,

> My step mom used to lock me in my room and yell at me, how no one would want me, how my own mom didn't want anything to do with me. How I was nothing but a freak. She would smile and say I wasn't good enough. Cutting started as a self punishment.

Others described how they just generally felt that they deserved punishment. As Robert said of his alcohol and drug use,

> I wonder if these were my ways of punishing myself during times when I felt like I was a bad person.

Drug and alcohol abuse are not often considered to be self-harming behaviours, but Robert clearly identifies them as such. Olivia also described a clear reason for her initial self-harming, which subsequently led to an increase in the behaviours:

> When I started it was for one purpose: I felt sickened by myself, so I cut to punish myself. Almost as if I could cut the things I hated out of myself.

To regain control. Participants also reported that prior to self-harming, their emotional distress had reached a point which felt completely out of control. For these individuals, self-harm became a mechanism which empowered them to feel back in control as they could decide when and how they would self-harm:

> I felt like I was out of control and a pure slave to my emotions through that whole period … Like I just felt so, so unhappy that I couldn't see the way out. I was lost is the best way to describe it. Self-harming was a way to change that. (Hannah)

In contrast, Kate described how her need to regain control was not met by all self-harming behaviours:

> No matter how hard I hit myself that wasn't enough and I would go though times when I would starve myself and not drink anything … the starvation gave me a sense of control.

Relief and release. Whether directly or indirectly, all participants felt a sense of relief after self-harming. Although often not the intended primary function, self-harm aided them to cope with issues they were not emotionally strong enough to cope with or felt unable to confront. For some, this function was extremely clear:

> I began battling with severe depression and it was a coping mechanism. It gave me relief, release. (Josie)

Similarly, as Jill said in a very direct way,

> It makes me feel a lot better because it is better to bleed your problems out you know.

This sense of release and relief, however, was often only temporary and followed by a sense of shame and distress. As Liz said,

> It was amazing at first, but then it made me feel guilty which led to more self-harm and a vicious cycle followed, on and off, for the next 12 years.

Self-care. Self-harm was, therefore, seen as a means to manage the participant's private self through the expression of negative emotions and a sense of venting. However, for a few, self-harm also took on a more positive role of self-care.

For these people, self-harming was seen as productive and necessary in a comforting way. For example, Josie said,

> Not only is it stigmatized and misunderstood but it also becomes a dirty little secret and a security blanket that you don't want taken away and feel like you can't live without.

The notion of a security blanket is strangely contrasting with the violence and anger often associated with self-harming and suggests that the behaviour also generated comfort. Similarly, Lynne also felt that her behaviour brought comfort:

> it comforts me, helps me deal with emotional numbness … enables me to self care and soothe myself by tending to my wounds.

Similarly, Kate expressed quite dramatic benefits of self-harm:

> I still cut and the doctors know, my friends know, it's not a big deal and it keeps me alive.

Participant's reports indicate that self-harm was a means to manage their private self which reflects recent research on the reasons rather than causes of self-harm. For many, it was used to validate their distress by producing a physical manifestation of inner pain which was easier to cope with (Barton-Breck and Heyman, 2012; Briere and Gil, 1998; Harris, 2000). For some, it also functioned as self-punishment to express self-hatred and self-loathing (Adshead, 2010; Gratz, 2003). Regaining control was especially important to participants living within chaotic, turbulent or threatening environments (Chandler, 2014; Harris, 2000). These participants felt unable to exert control over certain aspects of their lives, and self-harm helped them regain a sense of control (Barton-Breck and Heyman, 2012; Chandler, 2014). Participants also used self-harm to alleviate negative affect and provide relief and release (Briere and Gil, 1998; Chapman and Dixon-Gordon, 2007). Several also used it as a form of self-soothing and self-care (Harris, 2000). Self-harm can, therefore, be understood as a regulation strategy with accounts illustrating how self-harm can be a private act that allows participants to manage their private selves.

Theme 2: managing the public self

As well as a means to manage their private selves, participants also described how self-harm helped them to manage their public self and the ways in which they were perceived by others. For some, self-harming and their ability to keep it hidden symbolised self-reliance and functioned as a signal that they were self-sufficient. For others, self-harming acted as a form of communication and a cry for help.

Symbol of self-reliance. For some participants, particularly those who had not sought help, self-harm was a symbol that they were coping on their own. It was kept hidden, but knowing that it was there, and that no one knew about it, was a source of strength. Some participants described how they actively kept their scars hidden:

> At first I would cut the upper part of my wrist, near my hand but people would see the scars and I actually didn't want that – contrary to popular belief my self-harming was not a cry for attention. So I then began cutting more in the middle of my inner arm. (Hannah)

Others presented a strong sense of self as being independent and self-reliant:

> I am the kind of person that likes to be able to do things for myself. I hate talking to anyone about personal things and would definitely never dream of talking about this to anyone I knew. (Rosie)

Similarly, Amelia was very clear that she was self-sufficient and even 'proud' of her cuts. She avoided help and did not want people to feel sorry for her as she felt that she was managing on her own:

> I don't want any pity from them … I'm actually almost proud of it … I don't need anybody's help. Even though I started up again, I can quit when I want. (Amelia)

She then continued to explain how she even felt like cutting herself while completing the online questionnaire but was emphatic that this was not for attention:

> As I sit here now, I'm wanting to do it. I cut just deep enough where I can feel it and even though it bleeds, it shouldn't scar. Some people think, we do this for attention. If I wanted attention, I'd have shown it off almost 9 yrs and now. (Amelia)

Similarly, Helen was also adamant that she was independent and that self-harming, and not telling anyone, was a sign of her ability to be self-reliant:

> I wanted no-one's support except my own. I find my own ways of recovery.

Method of communication. For many participants, however, self-harm was utilised as a method to communicate their feelings with the hope that their suffering would be acknowledged and addressed. For them, the verbal expression of emotions was problematic, but the physical signs of self-harm offered an alternative way to get their message heard. For Hannah, this desire for someone to acknowledge how she was feeling was clear. When talking about her self-harming scars she said,

> Secretly I liked that it was a mark people would be shocked by. More for sympathy than any awe about self-harming … I guess I felt so lonely that I needed someone to show they cared. (Hannah)

Similarly, Jaz called her self-harm 'a cry for help'. In contrast, Liz's desire to communicate appeared subconscious:

> I sought help from my friends when they started to notice the cuts on my arms and legs and they told me they would be there for me.

Although Liz did not intentionally make her self-harm visible, when they offered support, she readily accepted it, suggesting that there may have been some underlying hopes for recognition. Therefore, the scars acted a visible rather than a verbal statement of distress. This form of communication is also clearly described by Christine:

> I could not communicate my feelings well and didn't know how to.

Therefore, accounts illustrated how self-harming was utilised by participants as a means to manage their public self. For some, the knowledge that they self-harmed, but that no one knew of their behaviour, was a symbol of self-reliance and self-sufficiency. And in the main, these participants had not sought help which supports previous research on the barriers to help seeking (Freedenthal and Stiffman, 2007). However, others believed that the visible scars were a form of communication and a cry for help. Such difficulty in verbal communication may reflect a belief that words are unable or insufficient to express their pain (Adams et al., 2005; Rodham et al., 2004). It may also illustrate a degree of alexithymia (Adshead, 2010) with individuals having to communicate their psychological distress in a physical way (Paivio and McCulloch, 2004; Zlotnick et al., 1996).

Theme 3: moving on

The third theme related to a sense of moving on and a need for change. This was most evident in the accounts of those who had sought help but particularly apparent in those who had engaged and benefited in the help they had received. Moving on was illustrated in terms of (1) the right time, (2) help that was non-judgmental and (3) being challenged.

Right time. For many, the process of moving on was characterised by a sense that the time was right. Sometimes, this was unrelated to help seeking or therapy and was triggered by a change in circumstance. For example, Rosie, who had never sought professional help, described how her self-harming behaviour had subsided after her lifestyle changed:

> It takes a lot to admit you have a problem and need help. In the end I kind of got myself through it. My circumstances changed and I managed to finish my degree. A more structured life (working as opposed to being a student) helped me to break the cycle.

In contrast, others described how moving on was facilitated through external help. Olivia described how she started to improve due to a specific comment from a friend:

> at one point, I was planning on killing myself and told a friend this. They told me to try seeing a therapist because if it didn't help I could always kill myself later. It was truly the best advice I'd ever been given.

While Lucy described how she had sought help for other problems which in turn had enabled her to gain help for her self-harming behaviour:

> I never directly sought help for self-harm, however I did seek help for other things. I never really saw my self-harm as the main issue … I initially did seek help from my GP, not specifically to do with self-harm, but to do with my general low mood.

Non-judgmental support. Moving on was also facilitated by support that was non-judgmental and involved being listened to. Therefore, participants searched for a sense of acceptance and care. As Liz said of her friends,

> Help from friends was helpful as all they did was accepted it was an issue and said they would be there for me. I always thought people would think I was attention seeking and bringing it on myself, but they were actually very supportive.

Furthermore, Jan appreciated her counsellor for similar reasons:

> I find a lot of people think you're a nutter and can't understand why you would do it. But I am so grateful that I found a very understanding counsellor.

Similarly, Christine described her social worker as 'non-judgmental and helpful' and Annabelle described how her therapist 'doesn't make me feel bad if I slip and self-harm'.

Being challenged. However, several participants appreciated a more challenging approach and valued input that was more than just being listened to. As some participants had received help from many different sources, they were able to compare the effectiveness of different approaches and decide what had worked best for them. For Olivia, the most effective form of support involved a degree of confrontation and challenge. As she said of her second and then third therapists,

> She was a little more helpful. Listened a little more, but was super easy to get off track and ultimately not so helpful. The next one was probably the most helpful. She would ask hard questions and proposed solutions. She got me in a DBT group and eventually I stopped harming myself. (Olivia)

Olivia then further described how the therapist had challenged her way of thinking through language:

> He believed in the power of words affecting what a person thinks. That changing how you word something can take away or give power to a thought or action and therefore change a behavior. Words can change a person's view of something. It was pretty awesome.

Therefore, participants described the ways in which they had started to recover and move on from their self-harming behaviour. For some, this was instigated by the time being right, a shift in circumstances or a comment from others. For many, it was also facilitated by the kind of help they received which was mostly valued if it was not only supportive and non-judgmental but also sometimes more challenging and directive. This reflects previous research which has highlighted the value of similar kinds of support and which also indicates that continued help seeking is facilitated by receiving the right kind of support in the first instance (Harris, 2000).

Overarching theme: thresholds for change

The experience of self-harm was, therefore, described by participants in terms of managing both their private and public selves and moving on. Transcending these themes was a notion of thresholds for change which was reflected in the shift between a time when self-harming appeared to make life bearable and a sense that change was needed. In particular, participants' accounts illustrated a series of thresholds which when surpassed prompted a need for a different approach to self-regulation, and at times, this involved seeking help. These thresholds related to (1) physical and mental health, (2) seeing the future and (3) public reactions.

Physical and mental well-being. Participants' accounts illustrated a balance between a level of self-harm that functioned to improve their health and times when a threshold had been crossed, and the impact on either their physical or mental well-being seemed detrimental. When this balance shifted, participants were, only then, motivated to communicate a need for support and sought help. For Christine, this threshold related to her health in the broadest sense:

> When I almost collapsed of physical and mental exhaustion from the depression and the blood I was losing from the cut I made earlier that day I sought help.

For others, it was an emotional crisis that tipped them across the threshold:

> I had reached the point of wanting anything that would help me feel better. I felt so emotionally drained that I felt as if i didn't have the energy to make any decisions for myself. (Lucy)

The realisation that their self-harm was no longer a help but a hindrance to their well-being was also reflected in a sense of losing control. As Annabelle said,

> I sought help to stop the behaviour when it started getting out of control.

In contrast, Lucy who was receiving help but said 'I didn't feel as if I was actively seeking help but rather forcibly given it' ignored changes in her health and didn't experience them as a threshold for change. Eventually, however, the threshold was reached and change started to happen:

> I ended up being an inpatient at [a clinic] a total of I think 4 times. This figure suggests it wasn't particularly helpful as obviously I kept needing to go back, but I do think that the combined effect of those stays certainly contributed to my recovery. (Lucy)

Seeing the future. An additional threshold for change related to how participants viewed their future. Some people were very much focused on the here and now and their ability to manage their daily shifts in emotions. For them, self-harming was an integral part of their emotional regulation, and they could not imagine functioning without it. However, a few were able to stand back from their behaviour and see the picture in longer term. For example, Robert said,

> I finally decided to see a therapist when I realised that, despite feeling suicidal, I did not have the guts to confront death. I figured that if I had to spend the next 70 years on this planet then I'd better make some sort of investment in my mind to make the journey a bit less uncomfortable.

Public reactions. The final threshold for change related to public reactions to the scars created by self-harming. For some, it was the reaction of their children which made them realise something had to change. As Louise said,

> My daughter noticing the scars was what made me decide to get help. I didn't really have any expectations to be honest and I am doubtful of anything ever changing.

Similarly, Ali described her attempts to hide her behaviour from her daughter and then the feeling of regret when her daughter found out what she had done:

> I've cut my wrist, but the wounds were too obvious, so I started cutting my stomach. I used shards of broken glass, didn't care about infection. I wrote 'I HATE YOU' in cuts across my stomach, until my little girl began to read it when I'd forgotten to cover up or I'd accidentally shown it when dressing.

Not all public reactions triggered change, and several accounts illustrated the ability to ignore the pleas of others for them to stop. As Lynne said,

> I get nagged by my husband to stop but it is very ingrained into my life.

Therefore, participants described the ways in which their self-harm functioned as a means to manage their private and public selves, and some presented a process of moving on. Transcending these themes was a notion of thresholds for change relating to their health, the ability to see the future and the reactions of important others. These thresholds for change reflected a balance between self-harm successfully fulfilling a need, compared to a state when change was seen as desirable. In particular, when their self-harming behaviour was deemed to be an effective means to manage their private self, the public self presented an identity of being self-reliant, no help was sought and the participants' behaviour continued. However, when self-harm became ineffective as illustrated by a deterioration in their health status, a need for a better future or public reactions from others, the public self turned outwards and the scars could be utilised as a form of communication to gain help; the thresholds were surpassed, and a cry for help was made. This reflects a fluid dichotomy between the public and private selves which echoes the classic work of Goffman (1961) and illustrates the ways in which individuals can shift their mode of presentation depending upon the situation in which they find themselves. It also reflects previous research on the use of self-harm as a form of communication (Adshead, 2010) but suggests that when and if an individual publicly communicates their need for help depends upon the extent to which they are successful in managing their private self.

Conclusion

This study explored how adults experience self-harming and the ways in which their reasons for self-harm may affect whether or not they seek help. The results suggest that self-harming functioned for participants as a means to manage their private selves in terms of a range of emotional issues such as the validation of distress, self-punishment, regaining control, release and as a form of self-soothing and self-care. The results illustrate that participants also utilise self-harming to manage their public selves either through keeping their scars hidden and deriving a sense of self-reliance or by making them visible thereby communicating a desire for help. Furthermore, accounts indicate a process of moving on which was facilitated by it being the right time and support that was non-judgmental and at times challenging and directive. Transcending these themes was the notion of thresholds for change. To this end, participants illustrated a dynamic between self-harm as an effective form of self-management which required no help, and times when it no longer seemed so effective, which was dependent upon a set of thresholds being surpassed. Accordingly, when self-harm enabled the private self to be managed effectively, the public self was one of self-reliance and self-sufficiency. But when this process started to break down, the public self became one of communication and a cry for help, thereby instigating help seeking behaviour.

These results can be understood within the context of self-regulation and the need for equilibrium. Self-regulatory mechanisms are core to several psychological theories such as Cognitive Adaptation Theory (Taylor, 1983), the Model of Behavioural Self-Regulation (Carver and Scheier, 1998), the Reflective–Impulsive Model of Behaviour (Strack and Deutsch, 2004) and the Common Sense Model (Cameron and Leventhal, 2003). Across a number of domains, these theories have been developed and used to explore how individuals manage their cognitions, emotions and behaviour to regulate their selves. Although often focusing upon different components of self-regulation, central to these models is the notion of balance and a fundamental motivation for individuals to restore equilibrium if this is disturbed. The results from this study suggest that, for many, self-harm is a process of self-regulation and functions to maintain a sense of equilibrium through successfully managing the private self. When the thresholds are surpassed, however, and this is challenged, the individual manages their public self by calling for help, and help is sought. However, such help must fit with the needs of the patient if the patient is to find more benefit in the help they receive than they find their self-harming behaviour. The drive is always, therefore, to achieve equilibrium; this can be achieved either by self-harming or by seeking help to stop this behaviour. If those who self-harm are to be helped to stop this behaviour, the help they receive and the new life they can form without self-harming need to represent a better form of equilibrium than the one that they are used to.

There are some limitations with the design of the study which need to be addressed. First, although the online survey methodology may have increased the diversity of the sample in comparison to previous research, using Facebook may have precluded those who do not use the social media site; possibly older adults. Additionally, the online study did not allow for prompts from the researcher or answers to be followed up and, therefore, missed the opportunity to gain further detail. Future qualitative research could utilise a more interactive approach, while maintaining anonymity through blogs or discussion forums, or a large-scale quantitative survey would enable some of the ideas identified in this study to be mapped across a wider population. Second, the sample was predominantly female with only a small number of men taking part. Further research is needed which specifically targets men who self-harm as these remain a neglected population and may provide some novel insights into both the function of self-harm for men and how this function may relate to help seeking.

To conclude, previous research has emphasised either participants' reasons for self-harm or the barriers to help seeking. The results from this study indicate that these two factors are intricately linked. In particular, it is argued that self-harm is utilised by individuals to manage their private and public selves and can be considered a form of self-regulation. Furthermore, help is only sought, if a number of

thresholds for change are surpassed, and this equilibrium is disturbed. However, if the style and content of this help does not meet the needs of the individual, they may well consider that self-harming is a more satisfactory way to regulate their private selves and return to their old habits. But if help can be offered at the right time, in a non-judgmental way while offering a degree of challenge, then a new equilibrium may be established in which self-harming is no longer deemed to be an effective means to self-care. The balance between self-harming and not self-harming is, therefore, a precarious one. People who self-harm find benefit in their behaviour. Health professionals need to acknowledge this benefit and expect a gradual and fluctuating road to recovery.

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