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Interpersonal, Intrapersonal and Contextual Factors Related to Self-Injury

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Bethan Gray

Doctorate in Clinical Psychology

Lancaster University

Statement of Total Word Count

Section	Main Text	Appendices (Including Title Pages, References, Tables and Figures)	Total
Thesis Abstract	300	-	300
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Empirical Paper	7,997	10,097	18,094
Critical Appraisal	3,868	1,561	5,429
Ethics Proposal	2,599	7,281	9,880
Total	22,758	26,760	49,518

Thesis Abstract

Self-injury is the intentional harming of oneself and can occur either in the presence or absence of suicidal intent. This thesis aimed to gain a better understanding of self-injury within two populations with an increased prevalence: adolescents and young adults, and LGBTQ+ individuals. The terminology of 'self-harm' is used in the systematic literature review to reflect the language used by participants in the original studies, while 'self-injury' is used to operationalise the outcome measure in the empirical paper.

Section one reports a qualitative systematic literature review of LGBTQ+ individual's experiences of self-harm. Five databases were systematically searched, resulting in nine papers from eight studies being included in the review. A meta-ethnographic approach discovered four main themes: discrimination, making sense of self-harming, experiences underlying self-harm engagement, and a developing identity. The discrimination faced by LBGTQ+ individuals due to existing in a heteronormative and cisnormative society was explored as central to the experience of self-harm in this population.

Section two describes an empirical study investigating thwarted belongingness, perceived burdensomeness and fear of self-compassion as predictors of the urge to self-injure in adolescents and young adults. This cross-sectional study invited participants aged 16 to 25 (N=127) who experienced thoughts or urges of self-injury in the past six months to complete an online survey. Regression analysis found that only participant age and perceived burdensomeness significantly predicted the urge to self-injure in the final model. This adds to the existing body of research showing that perceived burdensomeness predicts suicidality by extending these findings to self-injury. Implications for clinical practice and suggestions for future research are made.

Section three is a critical appraisal which explores the decisions made during the research process, the considerations explored regarding the appropriate use of language, and the power that language holds in these research fields. Associated clinical implications are explored.

Declaration

This thesis contains research conducted for the Doctorate of Clinical Psychology at the Division for Health Research at Lancaster University. The work presented here is the author's own except where due reference is made. The work has not been submitted for the award of any higher degree elsewhere.

Name: Bethan Gray

Signature: BGray

Date: Monday 11th March 2024

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Section One: Systematic Literature Review

Experiences of LGBTQ+ People Who Self-harm: A Meta-ethnography

Bethan Gray

Doctorate in Clinical Psychology

Division of Health Research

Lancaster University

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Excluding references, tables, figures and appendices

All correspondence should be addressed to:

Bethan Gray

c/o Doctorate in Clinical Psychology

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4AT

b.gray3@lancaster.ac.uk

Prepared in accordance with guidelines for authors for: *Psychology & Sexuality* (Appendix 1-A)

Abstract

Self-harm is the deliberate infliction of harm to oneself, and is a predictor for future suicide attempts and completed suicides. LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and any other minority gender or sexual identity) individuals are at a higher risk for self-harming behaviours. This meta-ethnography presents a synthesis of the qualitative research on LGBTQ+ individuals' experiences related to self-harming. Nine papers met the inclusion criteria, and four themes were identified: discrimination, making sense of self-harming, experiences underlying self-harm engagement, and a developing identity. Within the themes, the complexities of navigating a heteronormative and cisnormative society were explored. Facing discrimination due to perceived difference, a lack of positive representation, limited or lacking education related to LGBTQ+ identities, and social rejection from family and peers all were deemed to have a significant negative emotional impact on LGBTQ+ individuals. Clinical implications are considered, and recommendations for future research are made.

Keywords: self-harm, systematic review, gender identity, sexual orientation

Self-harm is any self-injury or self-poisoning, irrespective of motivation (NICE, 2022). Therefore, acts of self-harm include suicide attempts, as well as behaviours where there is no intent to end one's life or where the intention is unclear. Self-harming behaviours are a significant predictor of both suicide attempts and completed suicides (Hawton & Harriss, 2007; McManus et al., 2019), with higher frequencies of self-harm increasing the risk of suicide attempts (Griep & MacKinnon, 2022). Self-harm is highly prevalent in society, with around 200,000 hospital attendances for self-harm presentations each year in the United Kingdom (Geulayov et al., 2019). The lifetime prevalence of non-suicidal self-injury (NSSI), a specific type of self-injury to the skin, which does not include self-harm with suicidal intent or instances of self-poisoning, is estimated at 7.3% (McManus et al., 2019), making self-harm a highly prevalent phenomenon in society.

Certain groups have been shown to be at a higher risk for self-harm than others. Minority identities have been highlighted as one population with an increased risk of self-harm. The lifetime prevalence of self-harm is elevated in sexual (30%) and gender (47%) minorities, compared to heterosexual/cisgender peers (15%) (Liu et al., 2019). Furthermore, research suggests LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and any other minority gender or sexual identity) individuals have a higher risk of suicide and suicidal behaviours than their heterosexual peers (Miranda-Mendizábal et al., 2017). The increased risk of self-harm in this population warrants further exploration to increase understanding of the processes that underlie these experiences.

Meta-synthesis of the experiences of young people who self-harm highlighted that self-harm is used to cope and make life feel manageable in the face of overwhelming emotions, and feeling judged by others (Lindgren et al., 2022). This aligns with previous evidence that the function of self-harm for many is to regulate distressing emotional states (Taylor et al., 2018), such as feelings of shame (Brown et al., 2022; Sheehy et al., 2019). The experience of shame is highly prevalent in LGBTQ+ populations (McDermott et al., 2015), often due to feeling judged for being different or 'outside of the norm' (Alexander & Clare, 2004). Furthermore, the risk of self-harm engagement may be higher

for certain populations within the LGBTQ+ umbrella. A recent study highlighted that identifying as an LGBTQ+ female, non-binary, or transgender individual is a risk factor for self-harm and suicide (Jadva et al., 2023), with transgender and non-binary individuals being four times more likely to report self-harming behaviours. Therefore, while distressing emotional states and shame are not exclusively experienced by LGBTQ+ individuals, there is a social element to the risk factors for self-harm in this population, which may be related to experiences of discrimination and homophobia faced by the LGBTQ+ community.

The Interpersonal Theory of Suicide (ITS; Joiner, 2005; Van Orden et al., 2010) has received much interest as an explanatory theory of both suicide and self-harm. The ITS suggests that the desire to harm oneself emerges on the basis of two interpersonal constructs – thwarted belongingness and perceived burdensomeness. Thwarted belongingness is related to feelings of social isolation, loneliness and an absence of reciprocal care, all of which can be experienced by LGBTQ+ individuals due to their perceived difference by others and social rejection. Perceived burdensomeness is an evaluation of oneself as having a negative impact on others. Thwarted belongingness and perceived burdensomeness are proposed to influence suicidal desire and the desire to harm oneself, while acquired capability (i.e., a reduced fear of death and increased pain tolerance) increases the risk of suicide attempt. Self-harm has been proposed as one method by which the acquired capability of an individual may increase, as engagement in self-harm may influence an individual's appraisals of pain (Smith et al., 2010). While the ITS has been well-evidenced across populations and age groups, there is a comparative lack of literature exploring the ITS within the LGBTQ+ population (Ma et al., 2016). The model also results in significant unexplained variance when employed with LGBTQ+ populations (Silva et al., 2015), suggesting the ITS does not fully explain the experience of LGBTQ+ individuals and that there are other factors which underlie engagement in self-harm within this population.

An alternative theory which explores factors which may impact LGBTQ+ mental health and self-harm engagement is the Minority Stress Theory (MST; Meyer, 2003). The MST was developed based on sexual minority experiences, with the idea that this group faces unique stressors related to their identity. The MST proposes that the discrimination, violence and victimisation that stem from a pervasive homophobic culture are a primary driver for poor mental health and suicidality in sexual minority populations. Research supports the MST, evidencing LGBTQ+ experiences of discrimination throughout their lives related to their sexual and gender identity, including discrimination from family, friends and peers, violence (Meyer et al., 2021), microaggressions (Nadal et al., 2016) and an increased risk of experiencing chronic stressors such as poverty or homelessness (Frost et al., 2019). Discrimination has also been shown as a risk factor for self-harm in gender minority populations (Bird et al., 2024). Therefore, there are unique experiences related to LGBTQ+ identity which impact self-harm engagement.

One such experience which significantly impacts LGBTQ+ individuals is stigma (Meyer, 2003), the situation whereby individuals are "disqualified from full social acceptance" (Goffman, 2009, p. 154). Structural stigma (Link & Phelan, 2001) is proposed to inform societal and cultural norms, influencing government policies, the opportunities available and accessible, and the resources available to stigmatised groups (Corrigan et al., 2004; Link & Phelan, 2001). Structural discrimination reinforces processes such as shame and concealment, which build internalised stigma and are related to poorer mental health and wellbeing (Pachankis, 2007; Pachankis, Hatzenbuehler, Hickson, et al., 2015; Pachankis et al., 2014). These findings align with the MST, which explores the roles of internalised stigma as leading to the individual rejecting all or parts of themselves and potentially hiding parts of their identity in order to cope with the expectation of discrimination (Pachankis et al., 2020). These stressors, therefore, combine to create an extra stress burden experienced by minority individuals, putting these groups at greater risk of adverse physical and mental health outcomes (Flentje et al., 2020).

The current evidence and theories suggest specific mechanisms and risk factors for LGBTQ+ engagement in self-harming behaviours. However, a review of the experiences LGBTQ+ population would allow exploration of how LGBTQ+ individuals experience and make sense of these factors in relation to both their identity and engagement in self-harming behaviours. Therefore, exploring what feels central and important to LGBTQ+ individuals will allow a better understanding of self-harm behaviours within this group. A meta-ethnographic approach will allow for an in-depth exploration of the experience of LGBTQ+ individuals, building on existing research and theory to further our understanding of self-harm in this population (Seers, 2015).

Aims

The following review aims to explore and synthesise qualitative research exploring the experiences of LGBTQ+ individuals who self-harm.

Method

Design

A meta-ethnographic approach was employed to allow for the expansion of conceptual knowledge regarding the experiences of LGBTQ+ individuals who self-harm (Sattar et al., 2021). Meta-ethnography is both inductive and interpretative, meaning the research explores topics through the perspectives and experiences of those involved in the research (Luong et al., 2023). Meta-ethnographic approaches are widely used in health research (France, Uny, et al., 2019; Sattar et al., 2021). A meta-ethnographic approach allows bringing further understanding than what is present in the primary studies (Campbell et al., 2012; France, Cunningham, et al., 2019; Noblit & Hare, 1988). The eMERGe meta-ethnography reporting guidelines were used to guide the reporting of the review (France, Cunningham, et al., 2019).

Search Strategy

Scoping searches identified an existing body of literature on self-harming experiences within LGBTQ+ individuals, enabling the review question to be formed. The protocol for the meta-synthesis

was pre-registered on PROSPERO (ID: CRD42023422335). The primary review question to be addressed was, “What is the experience of LGBTQ+ individuals who engage in self-harming behaviours?”. This indicated three search strings: self-harm, LGBTQ+ identity, and qualitative methodology. A highly sensitive search strategy was co-designed with the support of an academic librarian at Lancaster University. The following databases were searched: PsycInfo, CINAHL, MEDLINE, LGBT+ Source, and SocINDEX. An example of the search strategy can be found in Table 1.

[Table 1-1]

The search was conducted in May 2023, identifying 518 papers. Duplicate papers were removed, then the remaining papers were screened using title and abstract to establish relevance. Finally, the remaining papers were obtained and reviewed for eligibility according to inclusion and exclusion criteria. An alert was set up within the databases which provided updates of any new articles which would be identified by the original search between the dates of May 2023 and October 2023, of which there was one; however, this paper was excluded as it was not written in English. A PRISMA diagram (Page et al., 2021) illustrating this process can be seen in Figure 1.

[Figure 1-1]

Inclusion/Exclusion Criteria

To be included papers were required to:

1. Use qualitative methodologies for data collection and analysis, and include participant quotes so that experiences of the participants could be understood
2. Explore self-harming thoughts and/or behaviours
3. Exclusively include individuals identifying as LGBTQ+
4. Be written in English

Papers were excluded if they contained:

1. An exploration of suicidality only (including suicidal behaviours)

2. Mixed-methods, or studies that did not employ a qualitative method of data analysis

Study Characteristics

Studies were carried out between 2004 and 2023. Five studies were conducted solely in the UK, one in the USA, and one included participants from the UK, USA and Israel. Two studies were completed online using excerpts from blogs and discussion forums, meaning it was not possible to report certain demographics on the participants in these studies, including participant location (McDermott, 2015; McDermott et al., 2015). Six studies were completed with under 25-year-olds, with the remaining three studies including participants ages 18 to 50 years old. Studies included a range of gender and sexual identities, with two studies presenting minority gender identity experiences of self-harm (non-binary and transgender identities), two presenting sexual minorities experiences (lesbian, gay, and bisexual identities), and three including a mixed sample of both participants with gender and/or sexual minority identities. Five studies conducted interviews, two completed a combination of interviews and focus groups, and two extracted data from online blogs and forums. Five studies employed thematic analysis, one used interpretative phenomenological analysis, one grounded theory, one directed content analysis and one Foucauldian discourse analysis. Study characteristics are shown in Table 2.

Two papers used data from the same data pool (McDermott et al., 2008; Scourfield et al., 2008), however, as they included unique participant quotes and interpretations, both papers were included in this review.

[Table 1-2]

Quality of the Selected Studies

Study selection in meta-ethnography is guided by the available literature (Noblit & Hare, 1988); therefore, studies were not excluded based on methodological quality. However, it remains important to consider the quality of the research being reviewed, and to use quality appraisal tools which focus on methodological strength (Long et al., 2020).

To evaluate the quality of the included studies, the Critical Appraisal Skills Programme (CASP) tool was used (CASP, 2018). The CASP tool provides a standardised approach for appraising the quality of qualitative studies for metasynthesis, and has been endorsed for qualitative studies by Cochrane and the World Health Organisation (Noyes et al., 2018). The CASP tool provides a framework for exploring the strengths and limitations of different methodological aspects of a study, scoring the prompts with “yes”, “can’t tell” and “no” to appraise the quality and transparency of the study. The CASP rating for each study can be seen in Table 3.

[Table 1-3]

The quality appraisal process allowed the reviewer to reflect on the quality of the papers in the review. Of note, only two papers reported on the relationship between the researcher and the participant (CASP tool question 6) (Gosling et al., 2022; Williams et al., 2023). This highlighted the importance of considering the original data as both level one and level two data, as detailed in the Data Synthesis below, prior to creation of level three data as the reviewer could not be aware of the lenses through which the original authors interpreted the data.

Data Synthesis

In line with the theoretical position of meta-ethnography, the data in this review was perceived as both authors’ interpretations and participant quotes. Meta-ethnography considers data on three levels: participant interpretations, understanding and experiences (level one); author (of the original paper) interpretation and understanding of the data (level two); and reviewer’s understanding and interpretation of the first two levels, creating a third order, or higher order, construct (Noblit & Hare, 1988).

In a meta-ethnographic approach, the data from each paper in the review is read and considered alongside each other. Meta-ethnography allows reciprocal (similar) or refutational (opposing) understandings to be drawn from the papers reviewed (France, Uny, et al., 2019). The reciprocal data in the papers reviewed is translated into each other, while refutational data is

explored and discussed, which allows the meta-ethnography to create a line of argument which considers and discusses aligned and opposing views and experiences from the original research. This allows the reviewer to incorporate their own understanding of what the data shows, and what might be unclear from the existing body of literature.

This synthesis followed the seven steps of meta-ethnography, as originally described by Noblit and Hare (1988): getting started, deciding what is relevant to the initial interest, reading the studies, determining how the studies are related, translating the studies into each other, synthesising translations, and expressing the synthesis. These steps were followed alongside the guidance written by Sattar et al. (2021).

All data relating to the review question was extracted from the studies into a table. One column included participant quotes (level one data), alongside a column with author identified themes and key findings (level two data). Quotes were extracted verbatim to preserve original terminology used, and reduce the risk of losing important meaning (Sattar et al., 2021). Themes relating to the LGBTQ+ experience of the COVID-19 pandemic specifically were not included in the analysis, as they did not pertain to the research question, which applied to two papers: Gosling et al. (2022) and Dunlop, Hunter, et al. (2022). A third column was added for notes and interpretations of the level one and level two data, creating level three data, or third order constructs, which capture the key aspects of the original participants' experiences. An example of data extraction can be found in Appendix 1-B. To improve rigour, two papers were selected at random to be reviewed by a colleague external to the research team. The concepts (level three data) generated by the external researcher were compared to the primary authors' extracted concepts, and a high level of similarity was found.

A list of emerging themes was developed by noting shared concepts from the third level data. At this stage, the concepts were group and re-grouped to explore the best way to represent the third level data. Following supervision from research supervisors (Thomas & Harden, 2008), four

overarching themes and two sub-themes were developed. An overview of how the papers contributed to the themes can be found in Table 4.

[Table 1-4]

Findings

The gender and sexual identities of participants varied across studies; however, the focus of all studies was related to LGBTQ+ individuals' experience of, and experiences related to, self-harm. In synthesising the nine papers, four interrelated constructs were established: (1) discrimination, (2) experiences underlying self-harm engagement, (3) making sense of self-harming, and (4) a developing identity.

[Figure 1-2]

The model in Figure 1-2 illustrates the relationships between the themes. The theme of discrimination was related to both LGBTQ+ identity and self-harm. Making sense of self-harming was related to experiences underlying self-harm engagement, as identifying what led to self-harm was often part of this process. Making sense of self-harming and a developing identity were related, as the meaning of self-harm was different across the sub-themes. The sub-themes of discovering difference, self-acceptance and finding community were related as ongoing and non-linear processes, as individuals gained new knowledge and experiences.

Theme 1: Discrimination

Discrimination was present throughout all themes explored in this review. Discrimination is understood in this theme as unjust treatment or prejudice against an individual or group due to their identity (Equality Act 2010). Discrimination due to LGBTQ+ identity was discussed as a shared experience within the LGBTQ+ community, present throughout different aspects and stages of life, in different ways.

Discrimination was often named as the core reason for self-harming. Discrimination was felt to underlie adverse experiences, which were perpetrated by others due to stigmatisation of LGBTQ+ identities. Discrimination was discussed as to be expected in daily life, and the acts of homophobia, victimisation and abuse aimed towards LGBTQ+ individuals were often minimised, “I got bottled actually in a homophobic attack and, eh, ended up in hospital a few years ago which is nothing you know really serious, plenty of people get bottled anyway … (laughs)” (McDermott et al., 2015, p. 822).

Some individuals spoke about receiving discrimination from their family following “coming out”, including being evicted from the family home and being a victim of verbal and physical abuse (Jackman et al., 2018). There was a sense for some that even when family members were not directly discriminating against them, they did not fully accept their gender and sexual identity: “Sometimes still with my family, especially with my mum, even though I feel that she accepts that I’m gay she still tries to get me to be someone that I’m not” (Williams et al., 2023, p. 387). This lack of acceptance led to some participants withholding expression of their identity from their family, for fear of rejection or judgement (McDermott et al., 2015).

Discrimination from peers was discussed as having a strong impact on emotions, and causing an invisible pain that was difficult to name or manage, often leading to self-harm, “people are harming me in more abstract ways therefore I deserve to be harmed in a more concrete way” (Gosling et al., 2022, p. 351).

Some individuals felt there was a choice regarding whether to put themselves at risk of discrimination, or to “pass” as within the norm (Goffman, 2009): “I’m either gonna have to hide it and be miserable or be out and face discrimination.” (Gosling et al., 2022, p. 354). However, for others the discrimination was inescapable as this was experienced regardless of how they presented (McDermott et al., 2008).

Discrimination was also present from within the LGBTQ+ community, most notably aimed towards bisexuals in the papers reviewed. Bisexual identities faced unique discrimination and exclusion:

> I've seen like, groups that have been tried to be set up, like, LGT groups, that just completely miss out the B … there are some members of the gay community that think that bi people are just closeted and, and it's homophobic of them not to just come out as gay. (Dunlop, Hunter, et al., 2022, p. 760)

An additional complexity of intersecting marginalised identities was explored by some participants, whereby some instances of discrimination were attributed to other marginalised identities such as race (Dunlop, Hunter, et al., 2022; Gosling et al., 2022). For some this intensified their feelings of difference and led to feelings of isolation, as there were multiple differences from others, "It was just kind of the feeling that I'm just innately different from everyone else […] and other people are never going to understand me." (Gosling et al., 2022, p. 352).

Ultimately, the persistent discrimination led to individuals feeling dehumanised, and to an internalisation of this poor treatment of themselves. For some, this gave permission to self-harm: "when I started to lose respect for my body, and I gained so much insecurity… I took it out on my body." (Gosling et al., 2022, p. 351). This highlights the depth of the impact of discrimination, and how this can affect how an individual feels towards themselves.

Theme 2: Making Sense of Self-harming

There was a theme of participants creating narratives and understandings of their engagement in self-harming and seeking ways to make sense of this. For many, self-harm was a way of coping with difficult emotions or feelings they had about themselves (Alexander & Clare, 2004; Gosling et al., 2022; McDermott, 2015). Self-harm was described as an "outlet" (Gosling et al., 2022, p. 355), and as often being a result of the emotional impact of discrimination and homophobia:

> I was a right mess, I couldn't move some days, I just felt like, argh, and then I started cutting myself on my arm and I was just a mess. I was upset because of the way people were with me because I was gay and it just aggravates me so much. (McDermott et al., 2008, p. 821).

For some, engagement in self-harm became routine, relied upon in times of need. This led to feelings that self-harming was addictive or a habit which was hard to break: “I think harming yourself becomes a habit, and that’s the worst thing about it, that it becomes a habit even when you don’t want it to.” (Alexander & Clare, 2004, p. 80).

One aspect of making sense of self-harming which varied across papers, was the relationship between self-harm and LGBTQ+ identity. Many individuals talked about accepting their identity, and even finding this a positive in their life. For some, it was important to clarify that self-harm was not due to having an LGBTQ+ identity, “I’ve attempted suicide many times and have mutilated myself in the past for much of my school days. but it IS NOT because i’m gay. if anything being gay makes me happier.” (McDermott et al., 2015, p. 881). For others, there was a connection between LGBTQ+ identity and self-harming, “it was again a form of punishment for me because I genuinely thought that what I was feeling was sinful and that I needed to get it out for me.” (Williams et al., 2023, p. 385).

Building a narrative about why they engage in self-harming behaviours helped LGBTQ+ individuals to make sense of their engagement in the behaviour; however, there were some differences in the ways in which people made sense of their self-harm. Making sense of self-harming was related to the theme of ‘experiences underlying self-harm engagement’, as for some, understanding what led to their self-harming helped to build their narrative of their engagement these behaviours.

Theme 3: Experiences Underlying Self-harm Engagement

In exploring their experiences of self-harm, experiences which led to self-harming behaviours were discussed. Discrimination was explored as a proximal and distal trigger for self-

harm, including social rejection, bullying, victimisation and abuse (Gosling et al., 2022; McDermott et al., 2015; McDermott et al., 2008; Williams et al., 2023). It was felt by participants that the discrimination experienced stemmed from LGBTQ+ identities being perceived as 'different' by others in society (McDermott et al., 2015; Scourfield et al., 2008). Additional adverse experiences not related to the individuals sexual and gender identities were also explored. The emotional impact of these experiences was suggested as the core reason and recurring trigger for many LGBTQ+ individual's engagement in self-harm.

Sub-theme 1: Adverse Experiences

Participants talked about adverse experiences which they perceived to not be related to their gender and sexual identity, such as physical and sexual abuse in their childhood (Alexander & Clare, 2004; Gosling et al., 2022; Williams et al., 2023). It was reflected that these experiences felt related to current self-harming behaviours, "I definitely think that if I hadn't been abused it's very unlikely that I would be a self-harmer." (Alexander & Clare, 2004, p. 74).

For some, experiences of abuse left an emotional impact that was difficult to process, bringing up difficult and unwanted emotions. Self-harm was one method of coping with these emotions that was discussed, "My problem was trauma. But it wasn't self-harm, self-harm was the way I dealt with it." (Williams et al., 2023, p. 388). For others, despite their engagement in self-harm to cope with their emotions, the experience of adverse events led to determination and strength. Some shared that following adverse experiences they felt a will to keep going, "Um like I said I got attacked, it just made me stronger to get through." (Scourfield et al., 2008, p. 331).

Difficult experiences in relationships were discussed, including violent and abusive experiences. For some, this made it difficult to trust others, as they worried about either experiencing memories of past abuse or being vulnerable to further abuse (Alexander & Clare, 2004). For some, adverse experiences and abuse were minimised or trivialised by others. This led to

LGBTQ+ individuals feeling they were not able to seek support. One participant spoke of how they felt support was not available in domestic violence situations where the perpetrator was a female:

> Sometimes you were really invisible, especially if you were a dyke, it's like 'it's only a woman that slapped you for gods sake, it's not a man', but at the end of the day, a slap is a slap, a kick is a kick. I just wanted someone to say 'oh god are you okay?' (Alexander & Clare, 2004, p. 76)

The emotional impact of these adverse experiences is amplified for LGBTQ+ individuals who feel their needs for support are not met due to feeling support is either not accessible or available because of their identity.

Additional difficult enduring experiences were discussed, such as high levels of academic pressure, carer responsibilities from a young age, and physical disabilities and illnesses which had a significant impact on the individuals life (Williams et al., 2023).

Sub-theme 2: Outside the 'norm'

Feeling different and being treated as different were common themes explored, which individuals felt was due to being outside of the social 'norm' of a heteronormative and cisnormative society. Being perceived by others as different, and the associated discrimination, was named as a trigger for self-harming.

The act of "coming out" or naming themselves as different from others was discussed. This is a process by which LGBTQ+ individuals are repeatedly required to position and articulate themselves as being outside of heteronormative society in order to share their identity. The process of coming out was fraught with anxiety and fear around being met with rejection, judgement, non-acceptance of their sexual and/or gender identity. This fear prevents many LGBTQ+ individuals from sharing their sexual and gender identity with others. A consequence of this, is that it prevents LGBTQ+ individuals from accessing key services and healthcare, "I'm at the point where I need to go to a

doctor and see about getting something to help with the anxiety. But at the same time, I'm terrified of coming out, terrified of being disowned, ignored, hated" (McDermott, 2015, p. 568). This led to an additional emotional burden, which increased the need for support. Even if support services offered anonymity, the fear and anxiety continued to be a barrier to access, "I want to call a helpline but I just can't bring myself to pick up a phone" (McDermott, 2015, p. 568).

For some, the feeling of being different was internalised, as they became aware that there was a social 'norm' which they were not a part of, which led to feeling something was wrong with them or they were not "good enough" (McDermott, 2015). This was discussed as particularly prevalent during the key formative years of secondary school:

> "Even if you're ok with your sexuality and things, the way things work, especially during educational years is that if you don't conform [...] even if you're ok with being gay, you're still different, you still feel different." (Alexander & Clare, 2004, p. 77)

As heteronormative and cisgender identities are presented as the 'norm' in society, this can lead to LGBTQ+ individuals feeling they do not fit in and are not fully accepted: "Not only did I not belong in this place of work or in this friend group but also that I didn't belong *anywhere*." (Gosling et al., 2022, p. 353).

Theme 4: A Developing Identity

Identity was a key concept throughout the individual's experiences. Identity was discussed in terms of gender and sexual identity, but also in terms of developing independence and an adult identity (McDermott et al., 2008). The idea of identity was discussed as something which required support, resources and self-understanding to be properly developed, which was explored as a process which may happen over time for some, or may happen suddenly given access to the right information. Identity was also explored as something individuals worked to accept, often following experiences of others not accepting them.

Sub-theme 1: Discovering Difference

For many individuals, developing an understanding of their sexual and gender identity was dependent on the availability of information and knowledge around these topics. It was recognised that to understand their gender and sexual identity, participants often had to seek out other ways of being than the heteronormative view of relationships: “I think that was very much there but I probably I didn’t have the terminology to understand erm, myself or that you could have a life anything other [than heteronormative relationship]” (Williams et al., 2023, p. 384).

For many, a lack of education or knowledge around LGBTQ+ identities meant that they were left with uncertainty about how to understand or express what they were feeling, as gender and sexual identities were not discussed in accessible forums, such as in school settings or by families and peers. This led to many LGBTQ+ individuals lacking the language to describe their internal experiences:

> The word trans was not something I heard until I was like 20 so, erm I didn’t think it was a possibility and I didn’t really connect me not liking my male body to me wanting to be a girl. (Williams et al., 2023, p. 384)

Discussed particularly by non-binary and transgender participants, dissatisfaction or gender dysphoria related to their physical appearance was a difficulty during the initial stages of building an understanding of their gender identity. This could be particularly poignant during puberty, as bodies start to present as more physically male or female: “As my body started to change, I started to feel like it… didn’t represent who I was anymore.” (Gosling et al., 2022, p. 349)

A lack of resources, visible role-models, and social groups led some feeling alone with how they were feeling. The idea of “confusion” is contentious within the LGBTQ+ community, as there is a stigma around young LGBTQ+ individuals especially being “confused” about their identity and who they are, and an assumption they will revert to conforming to the heterosexual and cisgender norm. This narrative was challenged in the studies reviewed, whereby the confusion felt by LGBTQ+ was

around not having the words to articulate their true feelings, rather than being confused about who they were and their gender and sexual identity:

> … it can be such a confusing process for people coming out, and there are still, and especially in the past, have been so few resources for trans youth and people who are struggling or people who do not exist within the kind of classic narrative […] Like, people who exist outside of that narrative also have so few resources and so little understanding of their experiences that, like, I think that self-harm feels like a logical place to turn when you do not feel like you have a community or support. (Jackman et al., 2018, pp. 591-592).

Sub-theme 2: Self-acceptance

Developing self-acceptance and the ability to feel proud of their identity was a process which was discussed. Discovering the range of gender and sexual identities which exist was discussed as a positive experience which allowed people to find ways of explaining how they felt and who they were: "It was nice to have the words to describe myself." (Gosling et al., 2022, p. 350). Developing a sense of pride and acceptance was discussed as positive for the mental health of LGBTQ+ individuals (Dunlop, Hunter, et al., 2022). This pride and acceptance of their gender and sexual identities was a protective factor for self-harm for some: "Self-harm has become less prevalent in my life since I've become more aware of my own gender identity and become more comfortable with it." (Gosling et al., 2022, p. 358).

Sub-theme 3: Finding Community

A key aspect of developing an LGBTQ+ identity was finding a community likeminded and accepting individuals. Participants searched for others who understood their experiences, and it appeared this was an important aspect of developing an LGBTQ+ identity for many. Even if individuals had supportive friends and family, finding a community of LGBTQ+ peers was important:

> And now I have a whole group of friends who actually understand now what being trans is. Even if my friends try to, like, understand I'm like, "You guys are cis[gender]. You don't

> understand." . . . So now I have trans friends who actually know what life is like, what's going on and how things are. (Jackman et al., 2018, p. 593)

Finding a community of LGBTQ+ peers allowed individuals to seek out positive representation and role-models who modelled the positive impact of self-acceptance:

> When I started to meet more queer people, and see that people could live happy lives and be queer, more specifically live happy lives and be bisexual, that like helped me to sort of come to terms with the fact that … it was OK if I dated a girl, it was OK if I pursued that side of myself (Dunlop, Hunter, et al., 2022)

In instances where it did not feel safe to seek out community in-person, or this community was lacking, many LGBTQ+ individuals chose to access an online support community (McDermott, 2015; McDermott et al., 2015).

Involvement in LGBTQ+ communities also allowed fostering of hope for change through involvement in politics and activism. This allowed people to act on their beliefs that the social environment and attitudes of society require challenging and changing to allow LGBTQ+ individuals to face less discrimination. Some individuals felt motivated to be involved in this change following their own experiences (Gosling et al., 2022), which allowed them to be involved in community activities, and in protecting their community and its values of inclusivity.

Discussion

This review explored the experiences of LGBTQ+ individuals who engage in self-harming behaviours. In synthesising nine papers, key constructs were identified as discrimination, making sense of self-harming, experiences underlying self-harm engagement, and a developing identity. Discrimination was central to the participants' experiences, often being the trigger for self-harming behaviours, and was present in all other themes. Participants noted other experiences underlying

self-harm engagement as adverse experiences and being outside of the heteronormative society in-group, both of which were intensified due to the accompanying discrimination.

In developing an understanding of their self-harming and of their own identity, participants developed narratives and beliefs about their identity and behaviours. The development of an understanding of their identity was impacted by access to knowledge and positive representation of LGBTQ+ identities. While LGBTQ+ inclusive representation is increasing (Cheng et al., 2023), the process of navigating identity for participants in the review was fraught with difficulty expressing what they were experiencing and feeling, indicating that further support is required. Participants described once they acquired the language for different sexual and gender identities, they were more able to develop self-acceptance. The process of developing self-awareness into self-acceptance is experienced by many LGBTQ+ individuals (King et al., 2020). As seen in this review, the process of developing an LGBTQ+ identity and self-acceptance is interlinked with connecting with the LGBTQ+ community. Connecting with a supportive group of others who have shared understanding relating to the experiences of LGBTQ+ identity facilitates self-acceptance (Legate & Ryan, 2014); however, this was not available to everyone, with some feeling they faced discrimination from within the LGBTQ+ community.

The review highlights discrimination as a key factor in LGBTQ+ experiences of self-harm and noted that this discrimination is extremely distressing at times. These findings align with statistics showing that 36% of young LGBTQ+ individuals experience victimisation such as bullying, which is 3.74 times more frequently than their cisgender heterosexual peers, and this victimisation is linked with both self-harming and suicidality (Williams et al., 2021). Discrimination being found as a central factor impacting mental health also aligns with the Minority Stress Theory (MST; Meyer, 2003).

The MST highlights that gender and sexual minorities are at an increased risk of discrimination due to being different than dominant societal norms, which aligns with the findings of this review. Methods of coping were discussed by participants, such as concealment versus

disclosure, the debate of whether to be outwardly themselves and face associated discrimination or conceal their identity with the aim of reducing the discrimination faced. However, both concealment and disclosure of LGBTQ+ identity have been shown to risk further distress for the individual, either due to a lack of authenticity related with concealment (Christie, 2021; Riggle et al., 2017), or by an increased risk of discrimination (Camacho et al., 2020). On the other hand, disclosure which is received positively can facilitate an increase in social support and belonging (Camacho et al., 2020). Therefore, concealment may be a barrier to LGBTQ+ individuals finding community and receiving social support. This highlights a key conflict experienced by LGBTQ+ individuals in navigating whether to share their identity with others, and the associated emotional and social implications.

Being outside the ‘norm’ was explored as a trigger for self-harming behaviours. In the current review, feeling outside of the ‘norm’ was commonly attributed to having an LGBTQ+ identity. This theme relates to feeling different than others, and as such, may be linked to the concept of thwarted belongingness described by the Interpersonal Theory of Suicide (ITS; Joiner, 2005; Van Orden et al., 2010). Research shows that thwarted belongingness is a common experience for LGBTQ+ youth who are ostracised during their education due to their perceived difference (Garcia et al., 2020), leaving these youth feeling isolated from peers. The experience of social isolation is highly related to self-harm (Garcia et al., 2020), highlighting the impact of feeling one does not belong within society.

A protective mechanism against the effects of thwarted belongingness may be related to the theme of finding community, as connecting with the LGBTQ+ community has been shown to foster resilience and increase social support (Meyer, 2015). However, social support is a complex issue for LGBTQ+ individuals, with recent research suggesting that social relationships can be both a source of resilience and hardship, simultaneously (Bartoș & Langdridge, 2019). Furthermore, some individuals feel excluded from LGBTQ+ groups and communities (McCormick & Barthelemy, 2021), as was noted as being experienced by some bisexuals in the current review. This highlights that while finding

likeminded peers was recognised as important for building connectedness and belonging, this can be a complex process to navigate.

Implications for Clinical Practice

The sub-theme of feeling outside the norm was identified as a barrier for LGBTQ+ individuals accessing services. Healthcare services are often perceived as unsafe by LGBTQ+ individuals due to fear of judgement and stigmatisation, resulting in delayed access to care (Macapagal et al., 2016) or not accessing services (Gonzales & Henning-Smith, 2017). LGBTQ+ individuals report feeling invalidated when seeking support from health professionals for self-harm, leading to further self-harming behaviours and a resistance to seeking further support (Alexander & Clare, 2004). Therefore, there is a need for improved care for this group.

To improve the support offered to LGBTQ+ individuals accessing health and social care, additional training is needed to reduce stigma and increase staff competence and understanding regarding the complex experiences of LGBTQ+ individuals. Mental health specific training for staff across health and social care should include information on the current theories of mental health for LGBTQ+ individuals, such as the Minority Stress Theory (Meyer, 2003). Training should also cover the contextual factors and experiences which may influence LGBTQ+ individuals feeling safe to access support, such as possible past experiences of judgement, stigma and discrimination from family, peers, wider society, and medical or healthcare professionals (Brandes, 2014). This will allow staff to support LGBTQ+ individuals in feeling understood, and allow staff to challenge any stigma or internalised stigma which may negatively impact the mental and physical health of LGBTQ+ individuals (Mccrone, 2018). Training to develop staff skills and knowledge regarding working in line with the attitudes and approaches of affirmative therapy could support development of a respectful and affirmative care experience for LGBTQ+ clients (Hinrichs & Donaldson, 2017; Travis & Arizona, 2017). Employing an affirmative therapy approach would also support psychologists to be responsive

to the LGBTQ+ experience, and the influences of social inequalities faced by this group on their mental health (O'Shaughnessy & Speir, 2018).

At a societal level, improving connectedness and belonging in LGBTQ+ youth would be an early intervention protective of their mental health (Day et al., 2018). Implementing safe and welcoming spaces within schools and community hubs, and allowing involvement in activism, community outreach and advocacy may facilitate a sense of belonging which protects against poor mental health (Moran, 2023). Connectedness with teachers has been shown as a protective factor for self-harming behaviours (Taliaferro et al., 2019), highlighting this as an important area for focus in improving the support available to LGBTQ+ youth. Therefore, specific targeted support for schools and teachers could form part of an early-intervention plan. Teachers who receive training related to homophobic bullying are more able to address this within their school (O’Donoghue & Guerin, 2017); however, 25% of students who experienced homophobic bullying named a teacher as the bully (Rivers, 2011).

Progress is needed to address both staff and student attitudes. Training provided should encourage an open and accepting attitude towards LGBTQ+ identities, and model non-stigmatising language. Supporting youth to develop their awareness of LGBTQ+ identities (Thorne et al., 2020) could be delivered as a teaching session to students. However, teachers may feel deskilled or that they lack knowledge around this topic, as it has only recently been mandated onto the curriculum in England (Department for Education, 2019). Therefore, an interactive training format, or opportunity for consultation, may be more effective than didactic training or online resources as this will allow teachers to engage with the topic and explore any anxieties or specific scenarios of concern (Parsons et al., 2012). Considering the complexity of this topic alongside the recommendation of consultation being made available, training should be provided by clinical psychologists or educational psychologists who have knowledge of the research and experience of working with LGBTQ+ youth (Carr & Miller, 2017).

For clinicians working with LGBTQ+ individuals, it will be important to explore the factors related to self-harm identified in this research and suggested by both the MST and the ITS. Individuals who self-harm often report feeling misunderstood by healthcare staff (Lindgren et al., 2018). Better assessment of self-harm will allow staff to better understand the individual's experiences. Improved understanding of self-harm will allow staff to work more collaboratively and in a person-centred way with LGBTQ+ clients to achieve positive outcomes (Doyle et al., 2017). Formulations and clinical interventions should also consider the role of discrimination and identity, allowing the client to express their own experiences with this and providing compassionate support where required. Early evidence suggests that an affirmative approach such as the ESTEEM model is supportive in combating the effects of minority stress (O'Shaughnessy & Speir, 2018; Pachankis, Hatzenbuehler, Rendina, et al., 2015), however this research is ongoing (Pachankis et al., 2019)

Future Research

Related to the clinical implications, it may be beneficial to undertake research regarding LGBTQ+ individuals views on how to make health and social care settings more approachable and accessible for them. The results of this research may vary by location, as different services may be received differently depending on factors such as commissioning and staff attitudes. Furthermore, this research may be able to include an exploration of what LGBTQ+ individuals feel staff would benefit from further training on, to tailor the training packages in each area relevant to the experiences of current service users.

Strengths and Limitations

The approach of this review embraces the experiential voice of LGBTQ+ individuals, adding a depth of understanding to the experience of self-harm within this population. Including evidence from across the spectrum of LGBTQ+ identities allowed for an exploration of shared experiences, and highlighted experiences which appeared unique to certain gender or sexual identities, such as experiences of biphobia from within the LGBTQ+ community. However, the evidence in this review

was limited in age range, and as policies and social attitudes change over time, the results may not be applicable across the age range and generations of LGBTQ+ individuals.

A limitation of this review is that the studies included were conducted exclusively in the global north, or were unable to report participant demographics due to methodology. There are distinct differences between the global north and south; such as religious beliefs, economies, and government policies and laws, which mean it is not possible to generalise the results of this study across global societies (Odeh, 2010). Furthermore, the review reflects the voices of LGBTQ+ individuals who were willing and able to participate in research. Participation may have been biased by whether the individual has processed or disclosed their LGBTQ+ identity, levels of self-acceptance, and access to participate.

The quality appraisal tool noted that few of the primary researchers discussed their relationship with the topic and with participants, which limited the ability of this review to consider this in the development of third order constructs. In future, research would benefit from researchers reflecting on their relationship with the topic, in order to situate themselves in relation to their research, and therefore allow both the researcher and reader be aware of the relevant lenses and experiences through which the author may have interpreted and understood the data (Darawsheh, 2014).

Reflexivity

It is important to consider the potential effect of the researcher on the project (France, Cunningham, et al., 2019). The main researcher of this paper does not hold an LGBTQ+ identity; however, considers themselves an active LGBTQ+ ally. The researcher has professional experience of supporting LGBTQ+ individuals with self-harm and is motivated to support research to better understand the experiences of LGBTQ+ individuals, and improve healthcare services for this population. This experience with and interest in the topic area may have influenced how the researcher understood and interpreted the data (Braun & Clarke, 2019), as the researcher was

motivated to complete meaningful and impactful research. The methodology of meta-ethnography ensured the voices of the participants were preserved in the review; however, it remained important for the researcher to revisit these positions and engage in supervision to explore any impact of these positions on the analysis.

Conclusion

LGBTQ+ individuals face discrimination due to others perceiving them as different, which has implications for their mental health, identity and impacts engagement in self-harming behaviours. This review contributes to deepening our understanding of the difficulties faced by LGBTQ+ individuals who self-harm, including discrimination, a lack of access to knowledge and information regarding gender and sexual identities, and shared experiences underlying self-harm engagement related to being outside of the societal norms for gender and sexual identity.

References

Alexander, E., Lyne, R., Mottaghi-Taromssari, Y. S., & Lever, I. (2020). The representation of LGBTQ+ people in medical assessment and teaching scenarios. *Future Healthcare Journal*, *7*(Suppl 1), s87.

Alexander, N., & Clare, L. (2004). You still feel different: The experience and meaning of women's self-injury in the context of a lesbian or bisexual identity. *Journal of Community & Applied Social Psychology*, *14*(2), 70-84. https://doi.org/10.1002/casp.764

Bartoș, S. E., & Langdridge, D. (2019). LGBQ resilience: A thematic meta-synthesis of qualitative research. *Psychology & Sexuality*, *10*(3), 234-247.

Bird, K., Arcelus, J., Matsagoura, L., O'Shea, B., & Townsend, E. (2024). Risk and protective factors for self-harm thoughts and behaviours in transgender and gender diverse people: A systematic review. *Heliyon*.

Brandes, A. (2014). The negative effect of stigma, discrimination, and the health care system on the health of gender and sexual minorities. *Tul. JL & Sexuality*, *23*, 155.

Brown, A. C., Latham, C., Danquah, A. N., Dunlop, B. J., & Taylor, P. J. (2022). "Cover up your arms, you're triggering people": A Mixed-Methods Investigation of Shame in those who Self-Injure. *Psychology and Psychotherapy: Theory, Research and Practice*, *95*(3), 701-716.

Camacho, G., Reinka, M. A., & Quinn, D. M. (2020). Disclosure and concealment of stigmatized identities. *Current Opinion in Psychology*, *31*, 28-32.

Campbell, R., Pound, P., Morgan, M., Daker-White, G., Britten, N., Pill, R., Yardley, L., Pope, C., & Donovan, J. (2012). Evaluating meta ethnography: systematic analysis and synthesis of qualitative research.

Carr, E. R., & Miller, R. (2017). Expanding our reach: Increasing the role of psychologists in public and community mental health. *Psychological Services*, *14*(3), 352.

CASP. (2018). *CASP systematic review checklist*. Retrieved from https://casp-uk.net/casp-tools-checklists/

Cheng, Y., Zhou, X., & Yao, K. (2023). LGBT-inclusive representation in entertainment products and its market response: evidence from field and lab. *Journal of Business Ethics*, *183*(4), 1189-1209.

Christie, C. (2021). What is hidden can still hurt: Concealable stigma, psychological well-being, and social support among LGB college students. *Sexuality Research and Social Policy*, *18*, 693-701.

Corrigan, P. W., Markowitz, F. E., & Watson, A. C. (2004). Structural levels of mental illness stigma and discrimination. *Schizophrenia bulletin*, *30*(3), 481-491.

Day, J. K., Perez-Brumer, A., & Russell, S. T. (2018). Safe schools? Transgender youth's school experiences and perceptions of school climate. *Journal of Youth and Adolescence*, *47*, 1731-1742.

Department for Education. (2019). *Relationships, Education Relationships and Sex Education*. Retrieved from https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education

Doyle, L., Sheridan, A., & Treacy, M. (2017). Motivations for adolescent self-harm and the implications for mental health nurses. *Journal of Psychiatric and Mental Health Nursing*, *24*(2-3), 134-142.

Dunlop, B. J., Hunter, C., Shafti, M., Coleman, S. E., Hartley, S., & Taylor, P. J. (2022). 'Why is it so different now I'm bisexual?': young bisexual people's experiences of identity, belonging, self-injury, and COVID19. *Psychology & Sexuality*, *13*(3), 756-773. https://doi.org/10.1080/19419899.2021.1924241

Flentje, A., Heck, N. C., Brennan, J. M., & Meyer, I. H. (2020). The relationship between minority stress and biological outcomes: A systematic review. *Journal of Behavioral Medicine*, *43*, 673-694.

France, E. F., Cunningham, M., Ring, N., Uny, I., Duncan, E. A., Jepson, R. G., Maxwell, M., Roberts, R. J., Turley, R. L., & Booth, A. (2019). Improving reporting of meta-ethnography: the eMERGe reporting guidance. *BMC medical research methodology*, *19*, 1-13.

France, E. F., Uny, I., Ring, N., Turley, R. L., Maxwell, M., Duncan, E. A., Jepson, R. G., Roberts, R. J., & Noyes, J. (2019). A methodological systematic review of meta-ethnography conduct to articulate the complex analytical phases. *BMC medical research methodology*, *19*(1), 1-18.

Frost, D. M., Fine, M., Torre, M. E., & Cabana, A. (2019). Minority stress, activism, and health in the context of economic precarity: Results from a national participatory action survey of lesbian, gay, bisexual, transgender, queer, and gender non-conforming youth. *American Journal of Community Psychology*, *63*(3-4), 511-526.

Garcia, J., Vargas, N., Clark, J. L., Magaña Álvarez, M., Nelons, D. A., & Parker, R. G. (2020). Social isolation and connectedness as determinants of well-being: Global evidence mapping focused on LGBTQ youth. *Global Public Health*, *15*(4), 497-519. https://doi.org/10.1080/17441692.2019.1682028

Geulayov, G., Casey, D., Bale, L., Brand, F., Clements, C., Farooq, B., Kapur, N., Ness, J., Waters, K., & Tsiachristas, A. (2019). Suicide following presentation to hospital for non-fatal self-harm in the Multicentre Study of Self-harm: a long-term follow-up study. *The Lancet Psychiatry*, *6*(12), 1021-1030.

Goffman, E. (2009). *Stigma: Notes on the management of spoiled identity*. Simon and schuster.

Gonzales, G., & Henning-Smith, C. (2017). Barriers to care among transgender and gender nonconforming adults. *The Milbank Quarterly*, *95*(4), 726-748.

Gosling, H., Pratt, D., & Lea, J. (2022). Understanding self-harm urges and behavior amongst non-binary young adults: A grounded theory study. *Journal of Gay & Lesbian Mental Health*. https://doi.org/10.1080/19359705.2022.2073310

Griep, S. K., & MacKinnon, D. F. (2022). Does nonsuicidal self-injury predict later suicidal attempts? A review of studies. *Archives of Suicide Research*, *26*(2), 428-446.

Hawton, K., & Harriss, L. (2007). Deliberate self-harm in young people: characteristics and subsequent mortality in a 20-year cohort of patients presenting to hospital.[CME]. *Journal of Clinical Psychiatry*, *68*(10), 1574.

Hinrichs, K. L., & Donaldson, W. (2017). Recommendations for use of affirmative psychotherapy with LGBT older adults. *Journal of Clinical Psychology*, *73*(8), 945-953.

Jackman, K., Edgar, B., Ling, A., Honig, J., & Bockting, W. (2018). Experiences of transmasculine spectrum people who report nonsuicidal self-injury: A qualitative investigation. *Journal of Counseling Psychology*, *65*(5), 586-597. https://doi.org/10.1037/cou0000304

Jadva, V., Guasp, A., Bradlow, J. H., Bower-Brown, S., & Foley, S. (2023). Predictors of self-harm and suicide in LGBT youth: The role of gender, socio-economic status, bullying and school experience. *Journal of Public Health*, *45*(1), 102-108. https://doi.org/10.1093/pubmed/fdab383

Joiner, T. E. (2005). *Why people die by suicide*. Harvard University Press.

Kapatais, A., Williams, A. J., & Townsend, E. (2023). The mediating role of emotion regulation on self-harm among gender identity and sexual orientation minority (LGBTQ+) individuals. *Archives of Suicide Research*, *27*(2), 165-178.

King, B., McIntyre, C., & Parker, K. (2020). The process of self-acceptance of transgender individuals through narratives and photos. *Journal of LGBT Issues in Counseling*, *14*(3), 228-247.

Legate, N., & Ryan, W. S. (2014). Autonomy support as acceptance for disclosing and developing a healthy lesbian, gay, bisexual or transgendered identity. In *Human motivation and interpersonal relationships: Theory, research, and applications* (pp. 191-212). Springer.

Lindgren, B.-M., Svedin, C. G., & Werkö, S. (2018). A systematic literature review of experiences of professional care and support among people who self-harm. *Archives of Suicide Research*, *22*(2), 173-192.

Lindgren, B.-M., Wikander, T., Neyra Marklund, I., & Molin, J. (2022). A necessary pain: A literature review of young people's experiences of self-harm. *Issues in Mental Health Nursing*, *43*(2), 154-163.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual review of Sociology*, *27*(1), 363-385.

Liu, R. T., Sheehan, A. E., Walsh, R. F., Sanzari, C. M., Cheek, S. M., & Hernandez, E. M. (2019). Prevalence and correlates of non-suicidal self-injury among lesbian, gay, bisexual, and transgender individuals: A systematic review and meta-analysis. *Clinical Psychology Review*, *74*, 101783.

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, *1*(1), 31-42.

Luong, V., Bearman, M., & MacLeod, A. (2023). Understanding Meta-Ethnography in Health Professions Education Research. *Journal of Graduate Medical Education*, *15*(1), 40-45.

Ma, J., Batterham, P. J., Calear, A. L., & Han, J. (2016). A systematic review of the predictions of the Interpersonal–Psychological Theory of Suicidal Behavior. *Clinical Psychology Review*, *46*, 34-45.

Macapagal, K., Bhatia, R., & Greene, G. J. (2016). Differences in healthcare access, use, and experiences within a community sample of racially diverse lesbian, gay, bisexual, transgender, and questioning emerging adults. *LGBT Health*, *3*(6), 434-442.

McCormick, M., & Barthelemy, R. S. (2021). Excluded from "inclusive" communities: LGBTQ youths' perception of "their" community. *Journal of Gay & Lesbian Social Services*, *33*(1), 103-122.

Mccrone, S. (2018). LGBT healthcare disparities, discrimination, and societal stigma: The mental and physical health risks related to sexual and/or gender minority status. *American Journal of Medical Research*, *5*(1), 91-96.

McDermott, E. (2015). Asking for help online: Lesbian, gay, bisexual and trans youth, self-harm and articulating the 'failed' self. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, *19*(6), 561-577. https://doi.org/10.1177/1363459314557967

McDermott, E., Roen, K., & Piela, A. (2015). Explaining self-harm: Youth cybertalk and marginalized sexualities and genders. *Youth & Society*, *47*(6), 873-889. https://doi.org/10.1177/0044118X13489142

McDermott, E., Roen, K., & Scourfield, J. (2008). Avoiding shame: Young LGBT people, homophobia and self-destructive behaviours. *Culture, Health & Sexuality*, *10*(8), 815-829. https://doi.org/10.1080/13691050802380974

McManus, S., Gunnell, D., Cooper, C., Bebbington, P. E., Howard, L. M., Brugha, T., Jenkins, R., Hassiotis, A., Weich, S., & Appleby, L. (2019). Prevalence of non-suicidal self-harm and service contact in England, 2000–14: repeated cross-sectional surveys of the general population. *The Lancet Psychiatry*, *6*(7), 573-581.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological bulletin*, *129*(5), 674.

Meyer, I. H. (2015). Resilience in the study of minority stress and health of sexual and gender minorities. *Psychology of Sexual Orientation and Gender Diversity*, *2*(3), 209.

Meyer, I. H., Russell, S. T., Hammack, P. L., Frost, D. M., & Wilson, B. D. (2021). Minority stress, distress, and suicide attempts in three cohorts of sexual minority adults: A US probability sample. *PLoS ONE*, *16*(3), e0246827.

Miranda-Mendizábal, A., Castellví, P., Parés-Badell, O., Almenara, J., Alonso, I., Blasco, M., Cebrià, A., Gabilondo, A., Gili, M., & Lagares, C. (2017). Sexual orientation and suicidal behaviour in adolescents and young adults: systematic review and meta-analysis. *The British Journal of Psychiatry*, *211*(2), 77-87.

Moran, P. (2023). Do We Belong? Promoting a Sense of Belonging in LGBTQ Youth Through Artistic Community Engagement: A Literature Review.

Nadal, K. L., Whitman, C. N., Davis, L. S., Erazo, T., & Davidoff, K. C. (2016). Microaggressions toward lesbian, gay, bisexual, transgender, queer, and genderqueer people: A review of the literature. *The journal of sex research*, *53*(4-5), 488-508.

NICE. (2022). Self-harm: assessment, management and preventing recurrence.

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing qualitative studies* (Vol. 11). sage.

Noyes, J., Booth, A., Flemming, K., Garside, R., Harden, A., Lewin, S., Pantoja, T., Hannes, K., Cargo, M., & Thomas, J. (2018). Cochrane Qualitative and Implementation Methods Group guidance series—paper 3: methods for assessing methodological limitations, data extraction and synthesis, and confidence in synthesized qualitative findings. *Journal of clinical epidemiology*, *97*, 49-58.

O'Shaughnessy, T., & Speir, Z. (2018). The state of LGBQ affirmative therapy clinical research: A mixed-methods systematic synthesis. *Psychology of Sexual Orientation and Gender Diversity*, *5*(1), 82.

O'Donoghue, K., & Guerin, S. (2017). Homophobic and transphobic bullying: Barriers and supports to school intervention. *Sex Education*, *17*(2), 220-234.

Odeh, L. E. (2010). A comparative analysis of global north and global south economies.

Pachankis, J. E. (2007). The psychological implications of concealing a stigma: a cognitive-affective-behavioral model. *Psychological bulletin*, *133*(2), 328.

Pachankis, J. E., Hatzenbuehler, M. L., Hickson, F., Weatherburn, P., Berg, R. C., Marcus, U., & Schmidt, A. J. (2015). Hidden from health: structural stigma, sexual orientation concealment, and HIV across 38 countries in the European MSM Internet Survey. *AIDS (London, England)*, *29*(10), 1239.

Pachankis, J. E., Hatzenbuehler, M. L., Rendina, H. J., Safren, S. A., & Parsons, J. T. (2015). LGB-affirmative cognitive-behavioral therapy for young adult gay and bisexual men: A

randomized controlled trial of a transdiagnostic minority stress approach. *Journal of Consulting and Clinical Psychology*, *83*(5), 875.

Pachankis, J. E., Hatzenbuehler, M. L., & Starks, T. J. (2014). The influence of structural stigma and rejection sensitivity on young sexual minority men's daily tobacco and alcohol use. *Social Science & Medicine*, *103*, 67-75.

Pachankis, J. E., Mahon, C. P., Jackson, S. D., Fetzner, B. K., & Bränström, R. (2020). Sexual orientation concealment and mental health: A conceptual and meta-analytic review. *Psychological bulletin*, *146*(10), 831.

Pachankis, J. E., McConocha, E. M., Reynolds, J. S., Winston, R., Adeyinka, O., Harkness, A., Burton, C. L., Behari, K., Sullivan, T. J., & Eldahan, A. I. (2019). Project ESTEEM protocol: a randomized controlled trial of an LGBTQ-affirmative treatment for young adult sexual minority men's mental and sexual health. *BMC public health*, *19*(1), 1-12.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., & Brennan, S. E. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *International journal of surgery*, *88*, 105906.

Parsons, M. B., Rollyson, J. H., & Reid, D. H. (2012). Evidence-based staff training: A guide for practitioners. *Behavior analysis in practice*, *5*, 2-11.

Riggle, E. D., Rostosky, S. S., Black, W. W., & Rosenkrantz, D. E. (2017). Outness, concealment, and authenticity: Associations with LGB individuals' psychological distress and well-being. *Psychology of Sexual Orientation and Gender Diversity*, *4*(1), 54.

Rivers, I. (2011). *Homophobic bullying: Research and theoretical perspectives*. Oxford University Press.

Sattar, R., Lawton, R., Panagioti, M., & Johnson, J. (2021). Meta-ethnography in healthcare research: a guide to using a meta-ethnographic approach for literature synthesis. *BMC health services research*, *21*, 1-13.

Scourfield, J., Roen, K., & McDermott, L. (2008). Lesbian, gay, bisexual and transgender young people's experiences of distress: Resilience, ambivalence and self-destructive behaviour. *Health & Social Care in the Community*, *16*(3), 329-336. https://doi.org/10.1111/j.1365-2524.2008.00769.x (Health and social care needs of children and young people)

Seers, K. (2015). Qualitative systematic reviews: their importance for our understanding of research relevant to pain. *British journal of pain*, *9*(1), 36-40.

Sheehy, K., Noureen, A., Khaliq, A., Dhingra, K., Husain, N., Pontin, E. E., Cawley, R., & Taylor, P. J. (2019). An examination of the relationship between shame, guilt and self-harm: A systematic review and meta-analysis. *Clinical Psychology Review*, *73*, 101779.

Silva, C., Chu, C., Monahan, K. R., & Joiner, T. E. (2015). Suicide risk among sexual minority college students: A mediated moderation model of sex and perceived burdensomeness. *Psychology of Sexual Orientation and Gender Diversity*, *2*(1), 22-33. https://doi.org/10.1037/sgd0000086

Smith, P. N., Cukrowicz, K. C., Poindexter, E. K., Hobson, V., & Cohen, L. M. (2010). The acquired capability for suicide: A comparison of suicide attempters, suicide ideators, and non-suicidal controls. *Depression and Anxiety*, *27*(9), 871-877.

Taliaferro, L. A., McMorris, B. J., Rider, G. N., & Eisenberg, M. E. (2019). Risk and protective factors for self-harm in a population-based sample of transgender youth. *Archives of Suicide Research*, *23*(2), 203-221. https://doi.org/10.1080/13811118.2018.1430639

Taylor, P. J., Jomar, K., Dhingra, K., Forrester, R., Shahmalak, U., & Dickson, J. M. (2018). A meta-analysis of the prevalence of different functions of non-suicidal self-injury. *Journal of Affective Disorders*, *227*, 759-769.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC medical research methodology*, *8*(1), 1-10.

Thorne, N., Yip, A. K.-T., Bouman, W. P., Marshall, E., & Arcelus, J. (2020). The terminology of identities between, outside and beyond the gender binary–A systematic review. *Non-Binary and Genderqueer Genders*, 20-36.

Travis, L. A., & Arizona, P. (2017). LGBT: What You Should Know About LGBT Older Adults. *ELDER CARE*.

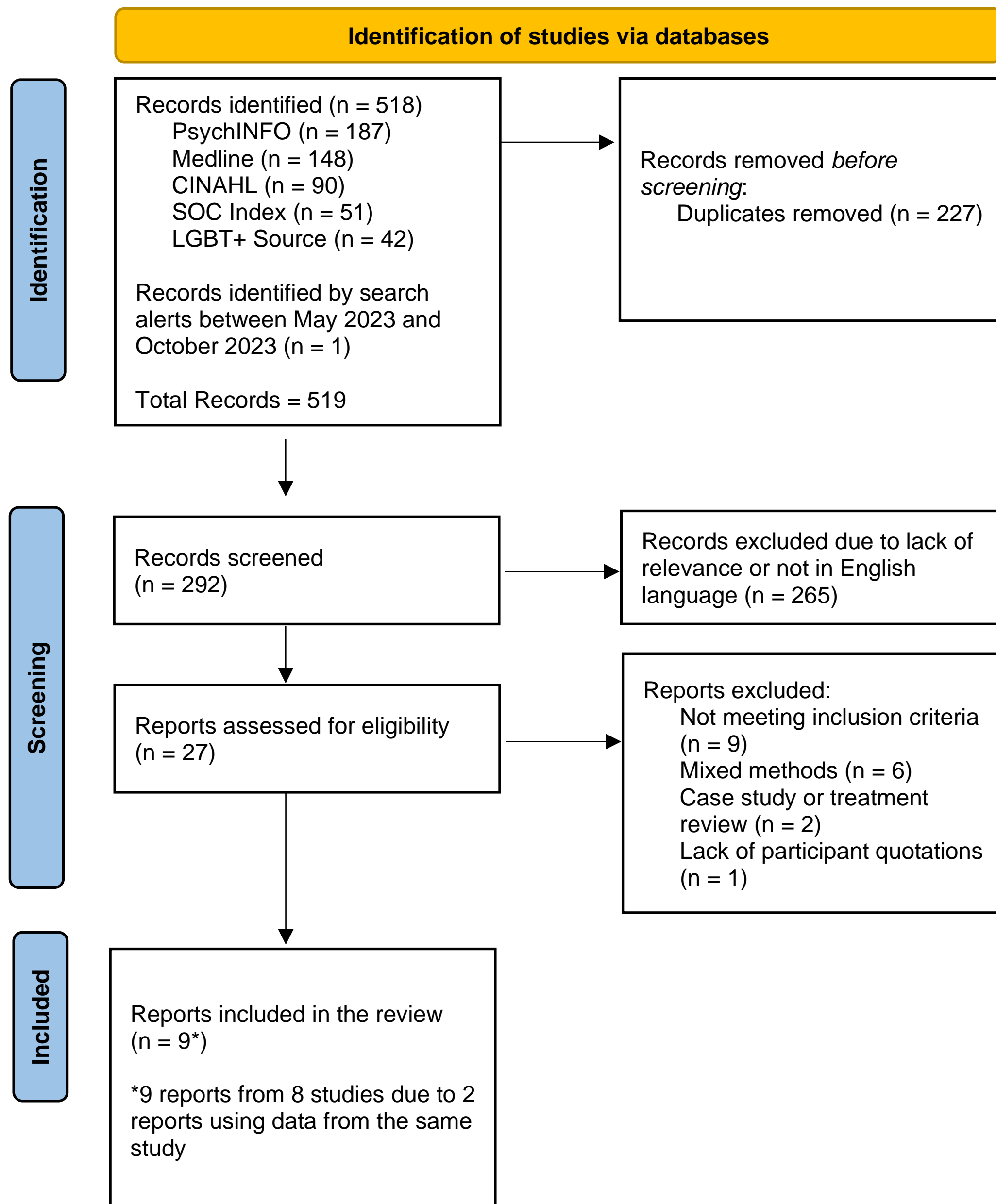
Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner Jr, T. E. (2010). The interpersonal theory of suicide. *Psychological review*, *117*(2), 575.

Williams, A. J., Arcelus, J., Townsend, E., & Michail, M. (2023). Understanding the processes underlying self-harm ideation and behaviors within LGBTQ+ young people: A qualitative study. *Archives of Suicide Research*, *27*(2), 380-396. https://doi.org/10.1080/13811118.2021.2003273

Williams, A. J., Jones, C., Arcelus, J., Townsend, E., Lazaridou, A., & Michail, M. (2021). A systematic review and meta-analysis of victimisation and mental health prevalence among LGBTQ+ young people with experiences of self-harm and suicide. *PLoS ONE*, *16*(1). https://doi.org/10.1371/journal.pone.0245268

Tables and Figures

Figure 1-1: A PRISMA Flow Diagram to Illustrate Study Identification via Databases



From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

For more information, visit: http://www.prisma-statement.org/

Figure 1-2: Visual representation of the relationships between themes

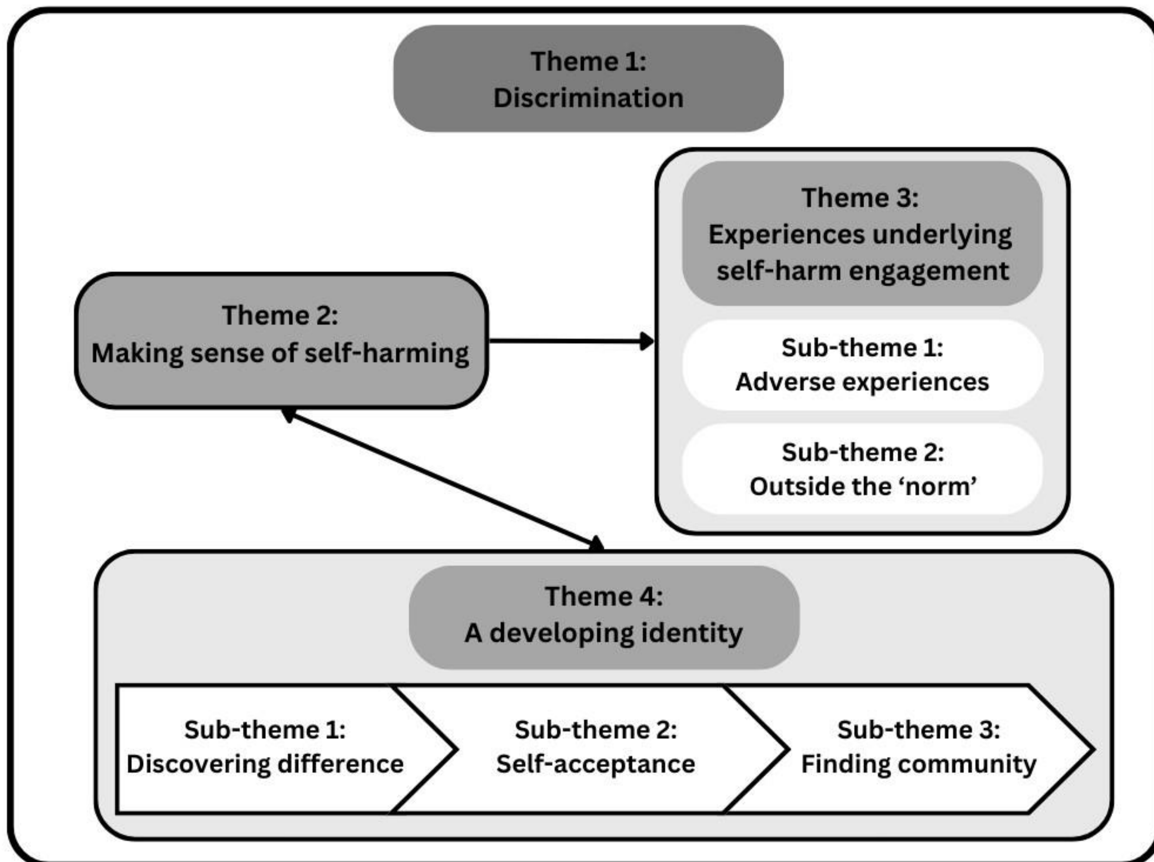


Table 1-1: Example of a search strategy for a specific database (PSYCinfo)

Database: PSYCinfo

NSSI	(DE "Self-Destructive Behavior" OR DE "Head Banging" OR DE "Self-Inflicted Wounds" OR DE "Self-Poisoning”) OR TI ((“self-harm*" OR "deliberate self-harm*” OR “self-injury" OR ("self-mutilation" OR “self mutilation”) OR "self-injurious behavio?r*” OR "nssi" OR "nonsuicidal self-injury” OR non-suicidal self-injury)) OR AB ((“self-harm*" OR "deliberate self-harm*” OR “self-injury" OR ("self-mutilation" OR “self mutilation”) OR "self-injurious behavio?r*" OR "nssi" OR "nonsuicidal self-injury" OR non-suicidal self-injury))
LGBTQ+	DE "LGBTQ" OR TI ((lgbt* OR lesbian OR gay OR homosexual OR bisexual OR transgender OR queer OR sexual minorit* OR sexual orientation OR non-binary)) OR AB ((lgbt* OR lesbian OR gay OR homosexual OR bisexual OR transgender OR queer OR sexual minorit* OR sexual orientation OR non-binary))
Qualitative	(DE "Qualitative Methods" OR DE "Focus Group" OR DE "Grounded Theory" OR DE "Interpretative Phenomenological Analysis" OR DE "Narrative Analysis" OR DE "Semi-Structured Interview" OR DE "Thematic Analysis") OR TI ((Qualitative OR interview* OR “grounded theory” OR phenomenol* OR “thematic analysis” OR narrative OR semi-structured OR “focus group*” OR IPA OR “content analysis” OR ethnog* OR experience)) OR AB ((Qualitative OR interview* OR “grounded theory” OR phenomenol* OR “thematic analysis” OR narrative OR semi-structured OR “focus group*” OR IPA OR “content analysis” OR ethnog* OR experience))

Table 1-2: Paper characteristics

Author (year)	Title	Country	Participants	Participant self-harm engagement	Aims	Method of data collection	Method of analysis	Findings
Alexander and Clare (2004)	You still feel different: the experience and meaning of women's self-injury in the context of a lesbian or bisexual identity	UK	18-50yrs 16 participants x14 lesbian/gay x2 bisexual	Self-harm engagement was over 1.5 to 41 years	Explore the meaning of women's self-injury in the context of having a lesbian or bisexual identity	Interviews	Interpretative Phenomenological Analysis	Themes of previous bad experiences, feeling invisible or invalidated, and feeling different were linked to self-harm, as well as ideas around "just doing it" and what helped to stop self-harming.
Dunlop, Hunter, et al. (2022)	'Why is it so different now I'm bisexual?': Young bisexual people's experiences of identity, belonging, self-injury and COVID-19	UK	16-25yrs 15 participants All bisexual	13 had self-harm engagement in the past month, all had lifetime engagement	To understand the relationship between bisexual identity, non-suicidal self-injury, and lockdown.	Interviews	Thematic Analysis	Discrimination and invalidation related to being neither hetero- or homosexual related to engagement in self-harm. A Lack of positive representation led to self-loathing, which self-harm was used to cope with.
Gosling et al. (2022)	Understanding self-harm urges and behaviour amongst non-binary young adults: A grounded theory study	UK	18-30 yrs 11 participants All non-binary	X2 current self-harm engagement X2 self-harm in the last year X7 more than one year ago	Gain an understanding of relationships between self-harm and identifying as non-binary in young adults	Interviews	Grounded Theory	Themes of Growing up feeling outside of the binary, family discord, and the pain of living in a cisnormative society were linked to self-harm.
Jackman et al. (2018)	Experiences of Transmasculine spectrum people who report nonsuicidal	USA	17-38 yrs 18 participants All trans-masculine	X 9 self-harm in the last year X 9 lifetime engagement	Explore the experiences of transmasculine people who self-	Interviews	Directed content analysis	Themes around adverse early life experiences, the impact and reactions of

	self-injury: A qualitative investigation		(defined as being assigned female sex at birth, with a gender identity of man, male, genderqueer, or non-binary)	but not in the last year	harm, and how this is related to their identity and their resilience			others to participant gender non-conformity, concealment of identity and expecting rejection from others.
McDermott (2015)	Asking for help online: Lesbian, gay, bisexual and trans youth, self-harm and articulating the 'failed' self	-	13-25yrs Estimated 290 contributors, data excerpts included 12 blogs and 37 discussion forums	-	To explore why LGBT young people may have difficulty asking for help	Online extracts – from blogs and forums	Thematic Analysis	Themes around LGBT youth asking for help online from peers, online spaces being a place where they can articulate their emotional distress, and "telling the failed self" – discussing themselves as different
McDermott et al. (2015)	Explaining self-harm: Youth marginalised sexualities and genders	-	16-25yrs Estimated 290 contributors, Data excerpts included 12 blogs and 37 discussion forum	-	To answer 'How to LGBT youth explain the role of gender and sexuality in relation to self-harm?'	Online extracts – from blogs and forums	Thematic Analysis	Themes around self-harm being a result of homophobia and transphobia; self-harm being due to self-hatred, fear and shame; and, self-harm not being related to sexuality or gender identity
McDermott et al. (2008)	Avoiding shame: young LGBT people, homophobia and self-destructive behaviours	UK	16-25yrs 27 participants, identifying as lesbian, gay, bisexual and/or transgender	14 had attempted suicide or self-harmed	To explore the perspectives of LGBT youth of how non-normative sexual and gender identities are related to distress,	Interviews & Focus Groups	Foucauldian discourse analysis	Theme of homophobia being related to self-harm. Participants navigated homophobia via shame avoidance: routinization and minimisation of homophobia,

					self-harm and suicidality.			maintaining individual adult responsibility, and constructing a proud identity
Scourfield et al. (2008)	Lesbian, gay, bisexual and transgender young people's experiences of distress: resilience, ambivalence and self-destructive behaviour	UK	16-25yrs 69 participants X 36 heterosexual X 15 gay or lesbian X 12 bisexual X 2 transgender X 4 prefer not to say	-	To explore how young LGBTQ+ individuals think about suicide and self-harm	13 Interviews & 11 Focus Groups	Thematic analysis	Identified strategies that are employed in the face of distress, including resilience, ambivalence and self-destructive behaviours.
Williams et al. (2023)	Understanding the processes underlying self-harm ideation and behaviours within LGBTQ+ young people: A qualitative study	UK, USA & Israel	16-25yrs X11 cisgender X6 transgender X2 non-binary	'Majority' had experience of self-injurious behaviours, and just under half had attempted suicide at least once	To understand the processes underlying self-harm thoughts and behaviours in LGBTQ+ people	Interviews	Thematic analysis	Themes around struggling to process and understand LGBTQ+ identity, negative responses from others due to LGBTQ+ identity, and life stressors.

Table 1-3: Quality Appraisal using Critical Appraisal Skills Programme (CASP)

CASP Checklist Question	Alexander and Clare (2004)	Dunlop, Hunter, et al. (2022)	Gosling et al. (2022)	Jackman et al. (2018)	McDermott (2015)	McDermott et al. (2015)	McDermott et al. (2008)	Scourfield et al. (2008)	Williams et al. (2023)
Was there a clear statement of the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is a qualitative methodology appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was the research design appropriate to the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was the recruitment strategy appropriate to the aims of the research?	Yes	Yes	Yes	Yes	Yes	Yes	Can’t tell	Yes	Yes
Was the data collected in a way that addressed the research issue?	Yes	Yes	Yes	Yes	Can’t tell	Can’t tell	Yes	Yes	Yes
Has the relationship between researcher and participant been adequately considered?	Can’t tell	Can’t tell	Yes	Can’t tell	No	No	No	No	Yes
Have ethical issues been taken into consideration?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Was the data analysis sufficiently rigorous?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is there a clear statement of findings?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
How valuable is the research?	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes

Table 1-4: Themes and how the papers contributed to each theme

Theme	Alexander and Clare (2004)	Dunlop, Hunter, et al. (2022)	Gosling et al. (2022)	Jackman et al. (2018)	McDermott (2015)	McDermott et al. (2015)	McDermott et al. (2008)	Scourfield et al. (2008)	Williams et al. (2023)
1. Discrimination	✓	✓	✓	✓		✓	✓		✓
2. Making sense of self-harming	✓	✓	✓		✓	✓		✓	✓
3. Experiences underlying self-harm engagement	✓	✓	✓	✓	✓	✓		✓	✓
3.1 Adverse experiences	✓		✓		✓		✓	✓	✓
3.2 Outside the 'norm'	✓	✓	✓	✓	✓				✓
4. A developing identity	✓	✓	✓					✓	✓
4.1 Discovering difference	✓	✓	✓	✓				✓	✓
4.2 Self-acceptance		✓	✓				✓		
4.3 Finding community		✓	✓	✓		✓	✓		

Appendices

Appendix 1-A: Guidelines for Publication for Psychology & Sexuality Research Journal

About the Journal

Psychology & Sexuality is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

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*Citations received up to 9th June 2021 for articles published in 2018-2022. Data obtained on 23rd August 2023, from Digital Science's Dimensions platform, available at https://app.dimensions.ai **Usage in 2020-2022 for articles published in 2018-2022.

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Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

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Please include a word count for your paper.

A typical paper for this journal should be no more than 6000 words, inclusive of:

- Abstract

- Figure or table captions

Format-Free Submission

Authors may submit their paper in any scholarly format or layout. Manuscripts may be supplied as single or multiple files. These can be Word, rich text format (rtf), open document format (odt), PDF, or LaTeX files. Figures and tables can be placed within the text or submitted as separate documents. Figures should be of sufficient resolution to enable refereeing.

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   This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].

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Updated 28th November 2023.

Appendix 1-B: Example of Development of Third Order Constructs and Themes

Paper: Gosling et al. (2022)

Second Order Construct	First Order Construct	Third Order Construct	Themes
Growing up feeling outside of the binary *Not a boy not a girl* Feeling they do not 'fit in' with gender norms was a common experience. Lack of knowledge of different gender identities maintained this.	I've tried to compare it is like… sort of a feeling like you get given a pair of shoes, like girls get one pair and boys get one pair like… I don't know, boots and trainers. And I feel like my pair of shoes, like they didn't really fit and they gave me blisters and they were uncomfortable but I could like walk around in them… and I didn't know that you could have anything else. (Frankie)	Feeling different from their peers, feeling as though they do not fit into what is expected of them, and not having the language to describe this. Not feeling their body represented who they were.	Discovering Difference
	As my body started to change, I started to feel like it… didn't represent who I was anymore. (Robin)		
	In the case of how I feel about, or how I don't feel connected to my body… it was a way of serving control over that and reminding myself that it is connected. (Robin)		
Growing up feeling outside of the binary *A lack of family support* Feeling hurt by a lack of acceptance and understanding from families – present as a theme throughout growing up.	So because I'm still being misgendered and still being birth named… well I was being birth named by my family. Like… it just… urgh… like I always go back to self-harming. (Kayden)	Coping with distress caused by others through self-harm.	Making sense of self-harming
Growing up feeling outside of the binary *Positive exposure to gender diversity* Exposure to different gender identities provided understanding, helping individuals to feel confident in	I had some fantastic friends in high school who were very much into supporting LGBTQ + people. And I think their acceptance and their knowledge about those things, because it wasn't something I had a lot of knowledge about before that… really helped me to… to explore that part of me. (Robin)	Developing more knowledge of LGBTQ+ identities helped to develop their own identity.	Discovering difference
	Outside of work I'd play around with make-up… I was inspired quite heavily by erm Ru Paul's Drag Race,		

exploring their own gender identity.	erm… having the exposure of queer people that I'd never really touched in before. (Fynn)		
Growing up feeling outside of the binary *The validation of labelling myself as non-binary* Having the language to describe their gender identity was validating and feel relief from the difficult experience related to not being able to express themselves.	It was nice to feel like, oh ok, so the thing I'm feeling isn't just, I'm not just like a weird girl or like a tomboy or whatever. It was nice to have the words to describe myself. (Nico) When I started talking to transgender people about gender and gender presentation, I really did go through a period of what most people call gender euphoria… which is where you start to understand and accept yourself in relativism to other people. (Blair)	Discovering the language used to describe LGBTQ+ identities was validating, helping them to express themselves and describe their experiences.	Self-acceptance
The Pain of living in a cisnormative world *Discrimination and victimisation* Discrimination due to their gender-identity was common, re-enforcing negative views people had about themselves which led to increased self-harming.	I've been followed home before…erm. I've been kicked, I've been spat on in day-to-day life. (Fynn) That feeling… feeling worthless, that you don't deserve to be here. (Isa) I guess it's kind of a concentration of everything that's going on around you like… erm… people are harming me in more abstract ways therefore I deserve to be harmed in a more concrete way. (Piper) I think that links to my self-harm, because when I started to lose respect for my body, and I gained so much insecurity… I took it out on my body. (Beck) That was gonna help shape the NHS, that was gonna reshape government… all this kind of stuff… they were willing to put away 70% of people who participated in that… we'll go with the 30% that oppose it? That's the problem. Trans voices aren't heard enough. (Fynn) It just made me feel like the world is terrible and it doesn't want me in it. (Nico) But my teachers are not educated about trans things… the pastoral support in school didn't know	Self-harming used to cope with the distress and emotions caused by discrimination and victimisation.	Discrimination

	anything about trans things so I just had to grin and bear it. (Kayden)		
The Pain of living in a cisnormative world *Intersectional Identities* Layers of difference leading to feeling additionally different from others, and experiencing complex forms of oppression.	It was just kind of the feeling that I'm just innately different from everyone else. And I'm never gonna be the same or feel the same or… understand the things that most people go through… and other people are never going to understand me. (Ash) I am autistic as well so erm… sometimes it would be a case of like sensory overwhelm. (Piper) It's weird going to a therapist that understands autism but is clueless about gender… or understands gender but is clueless about autism. (Ash) The hijab, the social expectations, the fact that I need to hide myself. Er… I can't go publicly with my short hair because I will be harassed by the police. Erm… all of that… yeah all of that played in a role of me wanting to hurt myself. (Isa) I mean it's more that just it's not talked about and like…even if I went around looking quite gender non-conforming… people would still like "miss and maam" me…which is frustrating (Ash)	Feeling different from others causing them to feel that other people to do not understand them. The views of others regarding their intersectional identities and lack of understanding leading to self-harm.	Outside the 'norm' Discrimination
The Pain of living in a cisnormative world *Belonging versus authenticity* Left feeling like they don't belong, are worthless and isolated due to being different. This led to people hiding parts of their identity to try to 'fit in'.	Not only did I not belong in this place of work or in this friend group but also that I didn't belong anywhere. (Allyn) I'm either gonna have to hide it and be miserable or be out and face discrimination. (Nico) "actively trying to hide parts of myself" (Blair) If you were a binary trans person… there is something that you can transition to and then live your life and kind of blend in… but if you're non-binary either you choose to like pick a side… or you're going to be visibly a freak the entirety of your life (Ash)	Feeling different from others left them feeling isolated, and as though there is no option which minimises distress – either they hide their identity in an attempt to minimise negative experiences and feel distress due to not being able to present their true identity, or they face discrimination for presenting	Discrimination Outside the 'norm'

		outside of the social norms. The perception that some other LGBTQ+ identities do not experience this.	

Section Two: Empirical Paper

Fear of Compassion, Perceived Burdensomeness and Self-Injury in Adolescents and Young Adults

Bethan Gray

Doctorate in Clinical Psychology

Division of Health Research

Lancaster University

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All correspondence should be addressed to:

Bethan Gray

c/o Doctorate in Clinical Psychology

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4AT

b.gray3@lancaster.ac.uk

Prepared in accordance with guidelines for authors for: *Archives of Suicide Research* (Appendix 2-A)

Abstract

Objective: Adolescents and young adults are at an increased risk for engagement in self-injurious behaviours. Psychological factors such as low self-compassion, thwarted belongingness and perceived burdensomeness may explain this risk. The aim of the present study was to investigate the relationships between fear of self-compassion, perceived burdensomeness, thwarted belongingness, and urges to self-injure in adolescents and young adults.

Method: Participants aged 16-25, had experienced thoughts or urges to self-harm in the past six months and were from the United Kingdom took part in this online quantitative study. Multiple hierarchical regressions were used for analysis.

Results: Perceived burdensomeness and participant age were found to explain a significant proportion of variance in urges to self-injure, while thwarted belongingness and fear of self-compassion were both found to be non-significant with perceived burdensomeness in the model.

Conclusions: Findings add to previous research that perceived burdensomeness is a significant predictor of suicidality, by showing perceived burdensomeness also predicts the urge to self-injure. Preventative strategies and interventions targeting perceived burdensomeness may reduce self-harm risk.

Keywords: Non-suicidal self-injury, adolescents, compassion, perceived burdensomeness

Non-Suicidal Self-Injury (NSSI) is a global and clinical health concern. NSSI is the deliberate injury to oneself in the absence of suicidal intent (American Psychiatric Association (APA), 2013; Hooley et al., 2020; Nock, 2009). The increasing prevalence of this phenomenon has increasing costs to both lives and countries through healthcare costs, mortality and the impact on the economy (Peterson et al., 2021; Rockett et al., 2023). NSSI also has a negative emotional impact on the individual, their families, and others in their lives. (Lloyd et al., 2018; Mughal et al., 2022; Simm et al., 2010; Spillane et al., 2020). Prevalence estimates suggest rates of NSSI are increasing within the United Kingdom (Cybulski et al., 2021). In England, research suggests that in adults, rates have increased from 2.4% to 6.4% (McManus et al., 2019). The highest prevalence rates for NSSI have been suggested in 16 to 24-year-old females, with the latest figures showing 19.7% lifetime NSSI engagement within this group (McManus et al., 2019). However, not all NSSI is reported, especially if the behaviour does not result in medical attention, so true prevalence rates may be higher (Demuthova et al., 2020; Erlangsen et al., 2018).

NSSI may be one indicator that an individual is experiencing distress with which they are struggling to cope (Laye-Gindhu & Schonert-Reichl, 2005; Rasmussen et al., 2016), making it a sign that the individual may require support. NSSI behaviours are also a significant predictor of both suicide attempts and completed suicides (Hawton & Harriss, 2007; McManus et al., 2019), with higher frequencies of self-injury increasing the risk of suicide attempts (Griep & MacKinnon, 2022). Therefore, it is important to understand factors which underlie NSSI engagement to inform prevention strategies and intervention.

One key factor within the literature which has been shown as a significant predictor of self-injurious behaviour is self-esteem. Low self-esteem has been linked to self-injury in various populations (Dunlop, Coleman, et al., 2022; Forrester et al., 2017), which may be due to underlying negative cognitions about oneself. One theory which identifies specific negative perceptions about the self in relation to NSSI is the Interpersonal Theory of Suicide (ITS; Joiner, 2005; Van Orden et al.,

2012; Van Orden et al., 2010). The ITS suggests suicidal ideation and the desire to harm oneself develop based on the presence of two interpersonal constructs – Thwarted Belongingness (TB) and Perceived Burdensomeness (PB). TB is defined as the perception of disconnection from others, or a perceived lack of reciprocity in caring between the individual and others. TB develops in the presence of social isolation, loneliness, and an absence of reciprocal care, leading the individual to have an unmet need in belonging, a known risk factor for suicidality (Fässberg et al., 2012; Turecki & Brent, 2016). PB is the perception of oneself as flawed and having a negative impact on others, accompanied by self-hatred, which leads to the individual feeling their life is worth less to others than their death would be. TB and PB are dynamic states, which respond to interpersonal and intrapersonal factors, such as our evaluation of events and ourselves. The ITS posits that when an individual evaluates these interpersonal constructs to both be present, stable, and unchanging, they will develop a hopelessness that leads to a desire to harm themselves (Figure 1). The ITS proposes that suicidal desire will only be acted upon if the individual has a capability for suicide, which may in part be developed through exposure to painful and provocative events, such as abuse, combat exposure, past suicidal behaviours, or engagement in self-injurious behaviours. The development of capability of suicide is based on opponent-process theory, whereby repeated exposure to the painful stimulus of NSSI reduces the fear and pain responses, and increases the relief response (Solomon, 1980). Therefore, those who experience both TB and PB, with an associated desire to harm themselves may not have yet developed, a capability for suicide, but are at risk of developing this through continued engagement in self-injurious behaviours.

There is evidence to support the ITS in its relevance to self-injury, as the interpersonal factors described have been previously linked with self-injurious behaviours. Belonging and connectedness have been frequently noted as key factors related to self-injurious behaviours, particularly in adolescents (Copeland et al., 2019; Klemera et al., 2017). A sense of being rejected from, and therefore not belonging to social groups, is linked to self-injury in adulthood (Cawley et al., 2019). In qualitative research, the sense of feeling ‘flawed’ included in the definition of PB has

been described by individuals who self-injure as an underlying reason to engage in the behaviour (Harris, 2000), as has feeling like a burden on others (Hetrick et al., 2020). Therefore, the interpersonal factors proposed by the ITS have been evidenced as experienced by individuals who self-injure. However, there is room to explore the mechanisms which underlie the development of these perceptions within an individual.

Compassion (Gilbert, 1998, 2005, 2020) offers one understanding of human motivation systems which may provide insight into the emergence of TB and PB, aiding understanding of the development and maintenance of NSSI behaviours. Our understanding of compassion is based on Buddhist philosophies (Brach, 2004; Neff, 2023), and evolutionary theories of human motivation (Gilbert, 2014). Compassion can be defined as a sensitivity to the suffering of oneself and others, with a motivation to try and alleviate this suffering (Gilbert, 2014). Gilbert (2010) details three flows of compassion; self-to-other, other-to-self, and self-to-self (self-compassion). These flows of compassion highlight the reciprocal nature of compassion, whether this be with ourselves or others.

Self-compassion, the ability to recognise and respond to one's own suffering with understanding and kindness, is associated with psychological well-being and reduced mental health difficulties (MacBeth & Gumley, 2012). Those with higher levels of self-compassion are more likely to engage in adaptive coping strategies (Allen & Leary, 2010), while those with lower self-compassion and higher levels of self-criticism are more likely to engage in maladaptive coping strategies, including NSSI (Abdelraheem et al., 2019; Cleare et al., 2019; Nock, 2010; Suh & Jeong, 2021), suggesting that self-compassion is a protective factor for NSSI engagement. Self-compassion is negatively associated with TB and PB (Umphrey et al., 2020), suggesting the presence of self-compassion may protect against development of TB and PB.

Compassion for others, or the self-to-other flow of compassion, has been suggested to increase social connectedness and mental well-being (Cosley et al., 2010; Jazaieri et al., 2014), protecting against suicide risk. This may be due to social connectedness representing the inverse of

TB, as it considers the individual's perceptions of the strength and quality of their interpersonal relationships, as well as how often the individual is able to interact and connect with others (Hill et al., 2015). An increase in compassion for others may also increase our ability to receive social support (Cosley et al., 2010), suggesting we are more open to connect with others in times of vulnerability and receive compassion from others if we also have compassion for others.

However, all motivations have fears, blocks and resistances to being enacted (Gilbert & Mascaro, 2017), including the flows of compassion. Gilbert (2010) describes fears, blocks and resistances which impact the flows of compassion by preventing compassionate motivation. Fear of compassion is an individual's active resistance to engaging in compassionate experiences and behaviours (Gilbert et al., 2011), due to either avoidance or a fear response to compassion. Examples of fear of compassion may include a fear that showing compassion shows weakness, may be responded to negatively, or may lead to distress (Gilbert & Mascaro, 2017; Vitaliano et al., 2003). Fear of compassion has been linked to mental health difficulties which we know to relate to NSSI, such as depression, shame and self-criticism (Kirby et al., 2019). Therefore, fear of compassion may result in difficulty engaging in compassionate processes both with oneself and others, inhibiting the ability to respond to ourselves with kindness or seek social support in times of need, limiting the availability of positive coping strategies.

Difficulty engaging in compassion may underlie low levels of self-compassion. Both fear of compassion and low levels of self-compassion have been shown to be linked to NSSI engagement (Hasking et al., 2019; Suh & Jeong, 2021; Xavier et al., 2016). Furthermore, self-compassion buffers the relationship between interpersonal stressors such as abuse, peer victimisation and intrapersonal factors such as stress and depressive symptoms (Jiang et al., 2016; Wu et al., 2023), highlighting self-compassion as a protective factor in the face of difficult interpersonal experiences. Self-compassion also facilitates positive relationships, supporting healthy relationship functioning and repair of relationships following conflict (Lathren et al., 2021). This indicates that self-compassion supports

positive interpersonal relationships, allowing connection with others. Inversely, low relational evaluation, the perception that one's value and connection to others is low, is related to both suicidal thoughts and behaviours (Cheek et al., 2020). Therefore, there may be a relationship between individual levels of self-compassion, and the experience and interpretation of interpersonal relationships. This interpretation of interpersonal relationships also underlies development of TB and PB (Van Orden et al., 2010); therefore, factors such as a fear of compassion, or difficulty engaging in compassionate processes, may contribute to the development of TB and PB. However, there is a lack of research into the relationships between self-compassion, difficulty engaging in self-compassion, TB, PB and NSSI to explore the relationships between these constructs. Ultimately, the lack of research exploring the relationships between these two key theories, which have both independently been shown to be related to NSSI, may be limiting our full understanding of the underlying mechanisms for engagement in NSSI.

It is important to investigate the psychological processes which underlie NSSI within populations where NSSI engagement is most prevalent, such as in adolescents and young adults (McManus et al., 2019). Demographic factors such as age, gender, sexuality and ethnicity have been shown to be related to self-injury (Klonsky, 2011; Whitlock et al., 2011). Measuring these demographic factors and including them in the analysis model will allow exploration of factors which provide additional explanatory value, and ensures interpretations of results do not overstate the explanatory power of the variables of interest (Cohen et al., 2013). The urge to self-injure is a risk factor for engagement in NSSI behaviours (Miller & Smith, 2008), with thoughts and urges to self-injure presenting more commonly than behaviour in adolescents (Stallard et al., 2013), highlighting not all urges to self-injure are acted upon. A better understanding of the factors which underlie the urge to self-injure may allow development of more targeted support and early interventions prior to initial NSSI engagement.

Aims

This study will aim to build on the current body of research by exploring the relationships between the three fear of compassion sub-scales, TB, PB and the urge to self-injure in adolescents and young adults. The literature shows that fear of self-compassion is significantly related to NSSI engagement, as are TB and PB. Consequently, the following hypotheses were identified:

1. The fear of self-compassion will have a significant positive relationship with the urge to self-injure.
2. The fear of self-compassion will predict a significant amount of variance in the urge to self-injure after the variance accounted for by TB and PB.
3. The effects of fear of self-compassion on urge to self-injure will remain significant after mediating for TB and PB.

Exploratory analyses will be employed to explore whether fear of compassion for others or fear of compassion from others explain unique variance in urge to self-injure, after the variance accounted for by TB and PB. This will allow an exploration of whether these constructs explain variance in the model above that explained by TB and PB, and therefore may provide additional understanding to the experience of the urge to self-injure.

Method

Design

To explore the relationship between the urge to self-injure and the fear of self-compassion, TB and PB, the study used a non-experimental, non-randomised, cross-sectional correlational design.

Participants

Participants were recruited between 20th May 2023 and 30th November 2023. To be eligible to take part, participants were required to be (1) aged 16 to 25 years old, (2) living in the United Kingdom, and (3) to have had thoughts or urges to self-harm in the past 6 months. To take part,

participants also required (4) access to a computer or device with internet access and (5) the ability to understand written English.

A previous study exploring similar constructs, including PB and TB, as they relate to NSSI in emergent adults found that 79% of the variance remained unexplained in their model (La Guardia et al., 2020). Therefore, a conservative power calculation was completed suggesting the tested variable of fear of self-compassion would explain an additional 5% of the variance in the model. A predictive power calculation using G*Power (Faul et al., 2007) for a linear multiple regression with eight variables (tested predictor: fear of self-compassion; predictors: TB and PB; demographics: age, gender, sexuality, ethnicity and depression) indicated that a minimum sample size of 127 was needed to predict a small effect size ($f^2 = 0.06$).

Procedure

This study received ethical approval from Lancaster University Faculty of Health and Medicine Research Ethics Committee (FHM-2023-0934-RECR-2). Experts by experience, recruited via social media, were consulted on the accessibility of wording on the information sheet, consent form, and online advert as well as being invited to share their reflections on the proposed measures for the study (Appendix 2-B). The feedback was positive, with minor amendments being suggested for the language used during advertising and on the information sheet, the order of the questionnaires in the online study, and the adaptation of one demographic question from multiple choice to a free text entry box.

Participants responded to an online anonymous survey, which was advertised using social media posts on Instagram, Facebook, Reddit and X (formerly Twitter). Participants were required to complete a consent form indicating they had read the study and consent information, which outlined what participation would involve, including any potential risks. Participants were able to withdraw from the study at any point during completion by exiting the survey prior to submitting their responses; however, once responses were submitted it was not possible to withdraw consent

due to the anonymous nature of the study. Details of available information and support was provided both on the information page and debrief, should participants have required this (Appendix 2-C).

Measures

Demographic Questionnaire

A Demographics Questionnaire (Appendix 2-D) was used to measure age, gender, sexuality, and ethnicity as these are known risk factors for NSSI (Al-Sharifi et al., 2015; Fliege et al., 2009; Larkin et al., 2014; White et al., 2023). Ethnicity was dichotomised for analyses (White and non-White), as well as gender (same as assigned at birth and not the same as assigned at birth), and sexuality (heterosexual and non-heterosexual) as this allowed the analysis to consider the impact of being a minority identity within these categories.

Information regarding participants' engagement in self-injurious behaviours was collected by adapting five questions from the Self-Injurious Thoughts and Behaviours Interview Short Form (Nock et al., 2007), to measure the frequency and methods of self-injury. The question measuring methods of self-injury was adapted to an open text box for free text entry in response to participant involvement.

Center for Epidemiologic Studies Depression Scale (CES-D)

Depressive symptoms are a well-documented risk factor for self-injury (Fliege et al., 2009; Witt et al., 2019). The CES-D is a 20-item measure of depressive symptomology, using a four-factor structure to measure depressed affect, positive affect, somatic symptoms and interpersonal difficulties (Appendix 2-E; Radloff, 1977). The 4-point Likert scale assesses the presence of depressive symptoms over the past week. The CES-D recommends a cut-off of 16 for indicating the presence of subthreshold depression. A meta-analysis has since recommended a cut-off of 20, with a sensitivity of .83 and specificity of .78 (Vilagut et al., 2016).

The CES-D was originally established for an adult general population (Radloff, 1977) with a reliability coefficient alpha of .85; however, factor analysis has shown the scale to be suitable for use with English-speaking adolescents (Blodgett et al., 2021) and has been reviewed as .88 for children and adolescents (Stockings et al., 2015). Cronbach's Alpha was .83 in the current sample.

Compassionate Engagement and Action Scales (CEAS)

The three CEAS scales have 13 items each, measuring the three flows of compassion: compassion for others, compassion from others and compassion for self (Appendix 2-F; Gilbert et al., 2017). The responses are measured on a 10-point Likert scale from 1 (Never) to 10 (Always), providing a compassion engagement, compassion action, and total score for each flow of compassion. All scales were shown to have a Cronbach's alpha between .72 and .94. When used with adolescents, the reliability was shown to be higher, with Cronbach's alphas of .94 for the total scale score, .89 for the Engagement total, and .92 for the Action total, with a test-retest correlation of .97 to .98 across the scales (Cunha et al., 2023).

The reliability as measured by Cronbach's Alpha of the CEAS in the current sample was .66 for the Self-Compassion Scale total score, with a Self-Compassion Engagement scale reliability of .49 and a Self-Compassion Action scale reliability of .50. The CEAS Compassion to Others total score reliability was .75, with both the Engagement and Action sub-scale having a Cronbach's Alpha of .57. CEAS Compassion From Others combined scale Cronbach's Alpha was .78, with Engagement of .62 and Action of .65.

Fears of Compassion Scales

The Fears of Compassion scales are made up of 38 items which calculate three subscales: Fear of Self-Compassion, Fear of Compassion From Others and Fear of Compassion for Others (Appendix 2-G; Gilbert et al., 2011). Responses are measured on a 5-point Likert scale ranging from 0 (Don't agree at all) to 4 (Completely agree), with higher scores on each subscale indicating a higher fear of compassion. The scale was shown to have reliability between .84 and .92 in a student

population (Gilbert et al., 2011). In this current sample, reliability as measured by Cronbach's Alpha was .83 for the Fear of Compassion for Others scale, .84 for the Fear of Compassion From Others scale, and .88 for the Fear of Compassion to Self scale.

Interpersonal Needs Questionnaire (INQ)

The INQ is a 15-item measure of the two interpersonal constructs within the ITS: thwarted belongingness and perceived burdensomeness (Appendix 2-H; Van Orden et al., 2012). The scale uses a 7-point Likert scale from 1 (not at all true for me) to 7 (very true for me), with higher scores indicating higher levels of each construct. The INQ has been shown to have good internal consistency, and Cronbach's Alpha scores from .85 to .9 for PB and .81 to .87 for TB (Hill et al., 2015). In this sample, Cronbach's Alpha was .81 for TB and .92 for PB.

Alexian Brothers Urge to Self-Injure Scale (ABUSI)

The ABUSI is a 5-item measure using 7-point Likert scales to measure the urge to self-injure (Appendix 2-I; Washburn et al., 2010). The ABUSI measures the frequency of thoughts of self-injury, and the strength and duration of these thoughts as well as the individual's ability to resist the thoughts, providing an overall measure of the severity of the urge to self-injure. The scale has been shown to have an internal consistency, as measured by Cronbach's alpha, between .92 and .96, and a high test-retest reliability at .84 (Washburn et al., 2010). The ABUSI has been reviewed as one of the preferred measures for NSSI in adolescents (Chávez-Flores et al., 2019), with the ABUSI being identified as the most reliable and valid measure of NSSI as it is defined in the DSM-5 (American Psychiatric Association, 2013). Cronbach's Alpha of the ABUSI in the current sample was .90.

Validation of Fear of Compassion Scales for use with Adolescents

As far as the researcher is aware, the Fear of Compassion Scales have not previously been employed with an adolescent sample (under 18-year-olds). Therefore, the Compassionate Engagement and Action scales were employed in the current study as a validation of the Fear of

Compassion scales in this age group. Spearman's Rho correlations correlational analyses were completed on the scales due to the data not being normally distributed. Self-Compassion was significantly negatively correlated with Fear of Self-Compassion (r_s= -.27, *p* = .003), Compassion From Others and Fear of Compassion from Others were significantly negatively correlated (r_s= -.27, *p* = .002); however, Compassion to Others and Fear of Compassion for Others were not significantly correlated (p = .299).

Data Analysis

Data analysis was conducted using SPSS version 27. Descriptive statistics of the participant demographics were examined to explore the characteristics of the sample. Correlation analyses were used to measure the strength of the linear relationship between the variables, and to test hypothesis 1.

To test the main hypothesis, hypothesis 2, that fear of self-compassion explains unique variance in the urge to self-injure after the variance accounted for by TB and PB, a hierarchical regression analysis was conducted. The predictor variables were entered in three steps: 1) age, gender, sexuality, ethnicity, and depression, 2) TB and PB, and 3) fear of self-compassion, with an outcome variable of the urge to self-injure.

Additional exploratory regression analyses were also completed to explore the relationship between fear of compassion for others and fear of compassion from others with the urge to self-injure, after accounting for demographic variables, TB and PB. In each regression, the remaining fear of compassion sub-scales were entered in step three of the model.

Mediation analyses was employed to test hypothesis 3, exploring whether the effects of fear of self-compassion on urge to self-injure remained significant after mediating for TB and PB.

Finally, as the Fear of Compassion scales have not been validated for use with under 18-year-olds, the current study explored these scales in relation to the Compassionate Engagement and

Action Scales which have been previously validated for use with adolescents, using correlational analyses and completion of further regression analyses.

Results

Participant Characteristics

The total number of participants was 127. Ages ranged from 16 to 25 (mean = 20.26, SD = 3.09). The majority of participants identified as female (55.1%), and the most common sexual identity was bisexual (39.4%). Most participants (77.9%) were White British or White Other in ethnicity. Almost all participants (*N* = 119, 93.7%) had lifetime engagement of NSSI. More than half of participants (*N* = 78, 61.4%) had engaged in NSSI in the last month. The most reported methods of NSSI were cutting, punching or hitting, and burning. Further demographic details are provided in Table 1.

[TABLE 2-1]

Following the CES-D scoring instructions (Radloff, 1977; Vilagut et al., 2016), the majority (99.2%) of participants scored about the cut-off indicative of Major Depressive Disorder. The means, ranges and cut off scores for the sample are reported in Table 2.

[TABLE 2-2]

Correlational Analyses

Kolmogorov-Smirnov tests of normality were conducted to check for normality of data, as well as visual inspections of Histograms and Q-Q plots, which indicated that the participants' age ($p < .000$), depression ($p = .004$), compassion to others ($p = .013$), compassion from others ($p = .005$), fear of self-compassion ($p = .006$) and PB ($p < .000$) were not normally distributed. Data transformations were conducted as recommended by Field (2018); however, these did not result in normal distributions. Therefore, Spearman's Rho correlations were calculated to explore the relationships between variables (Table 3).

[TABLE 2-3]

Hypothesis 1, that fear of self-compassion would have a significant positive relationship with urges to self-injure, was supported (r_s= .41, p < .001). Urge to self-inure was also significantly positively correlated with depression (r_s= .33, p < .001), PB (r_s= .56, p < .001), and TB (r_s= .19, p =.036). Previous research varies on the significance of the relationship between TB and NSSI, depending on the sample and methodology used (Assavedo & Anestis, 2016; Marco et al., 2021). Urge to self-injure was also significantly positively correlated with fear of compassion from others (r_s= .39, p < .001), and significantly negatively correlated with age, (r_s= -.21, p = .020), and self-compassion, (r_s= -.30, p = .001).

Multiple Hierarchical Regression

Assumptions of a hierarchical multiple regression were checked as recommended in Field (2018). Urge to self-injure was linearly related to all predictor variables, as indicated by scatterplots of predictor variables and urge to self-injure. Residual terms were uncorrelated, as assessed by a Durbin-Watson statistic of 2.007. Homoscedasticity was confirmed using scatterplots of residuals versus predicted values, errors were normally distributed as indicated by histograms and P-P plots of residuals, and no multicollinearity was present, as indicated by variance inflation factors (VIF) with ranges between 1.038 and 1.764 and tolerance statistics which ranged between .567 and .963. The data was checked for outliers and influential cases, none of which were identified as indicated by non-significant Mahalanobis Distances (p = .001), scatterplots, and Cook's distances of below 1.

Hypothesis 2, that fear of self-compassion would predict a significant amount of variance in urges to self-injure after the variance accounted for by TB and PB, was tested by hierarchical multiple regression. This regression is summarised in Table 4, and shows that the model explains 38.6% of the variance in urge to self-injure. At stage one, the overall model was significant in that adjusted R^2 = .15, F (5, 121) = 5.27, p = <.001. Stage two of the model was also significant as adjusted R^2 = .35, F (2, 119) = 20.08, p = <.001. Stage one explained 17.9% of the variance in urge to self-

injure, with this increasing to 38.6% at stage two. Stage three was non-significant (*p* = .75) and did not increase the percentage of variance accounted for by the model. This indicates the effects of fear of self-compassion is not significant on urges to self-injure in the final model. Once all models had been entered, it was found that only age (*p* = .002) and PB (p < .001) were significant. Therefore, hypothesis 2, that fear of self-compassion would predict a significant amount of variance in urges to self-injure, after the variance accounted for by TB and PB, was not supported.

[TABLE 2-5]

In the final model, bivariate and adjusted associations were estimated (Table 5). In the Bivariate analyses, age (*p* = .019), depression (*p* <.001), PB (*p* <.001) and fear of self-compassion (*p* <.001) were all significant. However, in the regression model only age (*p* = .006) and PB (p < .001) were significant, suggesting that the effects of depression and fear of compassion on urges to self-injure were better explained by other variables in the model, leading to depression and fear of self-compassion being suppressed in the final model. While non-significant in both analyses, the beta values for sexuality and gender showed a notable reduction in the adjusted model, lowering the significance of these factors further in the final model.

[TABLE 2-6]

Exploratory Results

Two further multiple hierarchical regressions were conducted to explore whether fear of compassion for others or fear of compassion from others explained unique variance in urge to self-injure, after the variance accounted for by TB and PB. Stage one and two of the exploratory models were entered in the same way as the main regression analysis in Table 1, yielding the same results. The exploratory regressions in Table 6 show that the final model with fear of compassion for others as the tested predictor was non-significant (*p* = .36), as was the final model with fear of compassion from others as the tested predictor (*p* = .43). While the results were non-significant, including fear of compassion for others in the model increased the variance explained to 39%, and including fear of

compassion from others increased the variance explained to 38.9%. This indicates that neither the effects of fear of compassion for others nor fear of compassion from others are significant on urges to self-injure after the variance accounted for by the other factors in the model. As with the main analyses, in both exploratory models, once all stages had been entered it was found that age and PB were significant in predicting the urge to self-injure.

Three further regression analyses were undertaken, each with one sub-scale of the flows of compassion: self-compassion, compassion to others, and compassion from others. The results of these regression analyses can be found in Table 7. The flows of compassion were each non-significant in predicting urges to self-injure. In each regression, only age and PB remained significant, indicating that the flows of compassion and fear of compassion measures operate similarly in the current sample.

[TABLE 2-7]

Finally, to assess hypothesis 3, mediation analyses were conducted using the PROCESS extension for SPSS (Hayes, 2012). The models (Figures 1 and 2) consider the independent variable of fear of self-compassion against the interpersonal needs (mediators: TB and PB) and urge to self-injure.

The outcome of the mediation in Figure 2 details when PB is not in the model, fear of self-compassion significantly predicts urge to self-injure, c = .21, 95% CI [.34, .59], p <.001. The effects of fear of self-compassion on PB are significant a = .47, 95% CI [.34, .59], p < .001. The effects of PB on urge to self-injure are also significant b = .38, 95% CI [.26, .50] p < .001. Fear of self-compassion did not significantly predict urge to self-injure with PB in the model, c' = .04, 95% CI [-.06, .14], p = .459, indicating that any effect of fear of self-compassion on urge to self-injure was mediated by PB. The indirect effect of fear of self-compassion on urge to self-injure (via PB) suggests a significant mediation: ab = .30, 95% CI [.19, .43]. Given that the CI range does not include zero, it supports the idea that PB mediated the relationship between fear of self-compassion and urge to self-injure.

[FIGURE 2-2]

As in the previous mediation analyses, the outcome of the mediation in Figure 3 details when TB is not in the model, fear of self-compassion significantly predicts urge to self-injure, c = .21, 95% CI [.34, .59], p <.001. The effects of fear of self-compassion on TB are non-significant, a = = .07, 95% CI [-.05, .20], p =.257. The effects of TB on urge to self-injure are significant, b = .14, 95% CI [.00, .27], p = .047. Fear of self-compassion significantly predicts urge to self-injure with TB in the model, c' = .20, 95% CI [.11, .30], p < .001, indicating that the effects of fear of self-compassion on urge to self-injure are not mediated by TB. The indirect effect of fear of self-compassion on urge to self-injure (via TB) suggests the relationship is not significantly mediated: ab = .01, 95% CI [-.01, .04]. Given that the CI range does include zero, it supports the idea that the relationship between fear of self-compassion and urge to self-injure is not significantly mediated by TB.

[FIGURE 2-3]

Discussion

The current study explored the relationship between TB, PB, fear of self-compassion and the urge to self-injure. The findings supported the hypothesis that fear of self-compassion would be significantly related to the urge to self-injure; however, did not support the hypothesis that fear of self-compassion would explain significant additional variance in the urge to self-injure, after the variance accounted for by TB and PB.

In the final regression model, age and PB accounted for a significant amount of variance in urge to self-injure. This suggests that in the current sample, PB predicts the experience of the urge to self-injure, while TB does not. This aligns with reviews of the ITS, whereby effect of PB on suicidal ideation has been found to be significant across populations, and contributes to larger amounts of variance (36% to 41%) than TB, at times overriding TB and being the only significant predictor (Ma et al., 2016). A key finding of the current study is that similar percentages of variance are also

accounted for in the urge to self-injure by PB, highlighting this as a key factor to consider in both NSSI and suicide prevention.

The current sample may not be representative of all of those who self-harm, as those who engage in self-harm are a heterogeneous group (Lloyd-Richardson et al., 2007). In the current sample of adolescents and young adults, over 75% of participants identified as either a sexual or gender minority, or both. The levels of PB and TB in the current sample were comparatively higher than has previously been found in adolescents (Hill et al., 2020), and in sexual minority adults (Woodward et al., 2014), and sexual minority college students (Silva et al., 2015). PB scores in the current sample are higher even than has been reported in psychiatric outpatients (Mitchell et al., 2020). Feelings of burdensomeness are common in LGBTQ+ youth, often relating to parental rejection (Higa et al., 2014) or peer rejection; however, arguably, this experience of rejection also risks development of TB.

One factor which may relate to PB in this group is internalised stigma and internalised homophobia (Marzetti et al., 2022). Internalised stigma increases the negative attitudes and beliefs an individual has towards themselves, and can lead to feelings of self-hatred, which underpin PB. Dunlop, Coleman, et al. (2022) highlighted the importance of low self-esteem in explaining NSSI behaviours in sexual minorities, indicating this as a key factor to explore within this group, which may also underlie the current findings. This indicates the importance of negative self-appraisal and cognitions regarding the self within NSSI research and practice. Self-criticism has been proposed as learned through our experiences (Aronfreed, 1964). Therefore, key groups and identities may be at an increased risk for developing negative appraisals regarding themselves, due to life experiences and societal beliefs which are enacted by others and are subsequently internalised (Baloyi, 2020; Gilbey et al., 2022; Meyer, 2003). Further investigations into the factors underlying development of PB, and the generalisability of the current findings across different identities and age ranges is required.

Research suggests that both chronic and episodic interpersonal stress are associated with increased suicidal ideation, with this relationship being mediated by PB (Buitron et al., 2016). One mechanism by which experiences of interpersonal stress may lead to increased PB is via self-blame (Abramson & Sackheim, 1977; Unthank, 2019). Self-blame is proposed by the ITS to underlie the self-hatred aspect of PB (Van Orden et al., 2010). Therefore, there may be a relationship between interpersonal stressors and self-blame, which influences PB scores. Negative self-appraisals have been shown to be significantly correlated with self-blame (Engelbrecht & Jobson, 2020), suggesting these factors are related, and again highlighting the importance of self-appraisal, and cognitions and beliefs regarding the self, in relation to the presence and severity of PB felt by an individual. LGBTQ+ individuals are at a greater risk for interpersonal stressors, increasing the risk of PB and suicidal ideation (Frost et al., 2019; Meyer, 2003; Mingelli et al., 2019). Minority sexual and gender identities have been shown to have significantly higher levels of PB than their heterosexual peers (Hill & Pettit, 2012; Pate & Anestis, 2020). Furthermore, the relationship between sexual orientation and suicidal ideation has been shown to be partially accounted for by PB, but not TB (Hill & Pettit, 2012), suggesting LGBTQ+ individuals are at a higher risk for PB, and that PB is a key construct in understanding their experiences of suicidal ideation. The current study highlights that PB is also a key factor in understanding NSSI, finding that PB significantly predicts the experience of urges to self-injure.

One understanding of the key findings that PB is a significant predictor of the urge to self-injure could relate to the body of literature which links low self-esteem with NSSI. Low self-esteem is a negative or poor global judgement of oneself (Leary & Baumeister, 2000). Both low self-esteem (Forrester et al., 2017) and negative feelings towards oneself have been shown to be related to the initiation and maintenance of NSSI (Lloyd-Richardson et al., 2007; Muehlenkamp, Bagge, et al., 2013). Notably, measures of self-esteem and self-criticism have been reported to have poor discriminant validity (Porter et al., 2019), indicating they are measuring similar constructs. Self-esteem has been evidenced as highly negatively correlated with both PB and TB (Eades et al., 2019).

Furthermore, in the underlying theory of the ITS, low self-esteem and self-blame are two indicators which underpin the “self-hate” dimension of PB (Van Orden et al., 2010). Therefore, ITS posits that those with high PB feel self-hatred and see themselves as a liability, where they believe others would be better off without them. In this sense, PB is measuring negative cognitions and perceptions the individual has regarding themselves in relation to their value to others, which may be related to the constructs of low self-esteem and self-criticism. PB may be measuring specific negative cognitions about the self, relating to interpersonal relationships, which are significant in understanding the urge to self-injure. However, further research exploring PB, self-criticism and self-esteem in relation to NSSI could add to our understanding of how these factors relate to the experience of the urge to self-injure and NSSI behaviours.

One further factor which may have influenced the increased PB scores in the current sample may be the lasting and ongoing effects of the COVID-19 pandemic. Mental health has declined across all ages following the COVID-19 pandemic, with children and adolescents being uniquely affected due to educational closures and separation from peers during key developmental years (Imran et al., 2020; Octavius et al., 2020). COVID may have had a particular impact on LGBTQ+ individuals’ mental health, which has been shown to be impacted more severely than their heterosexual peers (Fish et al., 2021). LGBTQ+ hate crimes and discrimination increased throughout the early COVID-19 pandemic and lockdowns, and the impact of COVID-19 lockdowns was found to disproportionately negatively impact LGBTQ+ youth (Bleckmann et al., 2023). A close relationship with parents was found to be a protective factor for adolescents living at home during COVID-19 lockdowns (Cooper et al., 2021), however, LGBTQ+ individuals perceive lower support from their families than heterosexual youth (Montano et al., 2018), which could account for some of the additional PB felt by LGBTQ+ adolescents and young adults. Therefore, the findings of the current study may reflect increased levels of PB following the impacts of COVID-19.

A factor related to PB which is also of interest in the current data is the depression score. Depression has been evidenced as related to PB, with PB being shown to mediate the relationship between depression and suicidality (Jahn et al., 2011; Nalipay & Ku, 2019). The effects of depression on the model are non-significant after including PB in the model, suggesting that PB better explains the effects of depression on the urge to self-injure in the current sample. This is of interest as the mean depression score in the current sample was higher than comparable samples using the same measure with 99.2% of participants scores indicating severe depressive symptomology (Woodward et al., 2014). As the sampling strategy allowed participants to self-select, it is possible that there was a bias whereby individuals with higher levels of depression were more motivated to engage with this research topic. This result is of particular interest as depression is highly related to low self-esteem and self-criticism (Porter et al., 2019). This again indicates a key factor related to the negative view of the self in relation to PB, and therefore, NSSI. Therefore, the strong predictive power of PB, and the non-significance of depression in the final model, are clear evidence of the importance of PB, and the factors which facilitate development of PB, in our understanding of NSSI.

Age accounted for significant variance in the urge to self-injure and was significant negatively correlated with urge to self-injure in the current sample, suggesting that as age increases, the urge to self-injure reduces. This aligns with research showing prevalence rates of NSSI engagement are particularly high in 16 and 17 year olds (Morey et al., 2017), then decline through adulthood (McManus et al., 2019). However, of note, age and PB were not significantly correlated. This means that levels of PB do not decrease with age, and therefore, there are other factors influencing the reduced urge to self-injure with age which were not measured in the current study.

Clinical Implications

The findings of this study, that PB predicts the urge to self-injure, have meaningful implications for both services and clinicians. PB may be a barrier to some individuals seeking support with their mental health, as there may be a fear of increasing burden on their families (Wang et al.,

2023), or healthcare services (Cadorna et al., 2023). Furthermore, qualitative studies show that some individuals disengage from services due to feeling like a burden to the mental health staff (Edwards-Bailey et al., 2023). Therefore, PB is important to consider in the engagement of clients presenting with NSSI. To support these individuals to access services, all mental health staff should work to ensure care is person-centred and those presenting with mental health difficulties are given time to express themselves in how they feel and what they desire from support (Edwards-Bailey et al., 2023). This may require further training to raise awareness of these issues with staff. Training related to self-harm presentations is associated with more positive empathy, less negative attitudes and greater perceived knowledge and confidence, which allows staff to provide better care to individuals presenting with NSSI (Muehlenkamp, Claes, et al., 2013). These changes will work towards ensuring those who need care feel more able to access this, and will aim to reduce disengagement from services due to negative treatment experiences, overall reducing the risk for clients with NSSI and suicidality.

In delivering psychological therapies, the non-significant findings relating to compassionate processes predicting the urge to self-injure may inform the most appropriate modalities of therapy for this population. Therapies such as Compassion Focussed Therapy (CFT; Gilbert, 2009; Gilbert, 2020) may be effective in reducing the self-criticism and negative self-appraisals that individuals who self-harm often report, which may underlie the experience of PB. CFT, when combined with additional skills to cope with self-harm, has been shown to reduce subsequent engagement in self-harming (Rayner et al., 2022). However, it has been shown that in individuals who self-harm, these therapies do not lead to a significant change in self-compassion scores (Rayner et al., 2022), or in TB or PB scores (Bianchini & Bodell, 2024). One explanation for these research findings could be that the reduction in self-harming behaviours may be more attributable to the increase in coping skills (Thomassin et al., 2017), rather than a reduction in the urge to self-injure.

In line with the findings of the current study and the underlying theory of the ITS, there is early evidence supporting the efficacy of therapies aimed specifically at reducing perceived burdensomeness in reducing the likelihood of subsequent suicidal thoughts (Allan et al., 2018; Lieberman et al., 2023). Given the results of the current study, it could be theorised that these interventions may also be beneficial for NSSI presentations, as an intervention specifically targeting PB may be effective in reducing the urge to self-harm. Further research is required to explore the efficacy of these approaches in the treatment of NSSI. However, early research indicates that PB is modifiable by intervention, and, therefore, has the potential to be used to address both thoughts of self-harm and suicide.

Limitations

The cross-sectional design of the current study brings limitations, including that it represents one moment in time in participants' responses (Bowen & Wiersema, 1999). Given that TB and PB are dynamic states, scores could have been impacted by recent interpersonal difficulties, mood, or other internal or external factors. Furthermore, the methodology and recruitment strategy enabled participants to self-select, which may have biased the sample. Of note, the majority of the sample scored above the threshold for clinical depression, as well as the sample being highly representative of LGBTQ+ individuals at a rate which is not reflective of the most recent Census in the United Kingdom (Office for National Statistics, 2023). Therefore, this sample may have limited generalizability to the general population, and further studies to explore the replicability of these findings in further samples and populations. Additionally, by including demographic variables in the first step of the hierarchical regression analyses, we may have removed meaningful variance that could be confounded with the psychological variables of interest. This may have impacted our ability to fully understand the interactions between these variables and the psychological processes under investigation, potentially obscuring important sources of variance (Miller & Chapman, 2001).

A limitation of the current study is the inability to assess the direction of the relationship between PB and NSSI. While the ITS posits that the presence of PB underlies the development of an urge to harm oneself, it is also possible that engagement in NSSI behaviours increases PB. Longitudinal research would be required to explore the development of these two constructs over time, and how they relate to NSSI. Furthermore, the scope and design of the project did not allow for measurement of alternate mechanisms which may relate to the urge to self-injure, such as self-esteem or self-criticism. Further exploration of these factors may have improved our understanding of the current results.

Further Research

The current findings support previous research highlighting that negative cognitions and perceptions regarding the self are related to the urge to self-injure and engagement in NSSI. Further research would benefit from exploring factors which have previously been found to be related to NSSI, such as self-criticism and self-esteem (Dunlop, Coleman, et al., 2022; Zelkowitz & Cole, 2019), alongside PB to explore which factors remain significant in explaining variance in the urge to self-injure or NSSI. This would allow exploration if more general negative cognitions about the self better predict NSSI, or if PB remains a significant predictor measuring a more specific construct related to NSSI. Longitudinal research would also allow for an exploration of potential factors which precede the development of PB, such as those discussed in the current paper, including self-criticism, self-esteem, or a fear of compassion.

As noted previously, the current study provides evidence of a strong predictive relationship between PB and the urge to self-injure in adolescents and young adults. Intervention studies on the efficacy of intervention targeted at reducing perceived burdensomeness in those who self-injure and the subsequent effect on thought and the urge to self-injure, as well as self-injurious behaviours would allow exploration of whether the positive effects of these interventions for suicidality are replicable for NSSI.

Conclusion

This research highlighted that neither fear of self-compassion nor TB explained significant variance in the urge to self-injure when considering the variance accounted for by perceived burdensomeness; however, PB and participant age were found to be significant predictors. Possible explanations of the current findings were explored, and suggestions were made in relation to supporting individuals who self-injure. Early studies show efficacy of psychological interventions targeting PB to reduce experience of suicidal ideation. Therefore, it was suggested that further studies to explore the efficacy of these interventions targeting PB for those who self-injure, as this treatment may target the underlying factors which drive the urge to self-injure.

References

Abdelraheem, M., McAloon, J., & Shand, F. (2019). Mediating and moderating variables in the prediction of self-harm in young people: A systematic review of prospective longitudinal studies. *Journal of Affective Disorders*, *246*, 14-28. https://doi.org/10.1016/j.jad.2018.12.004

Abramson, L. Y., & Sackheim, H. A. (1977). A paradox in depression: uncontrollability and self-blame. *Psychological bulletin*, *84*(5), 838.

Al-Sharifi, A., Krynicki, C. R., & Upthegrove, R. (2015). Self-harm and ethnicity: A systematic review. *International Journal of Social Psychiatry*, *61*(6), 600-612.

Allan, N. P., Boffa, J. W., Raines, A. M., & Schmidt, N. B. (2018). Intervention related reductions in perceived burdensomeness mediates incidence of suicidal thoughts. *Journal of Affective Disorders*, *234*, 282-288.

Allen, A. B., & Leary, M. R. (2010). Self-Compassion, stress, and coping. *Social and personality psychology compass*, *4*(2), 107-118.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (Vol. 5). American psychiatric association Washington, DC.

Aronfreed, J. (1964). The origin of self-criticism. *Psychological review*, *71*(3), 193.

Assavedo, B. L., & Anestis, M. D. (2016). The relationship between non-suicidal self-injury and both perceived burdensomeness and thwarted belongingness. *Journal of Psychopathology and Behavioral Assessment*, *38*(2), 251-257. https://doi.org/10.1007/s10862-015-9508-8

Baloyi, M. E. (2020). Black self-hatred: regaining self-worth-from decolonisation towards reconciliation in South Africa-a practical theological appraisal. *Theologia Viatorum*, *44*(1), 1-8.

Banerjee, D., & Nair, V. S. (2020). “The untold side of COVID-19”: Struggle and perspectives of the sexual minorities. *Journal of Psychosexual Health*, *2*(2), 113-120.

Bianchini, G., & Bodell, L. P. (2024). An open trial of a brief, self-compassion intervention targeting thwarted belongingness and perceived burdensomeness. *Archives of Suicide Research*, 1-13.

Bleckmann, C., Leyendecker, B., & Busch, J. (2023). Sexual and gender minorities facing the Coronavirus pandemic: A systematic review of the distinctive psychosocial and health-related impact. *Journal of Homosexuality*, *70*(12), 2741-2762.

Blodgett, J. M., Lachance, C. C., Stubbs, B., Co, M., Wu, Y.-T., Prina, M., Tsang, V. W., & Cosco, T. D. (2021). A systematic review of the latent structure of the Center for Epidemiologic Studies Depression Scale (CES-D) amongst adolescents. *BMC Psychiatry*, *21*, 1-8.

Bowen, H. P., & Wiersema, M. F. (1999). Matching method to paradigm in strategy research: limitations of cross-sectional analysis and some methodological alternatives. *Strategic management journal*, *20*(7), 625-636.

Brach, T. (2004). *Radical acceptance: Embracing your life with the heart of a Buddha*. Bantam.

Buitron, V., Hill, R. M., Pettit, J. W., Green, K. L., Hatkevich, C., & Sharp, C. (2016). Interpersonal stress and suicidal ideation in adolescence: An indirect association through perceived burdensomeness toward others. *Journal of Affective Disorders*, *190*, 143-149.

Cadorna, G., Vera San Juan, N., Staples, H., Johnson, S., & Appleton, R. (2023). Systematic review and metasynthesis of qualitative literature on young people's experiences of going to A&E/emergency departments for mental health support. *Child and adolescent mental health*.

Cawley, R., Pontin, E. E., Touhey, J., Sheehy, K., & Taylor, P. J. (2019). What is the relationship between rejection and self-harm or suicidality in adulthood? *Journal of Affective Disorders*, *242*, 123-134. https://doi.org/10.1016/j.jad.2018.08.082

Chávez-Flores, Y. V., Hidalgo-Rasmussen, C. A., & Yanez-Peñúñuri, L. Y. (2019). Assessment tools of non-suicidal self-injury in adolescents 1990-2016: a systematic review. *Ciência & Saúde Coletiva*, *24*, 2871-2882.

Cheek, S. M., Reiter-Lavery, T., & Goldston, D. B. (2020). Social rejection, popularity, peer victimization, and self-injurious thoughts and behaviors among adolescents: A systematic review and meta-analysis. *Clinical Psychology Review*, *82*, 101936.

Cleare, S., Gumley, A., & O'Connor, R. C. (2019). Self-compassion, self-forgiveness, suicidal ideation, and self-harm: A systematic review. *Clinical Psychology & Psychotherapy*, *26*(5), 511-530. https://doi.org/10.1002/cpp.2372

Cooper, K., Hards, E., Moltrecht, B., Reynolds, S., Shum, A., McElroy, E., & Loades, M. (2021). Loneliness, social relationships, and mental health in adolescents during the COVID-19 pandemic. *Journal of Affective Disorders*, *289*, 98-104.

Copeland, M., Siennick, S. E., Feinberg, M. E., Moody, J., & Ragan, D. T. (2019). Social ties cut both ways: self-harm and adolescent peer networks. *Journal of Youth and Adolescence*, *48*, 1506-1518.

Cosley, B. J., McCoy, S. K., Saslow, L. R., & Epel, E. S. (2010). Is compassion for others stress buffering? Consequences of compassion and social support for physiological reactivity to stress. *Journal of experimental social psychology*, *46*(5), 816-823.

Cunha, M., Galhardo, A., Gilbert, P., Rodrigues, C., & Matos, M. (2023). The flows of compassion in adolescents as measured by the compassionate engagement and action scales. *Current Psychology*, *42*(9), 7737-7751.

Cybulski, L., Ashcroft, D. M., Carr, M. J., Garg, S., Chew-Graham, C. A., Kapur, N., & Webb, R. T. (2021). Temporal trends in annual incidence rates for psychiatric disorders and self-harm among children and adolescents in the UK, 2003–2018. *BMC Psychiatry*, *21*, 1-12.

Daly, M., Sutin, A. R., & Robinson, E. (2022). Longitudinal changes in mental health and the COVID-19 pandemic: Evidence from the UK Household Longitudinal Study. *Psychological Medicine*, *52*(13), 2549-2558.

Demuthova, S., Vaclavikova, I., Selecka, L., & Blatny, M. (2020). The Problem of Self-Disclosure of Self-Harming Behaviour in Adolescence. *Postmodern Openings*, *11*(4), 01-19.

Dunlop, B. J., Coleman, S. E., Hartley, S., Carter, L. A., Taylor, P. J., & Carter, L.-A. (2022). Self-injury in young bisexual people: A microlongitudinal investigation (SIBL) of thwarted belongingness

and self-esteem on non-suicidal self-injury. *Suicide & Life-Threatening Behavior*, *52*(2), 317-328. https://doi.org/10.1111/sltb.12823

Eades, A., Segal, D. L., & Coolidge, F. L. (2019). Suicide risk factors among older adults: Exploring thwarted belongingness and perceived burdensomeness in relation to personality and self-esteem. *The International Journal of Aging and Human Development*, *88*(2), 150-167.

Edwards-Bailey, L., Cartwright, T., Smyth, N., & Mackenzie, J.-M. (2023). A qualitative exploration of student self-harm and experiences of support-seeking within a UK university setting. *Counselling Psychology Quarterly*, *36*(4), 638-662.

Engelbrecht, A., & Jobson, L. (2020). Self-concept, post-traumatic self-appraisals and post-traumatic psychological adjustment: what are the relationships? *Behavioural and Cognitive Psychotherapy*, *48*(4), 463-480.

Erlangsen, A., Qin, P., & Mittendorfer-Rutz, E. (2018). Studies of suicidal behavior using national registers. In: Hogrefe Publishing.

Fässberg, M. M., Van Orden, K. A., Duberstein, P., Erlangsen, A., Lapierre, S., Bodner, E., Canetto, S. S., Leo, D. D., Szanto, K., & Waern, M. (2012). A systematic review of social factors and suicidal behavior in older adulthood. *International journal of environmental research and public health*, *9*(3), 722-745.

Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G* Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior research methods*, *39*(2), 175-191.

Field, A. (2018). Discovering Statistics Using IBM Statistics. 5th edn. Ed: J. Seaman. In: London: Sage Publications.

Fish, J. N., Salerno, J., Williams, N. D., Rinderknecht, R. G., Drotning, K. J., Sayer, L., & Doan, L. (2021). Sexual minority disparities in health and well-being as a consequence of the COVID-19 pandemic differ by sexual identity. *LGBT Health*, *8*(4), 263-272.

Fliege, H., Lee, J.-R., Grimm, A., & Klapp, B. F. (2009). Risk factors and correlates of deliberate self-harm behavior: A systematic review. *Journal of psychosomatic research*, *66*(6), 477-493.

Forrester, R. L., Slater, H., Jomar, K., Mitzman, S., & Taylor, P. J. (2017). Self-esteem and non-suicidal self-injury in adulthood: A systematic review. *Journal of Affective Disorders*, *221*, 172-183.

Frost, D. M., Fine, M., Torre, M. E., & Cabana, A. (2019). Minority stress, activism, and health in the context of economic precarity: Results from a national participatory action survey of lesbian, gay, bisexual, transgender, queer, and gender non-conforming youth. *American Journal of Community Psychology*, *63*(3-4), 511-526.

Gilbert, P. (1998). Evolutionary psychopathology: Why isn't the mind designed better than it is? *British Journal of Medical Psychology*, *71*(4), 353-373.

Gilbert, P. (2005). *Compassion: Conceptualisations, research and use in psychotherapy*. Routledge.

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment*, *15*(3), 199-208.

Gilbert, P. (2010). *Compassion focused therapy: Distinctive features*. Routledge.

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology*, *53*(1), 6-41. https://doi.org/10.1111/bjc.12043

Gilbert, P. (2020). Compassion: From its evolution to a psychotherapy. *Frontiers in Psychology*, *11*, 3123.

Gilbert, P., Catarino, F., Duarte, C., Matos, M., Kolts, R., Stubbs, J., Ceresatto, L., Duarte, J., Pinto-Gouveia, J., & Basran, J. (2017). The development of compassionate engagement and action scales for self and others. *Journal of Compassionate Health Care*, *4*(1), 1-24.

Gilbert, P., & Mascaro, J. (2017). Compassion: Fears, blocks, and resistances: An evolutionary investigation. *The Oxford handbook of compassion science*, 399-420.

Gilbert, P., McEwan, K., Matos, M., & Rivis, A. (2011). Fears of compassion: Development of three self-report measures. *Psychology and Psychotherapy: Theory, Research and Practice*, *84*(3), 239-255.

Gilbey, D., Perry, Y., Lin, A., & Ohan, J. (2022). "Shame, Doubt and Sadness": A Qualitative Investigation of the Experience of Self-Stigma in Adolescents with Diverse Sexual Orientations. *Youth*, *2*(3), 352-365.

Griep, S. K., & MacKinnon, D. F. (2022). Does nonsuicidal self-injury predict later suicidal attempts? A review of studies. *Archives of Suicide Research*, *26*(2), 428-446.

Harris, J. (2000). Self-harm: Cutting the bad out of me. *Qualitative Health Research*, *10*(2), 164-173.

Hasking, P., Boyes, M. E., Finlay-Jones, A., McEvoy, P. M., & Rees, C. S. (2019). Common pathways to NSSI and suicide ideation: The roles of rumination and self-compassion. *Archives of Suicide Research*, *23*(2), 247-260. https://doi.org/10.1080/13811118.2018.1468836

Hawton, K., & Harriss, L. (2007). Deliberate self-harm in young people: characteristics and subsequent mortality in a 20-year cohort of patients presenting to hospital.[CME]. *Journal of Clinical Psychiatry*, *68*(10), 1574.

Hayes, A. F. (2012). PROCESS: A versatile computational tool for observed variable mediation, moderation, and conditional process modeling. In: University of Kansas, KS.

Hetrick, S. E., Subasinghe, A., Anglin, K., Hart, L., Morgan, A., & Robinson, J. (2020). Understanding the needs of young people who engage in self-harm: a qualitative investigation. *Frontiers in Psychology*, *10*, 2916.

Higa, D., Hoppe, M. J., Lindhorst, T., Mincer, S., Beadnell, B., Morrison, D. M., Wells, E. A., Todd, A., & Mountz, S. (2014). Negative and positive factors associated with the well-being of lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) youth. *Youth & Society*, *46*(5), 663-687.

Hill, R. M., Mellick, W., Alvis, L., Dodd, C. G., Do, C., Buitron, V., Sharp, C., Pettit, J. W., & Kaplow, J. B. (2020). Performance of the interpersonal needs questionnaire in adolescent clinical samples: Confirmatory factor analyses and evaluation of measurement invariance. *Suicide and Life-Threatening Behavior*, *50*(6), 1214-1222.

Hill, R. M., & Pettit, J. W. (2012). Suicidal ideation and sexual orientation in college students: The roles of perceived burdensomeness, thwarted belongingness, and perceived rejection due to sexual orientation. *Suicide and Life-Threatening Behavior*, *42*(5), 567-579.

Hill, R. M., Rey, Y., Marin, C. E., Sharp, C., Green, K. L., & Pettit, J. W. (2015). Evaluating the Interpersonal Needs Questionnaire: Comparison of the reliability, factor structure, and predictive validity across five versions. *Suicide and Life-Threatening Behavior*, *45*(3), 302-314.

Hooley, J. M., Fox, K. R., & Boccagno, C. (2020). Nonsuicidal self-injury: diagnostic challenges and current perspectives. *Neuropsychiatric disease and treatment*, 101-112.

Imran, N., Zeshan, M., & Pervaiz, Z. (2020). Mental health considerations for children & adolescents in COVID-19 Pandemic. *Pakistan journal of medical sciences*, *36*(COVID19-S4), S67.

Jahn, D. R., Cukrowicz, K. C., Linton, K., & Prabhu, F. (2011). The mediating effect of perceived burdensomeness on the relation between depressive symptoms and suicide ideation in a community sample of older adults. *Aging & Mental Health*, *15*(2), 214-220.

Jazaieri, H., McGonigal, K., Jinpa, T., Doty, J. R., Gross, J. J., & Goldin, P. R. (2014). A randomized controlled trial of compassion cultivation training: Effects on mindfulness, affect, and emotion regulation. *Motivation and emotion*, *38*, 23-35.

Jiang, Y., You, J., Hou, Y., Du, C., Lin, M.-P., Zheng, X., & Ma, C. (2016). Buffering the effects of peer victimization on adolescent non-suicidal self-injury: The role of self-compassion and family cohesion. *Journal of Adolescence*, *53*, 107-115. https://doi.org/10.1016/j.adolescence.2016.09.005

Joiner, T. E. (2005). *Why people die by suicide*. Harvard University Press.

Kirby, J. N., Day, J., & Sagar, V. (2019). The 'Flow'of compassion: A meta-analysis of the fears of compassion scales and psychological functioning. *Clinical Psychology Review*, *70*, 26-39.

Klemera, E., Brooks, F., Chester, K., Magnusson, J., Spencer, N., Brooks, F. M., & Chester, K. L. (2017). Self-harm in adolescence: protective health assets in the family, school and community.

International Journal of Public Health (Springer Nature), *62*(6), 631-638. https://doi.org/10.1007/s00038-016-0900-2

Kneale, D., & Bécares, L. (2020). The mental health and experiences of discrimination of LGBTQ+ people during the COVID-19 pandemic: initial findings from the Queerantine study. *MedRxiv*, 2020.2008. 2003.20167403.

La Guardia, A. C., Cramer, R. J., Bryson, C. N., & Emelianchik-Key, K. (2020). Analysis of personality, suicide, and self-injury in emerging adulthood. *Journal of College Counseling*, *23*(1), 57-70.

Larkin, C., Di Blasi, Z., & Arensman, E. (2014). Risk factors for repetition of self-harm: a systematic review of prospective hospital-based studies. *PLoS ONE*, *9*(1), e84282.

Lathren, C. R., Rao, S. S., Park, J., & Bluth, K. (2021). Self-compassion and current close interpersonal relationships: A scoping literature review. *Mindfulness*, *12*, 1078-1093.

Laye-Gindhu, A., & Schonert-Reichl, K. A. (2005). Nonsuicidal self-harm among community adolescents: Understanding the “whats” and “whys” of self-harm. *Journal of Youth and Adolescence*, *34*, 447-457.

Leary, M. R., & Baumeister, R. F. (2000). The nature and function of self-esteem: Sociometer theory. In *Advances in experimental social psychology* (Vol. 32, pp. 1-62). Elsevier.

Lieberman, A., Gai, A. R., Rogers, M. L., Jobes, D. A., Rudd, M. D., Chalker, S. A., Brenner, J. T., & Joiner, T. E. (2023). Targeting perceived burdensomeness to reduce suicide risk. *Behavior Therapy*, *54*(4), 696-707.

Lloyd-Richardson, E. E., Perrine, N., Dierker, L., & Kelley, M. L. (2007). Characteristics and functions of non-suicidal self-injury in a community sample of adolescents. *Psychological Medicine*, *37*(8), 1183-1192.

Lloyd, B., Blazely, A., & Phillips, L. (2018). Stigma towards individuals who self harm: Impact of gender and disclosure. *Journal of Public Mental Health*, *17*(4), 184-194.

Loades, M. E., Chatburn, E., Higson-Sweeney, N., Reynolds, S., Shafran, R., Brigden, A., Linney, C., McManus, M. N., Borwick, C., & Crawley, E. (2020). Rapid systematic review: the impact of

social isolation and loneliness on the mental health of children and adolescents in the context of COVID-19. *Journal of the American Academy of Child & Adolescent Psychiatry*, *59*(11), 1218-1239. e1213.

Ma, J., Batterham, P. J., Calear, A. L., & Han, J. (2016). A systematic review of the predictions of the Interpersonal–Psychological Theory of Suicidal Behavior. *Clinical Psychology Review*, *46*, 34-45.

MacBeth, A., & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review*, *32*(6), 545-552.

Marco, J. H., Gallego-Hernández de Tejada, B., Guillén, V., Baños, R. M., & Pérez, S. (2021). Meaning in life buffers the association between perceived burdensomeness, thwarted belongingness, and frequency of non-suicidal self-injuries in Spanish adolescents. *Journal of clinical medicine*, *10*(21), 4867.

Marzetti, H., McDaid, L., & O'Connor, R. (2022). “Am I really alive?”: Understanding the role of homophobia, biphobia and transphobia in young LGBT+ people's suicidal distress. *Social Science & Medicine*, *298*, 114860.

McManus, S., Gunnell, D., Cooper, C., Bebbington, P. E., Howard, L. M., Brugha, T., Jenkins, R., Hassiotis, A., Weich, S., & Appleby, L. (2019). Prevalence of non-suicidal self-harm and service contact in England, 2000–14: repeated cross-sectional surveys of the general population. *The Lancet Psychiatry*, *6*(7), 573-581.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological bulletin*, *129*(5), 674.

Miller, A. L., & Smith, H. L. (2008). Adolescent non-suicidal self-injurious behavior: The latest epidemic to assess and treat. *Applied and Preventive Psychology*, *12*(4), 178-188.

Mingelli, F., Perrone, D., Balducci, J., Sacchetti, A., Ferrari, S., Mattei, G., & Galeazzi, G. M. (2019). Minority stress and mental health among LGBT populations: An update on the evidence. *Minerva Psichiatrica*, *60*(1), 27-50.

Mitchell, S. M., Brown, S. L., Roush, J. F., Tucker, R. P., Cukrowicz, K. C., & Joiner, T. E. (2020). The Interpersonal Needs Questionnaire: Statistical considerations for improved clinical application. *Assessment*, *27*(3), 621-637.

Montano, G. T., Thoma, B. C., Paglisotti, T., Weiss, P. M., Shultz, M. K., McCauley, H. L., Miller, E., & Marshal, M. P. (2018). Disparities in parental support and parental attachment between heterosexual and sexual minority youth: A meta-analysis. *Journal of Adolescent Health*, *62*(2), S32-S33.

Morey, Y., Mellon, D., Dailami, N., Verne, J., & Tapp, A. (2017). Adolescent self-harm in the community: an update on prevalence using a self-report survey of adolescents aged 13–18 in England. *Journal of Public Health*, *39*(1), 58-64.

Muehlenkamp, J. J., Bagge, C. L., Tull, M. T., & Gratz, K. L. (2013). Body regard as a moderator of the relation between emotion dysregulation and nonsuicidal self-injury. *Suicide and Life-Threatening Behavior*, *43*(5), 479-493.

Muehlenkamp, J. J., Claes, L., Quigley, K., Prosser, E., Claes, S., & Jans, D. (2013). Association of training on attitudes towards self-injuring clients across health professionals. *Archives of Suicide Research*, *17*(4), 462-468.

Mughal, F., Troya, M. I., Dikomitis, L., Tierney, S., Evans, N., Townsend, E., & Chew-Graham, C. A. (2022). The experiences and needs of supporting individuals of young people who self-harm: A systematic review and thematic synthesis. *EClinicalMedicine*.

Nalipay, M. J. N., & Ku, L. (2019). Indirect effect of hopelessness on depression symptoms through perceived burdensomeness. *Psychological Reports*, *122*(5), 1618-1631.

Neff, K. D. (2023). Self-compassion: Theory, method, research, and intervention. *Annual review of psychology*, *74*, 193-218.

Nock, M. K. (2009). Why do people hurt themselves? New insights into the nature and functions of self-injury. *Current Directions in Psychological Science*, *18*(2), 78-83.

Nock, M. K. (2010). Self-injury. *Annual review of clinical psychology*, *6*(1), 339-363.

Octavius, G. S., Silviani, F. R., Lesmandjaja, A., Angelina, & Juliansen, A. (2020). Impact of COVID-19 on adolescents' mental health: a systematic review. *Middle East current psychiatry*, *27*, 1-8.

Pate, A. R., & Anestis, M. D. (2020). Comparison of perceived burdensomeness, thwarted belongingness, capability for suicide, and suicidal ideation among heterosexual and sexual minority individuals in Mississippi. *Archives of Suicide Research*, *24*(sup2), S293-S309.

Peterson, C., Miller, G. F., Barnett, S. B. L., & Florence, C. (2021). Economic cost of injury—United States, 2019. *Morbidity and Mortality Weekly Report*, *70*(48), 1655.

Porter, A. C., Zelkowitz, R. L., Gist, D. C., & Cole, D. A. (2019). Self-evaluation and depressive symptoms: A latent variable analysis of self-esteem, shame-proneness, and self-criticism. *Journal of Psychopathology and Behavioral Assessment*, *41*, 257-270.

Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied psychological measurement*, *1*(3), 385-401.

Rasmussen, S., Hawton, K., Philpott-Morgan, S., & O'Connor, R. C. (2016). Why do adolescents self-harm? *Crisis*.

Rayner, G. C., Bowling, G., Bluff, L., Wright, K., Ashworth-Lord, A., & Laird, C. (2022). A multi-method evaluation of a compassion-focused cognitive behavioural psychotherapy group for people who self-harm. *Counselling and Psychotherapy Research*, *22*(3), 569-582.

Rockett, I. R., Ali, B., Caine, E. D., Shepard, D. S., Banerjee, A., Nolte, K. B., Connery, H. S., Larkin, G. L., Stack, S., & White, F. M. (2023). Escalating costs of self-injury mortality in the 21st century United States: an interstate observational study. *BMC public health*, *23*(1), 285.

Silva, C., Chu, C., Monahan, K. R., & Joiner, T. E. (2015). Suicide risk among sexual minority college students: A mediated moderation model of sex and perceived burdensomeness. *Psychology of Sexual Orientation and Gender Diversity*, *2*(1), 22-33. https://doi.org/10.1037/sgd0000086

Simm, R., Roen, K., & Daiches, A. (2010). Primary school children and self harm: the emotional impact upon education professionals, and their understandings of why children self harm and how this is managed. *Oxford Review of Education*, *36*(6), 677-692.

Smith, A. R., Ribeiro, J. D., Mikolajewski, A., Taylor, J., Joiner, T. E., & Iacono, W. G. (2012). An examination of environmental and genetic contributions to the determinants of suicidal behavior among male twins. *Psychiatry Research*, *197*(1-2), 60-65.

Solomon, R. L. (1980). The opponent-process theory of acquired motivation: the costs of pleasure and the benefits of pain. *American Psychologist*, *35*(8), 691.

Spillane, A., Matvienko-Sikar, K., Larkin, C., & Arensman, E. (2020). How do people experience a family member's high-risk self-harm? An interpretative phenomenological analysis. *Archives of Suicide Research*, *24*(sup1), 280-302.

Stallard, P., Spears, M., Montgomery, A. A., Phillips, R., & Sayal, K. (2013). Self-harm in young adolescents (12–16 years): onset and short-term continuation in a community sample. *BMC Psychiatry*, *13*(1), 1-14.

Stockings, E., Degenhardt, L., Lee, Y. Y., Mihalopoulos, C., Liu, A., Hobbs, M., & Patton, G. (2015). Symptom screening scales for detecting major depressive disorder in children and adolescents: a systematic review and meta-analysis of reliability, validity and diagnostic utility. *Journal of Affective Disorders*, *174*, 447-463.

Suh, H., & Jeong, J. (2021). Association of self-compassion with suicidal thoughts and behaviors and non-suicidal self injury: A meta-analysis. *Frontiers in Psychology*, *12*, 633482.

Thomassin, K., Guérin Marion, C., Venasse, M., & Shaffer, A. (2017). Specific coping strategies moderate the link between emotion expression deficits and nonsuicidal self-injury in an inpatient sample of adolescents. *Child and Adolescent Psychiatry and Mental Health*, *11*, 1-8.

Turecki, G., & Brent, D. A. (2016). Suicide and suicidal behaviour. *The Lancet*, *387*(10024), 1227-1239.

Umphrey, L. R., Sherblom, J. C., & Swiatkowski, P. (2020). Relationship of Self-Compassion, Hope, and Emotional Control to Perceived Burdensomeness, Thwarted Belongingness, and Suicidal Ideation. *Crisis: The Journal of Crisis Intervention & Suicide Prevention*, 1-7. https://doi.org/10.1027/0227-5910/a000697

Unthank, K. W. (2019). How self-blame empowers and disempowers survivors of interpersonal trauma: An intuitive inquiry. *Qualitative Psychology*, *6*(3), 359.

Van Orden, K. A., Cukrowicz, K. C., Witte, T. K., & Joiner Jr, T. E. (2012). Thwarted belongingness and perceived burdensomeness: construct validity and psychometric properties of the Interpersonal Needs Questionnaire. *Psychological Assessment*, *24*(1), 197.

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner Jr, T. E. (2010). The interpersonal theory of suicide. *Psychological review*, *117*(2), 575.

Vilagut, G., Forero, C. G., Barbaglia, G., & Alonso, J. (2016). Screening for depression in the general population with the Center for Epidemiologic Studies Depression (CES-D): a systematic review with meta-analysis. *PLoS ONE*, *11*(5), e0155431.

Vitaliano, P. P., Zhang, J., & Scanlan, J. M. (2003). Is caregiving hazardous to one's physical health? A meta-analysis. *Psychological bulletin*, *129*(6), 946.

Wang, L., Zou, H., Yang, Y., & Hong, J. (2023). Adolescents' attitudes toward non-suicidal self-injury (NSSI) and their perspectives of barriers to seeking professional treatment for NSSI. *Archives of Psychiatric Nursing*, *45*, 26-35.

Wang, S., Chen, L., Ran, H., Che, Y., Fang, D., Sun, H., Peng, J., Liang, X., & Xiao, Y. (2022). Depression and anxiety among children and adolescents pre and post COVID-19: A comparative meta-analysis. *Frontiers in Psychiatry*, *13*, 917552.

Washburn, J. J., Juzwin, K., Styer, D. M., & Aldridge, D. (2010). Measuring the urge to self-injure: Preliminary data from a clinical sample. *Psychiatry Research*, *178*(3), 540-544.

White, J., Trinh, M.-H., & Reynolds, C. A. (2023). Psychological distress, self-harm and suicide attempts in gender minority compared with cisgender adolescents in the UK. *BJPsych Open*, *9*(5), e138.

Witt, K., Milner, A., Spittal, M. J., Hetrick, S., Robinson, J., Pirkis, J., & Carter, G. (2019). Population attributable risk of factors associated with the repetition of self-harm behaviour in young

people presenting to clinical services: a systematic review and meta-analysis. *European Child & Adolescent Psychiatry*, *28*, 5-18.

Woodward, E. N., Wingate, L., Gray, T. W., & Pantalone, D. W. (2014). Evaluating thwarted belongingness and perceived burdensomeness as predictors of suicidal ideation in sexual minority adults. *Psychology of Sexual Orientation and Gender Diversity*, *1*(3), 234.

Wright, N., Hill, J., Sharp, H., & Pickles, A. (2020). Impact of COVID-19 on young adolescent mental health: comparison of depression, anxiety and behaviour problems in 12 year olds immediately before and during the pandemic in a UK birth cohort. *Anxiety and Behaviour Problems in*, *12*.

Wu, J., Liu, S., Luo, J., Li, X., & You, J. (2023). The effects of childhood abuse, depression, and self-compassion on adolescent nonsuicidal self-injury: A moderated mediation model. *Child Abuse & Neglect*, *136*, 105993.

Xavier, A., Pinto Gouveia, J., & Cunha, M. (2016). Non-suicidal self-injury in adolescence: The role of shame, self-criticism and fear of self-compassion. *Child & Youth Care Forum*, *45*(4), 571-586. https://doi.org/10.1007/s10566-016-9346-1

Zelkowitz, R. L., & Cole, D. A. (2019). Self-Criticism as a Transdiagnostic Process in Nonsuicidal Self-Injury and Disordered Eating: Systematic Review and Meta-Analysis. *Suicide & Life-Threatening Behavior*, *49*(1), 310-327. https://doi.org/10.1111/sltb.12436

Tables and Figures

Table 1: Demographics

Demographic Variable	*N* (%)
Gender	
Female	70 (55.1)
Male	29 (22.8)
Non-binary	24 (18.9)
Other[a]	4 (3.1)
Gender identity same as sex assigned at birth[b]	84 (66.1)
Sexuality	
Straight or heterosexual	31 (24.4)
Gay or lesbian	25 (19.7)
Bisexual	50 (39.4)
Other[c]	21 (16.5)
Ethnicity	
White British	77 (60.6)
White Other	22 (17.3)
Black or Black mixed	13 (10.2)
Asian or Asian mixed	10 (7.9)
Other	5 (4)
Self-injurious behaviour engagement	
Lifetime engagement	119 (93.7)
Engagement in the past year	108 (85)
Engagement in the past month	78 (61.4)
Engagement in the past week	49 (38.6)
Method of self-injury (ever utilised)[d]	
Cutting	108 (85)
Punching or hitting self	39 (30.7)
Burning	39 (30.7)
Scratching	36 (28.3)
Head banging	20 (15.7)
Altering or restricting food intake (including purging)	16 (12.6)
Misuse of drugs or alcohol (including overdose)	14 (11)
Hair pulling	9 (7.1)
Biting self	6 (4.7)
Other[e]	29 (22.8)

a = Agender (1), Genderfluid (1), Masc Non-Binary (1), Trans Male (1)
b = includes non-binary and transgender identities, as well as any other gender identity which is either not the same as assigned at birth or is otherwise outside of the gender binary
c = Other sexualities include: Asexual (11), Queer (2), Pansexual (2), Unsure (2), Demisexual (1), Aromantic Bisexual (1), Cupio-Sexual (1), Unlabelled (1)
d = does not add up to 100% as participants had engaged in more than one method of self-harm, % is percentage of the 127 that named each method
e = Other methods include ligaturing, self-suffocation, engaging in sexual behaviours as a method of self-harming, using an elastic band to 'snap' the wrist, reckless behaviour (unspecified), hanging, drinking Dettol, and swallowing non-food objects.

Table 2: Means, Ranges, Cronbach's Alpha, and Cut-off Scores for predictor and outcome variables

Variable	Mean (SD)	Range	Cronbach's alpha (α)
Age	20.26 (3.09)	16 – 25	-
Depression	41.69 (8.68)	14 – 60	.83
Self-compassion	40.09 (14.22)	11 – 72	.66
Compassion to others	74.43 (15.55)	30 - 99	.75
Compassion from others	36.99 (19.35)	0 – 86	.78
Fear of self-compassion	36.09 (12.35)	7 – 60	.88
Fear of compassion for others	17.65 (7.87)	0 – 36	.83
Fear of compassion from others	30.28 (9.27)	9 – 50	.84
Perceived Burdensomeness	28.32 (10.21)	6 – 42	.92
Thwarted belongingness	44.56 (8.69)	21 – 61	.81
Urge to self-injure	24.31 (7.14)	9 – 37	.90
	% Scoring 20 or above (Indicative of Major Depressive Disorder; Vilagut et al., 2016)		
Depression	99.21		

Table 3: Spearman's Rho correlation matrix between variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Age	-													
2. Gender	.008	-												
3. Sexuality	-.166	.407***	-											
4. Ethnicity	-.178*	-.059	-.096	-										
5. Depression	.049	.104	.133	-.187*	-									
6. Perceived burdensomeness	.030	.149	.069	-.090	.532***	-								
7. Thwarted Belongingness	.046	-.105	-.029	-.184*	.315***	.265**	-							
8. Fear of self-compassion	-.102	.117	.008	-.019	.042***	.568***	.101	-						
9. Fear of compassion from others	-.043	.141	.084	-.175*	.377***	.542***	.222*	.162***	-					
10. Fear of compassion for others	-.143	-.66	-.178*	.092	.143	.112	.021	.351***	.319***	-				
11. Self-compassion	.099	-.063	.049	.156	-.091	-.333***	-.197*	-.265***	-.207**	-.071	-			
12. Compassion from others	.006	-.058	-.161	.122	-.174	-.226*	-.647***	-.052	-.273**	-.089	.247**	-		
13. Compassion to others	.113	-.035	.083	-.138	.162	-.080	-.143	.055	-.045	-.093	.085	.143	-	
14. Urge to self-injure	-.206*	.126	.090	-.062	.332***	.556***	.186*	.407***	.393***	.059	-.298**	-.142	-.042	-

** p significant at the 0.05 level (2-tailed)*

*** p significant at the .01 level (2-tailed)*

**** p significant at the .001 level (2-tailed)*

Table 4: Regression predicting urge to self-injure with tested predictor Fear of self-compassion (N=127)

	B	*SE B*	*β*	*t*	*p*	R^2	*Adj.* R^2	R^2 *Change*	*F*
Step 1 **Demographic Variables**						**.179**	**.145**	**.179**	**5.267****
Age	-.550	.197	-.238	-2.787	.006				
Gender	1.626	1.363	.108	1.193	.235				
Sexuality	-.517	1.533	-.031	-.337	.737				
Ethnicity	-1.066	1.460	-.062	-.730	.467				
Depression	.274	.069	.334	3.975	< .001				
Step 2 **Interpersonal Needs**						**.386**	**.350**	**.207**	**20.077****
Age	-.497	.172	-.215	-2.882	.005				
Gender	.900	2.209	.060	.744	.458				
Sexuality	-.158	1.338	-.010	-.118	.906				
Ethnicity	-.877	1.290	-.051	-.680	.498				
Depression	.052	.071	.064	.735	.464				
Perceived burdensomeness	.364	.059	.520	6.200	< .001				
Thwarted Belongingness	.035	.065	.042	.532	.595				
Step 3 **Fear of Self-compassion**						**.386**	**.345**	**.001**	**.100**
Age	-.488	.175	-.212	-2.790	.006				
Gender	.889	1.214	.059	.732	.465				
Sexuality	-.120	1.348	-.007	-.089	.929				
Ethnicity	-.876	1.295	-.051	-.676	.500				
Depression	.049	.073	.060	.675	.501				
Perceived burdensomeness	.354	.067	.506	5.283	< .001				
Thwarted Belongingness	.037	.066	.045	.558	.578				
Fear of self-compassion	.016	.052	.028	.316	.752				

Table 5: Results of linear regression analysis with urge to self-injure as outcome

Predictor	Bivariate		Adjusted	
	Unstandardised *B* (95% CI)	***p***	**Unstandardised *B* (95% CI)**	***p***
Age	-.479 (-.879, -.079)	.019	-.488 (-.835, -.142)	.006
Gender	1.962 (-.675, 4.599)	.143	.889 (-1.515, 3.294)	.465
Sexuality	1.601 (-1.315, 4.518)	.279	-.120 (-2.790, 2550)	.929
Ethnicity	-1.219 (-4.247, 1.810)	.427	-.876 (-3.440, 1.688)	.500
Depression	.280 (.144, .417)	<.001	.049 (-.095, .193)	.501
Perceived burdensomeness	.404 (.303, .505)	<.001	.354 (.221, .486)	< .001
Thwarted belongingness	.166 (.023, .308)	.023	.037 (-.094, .167)	.578
Fear of self-compassion	.214 (.119, .309)	<.001	.016 (.119, .370)	.752

Table 6: Regressions predicting urge to self-injure with tested predictors of Fear of compassion for others (N=127) and fear of compassion from others (N=127)

	B	*SE B*	*β*	*t*	*p*	R^2	*Adj.* R^2	R^2 *Change*	*F*
Model 2 Step 3 **Fear of compassion for others**						**.390**	**.349**	**.004**	**.832**
Age	-.522	.175	-.226	-2.987	.003				
Gender	.902	1.210	.060	.745	.458				
Sexuality	-.408	1.367	-.025	-.298	.766				
Ethnicity	-.791	1.294	-.046	-.611	.542				
Depression	.065	.073	.079	.895	.373				
Perceived burdensomeness	.366	.059	.524	6.228	< .001				
Thwarted Belongingness	.031	.065	.037	4.67	.642				
Fear of compassion for others	-.063	.069	-.069	-.912	.363				
Model 3 Step 3 **Fear of compassion from others**						**.389**	**.348**	**.003**	**.624**
Age	-.485	.173	-.210	-2.799	.006				
Gender	.841	1.213	.056	.693	.489				
Sexuality	-.164	1.340	-.010	-.122	.903				
Ethnicity	-.718	1.308	-.042	-.549	.584				
Depression	.042	.073	.052	.584	.560				
Perceived burdensomeness	.344	.064	.492	5.368	< .001				
Thwarted Belongingness	.032	.065	.039	.488	.626				
Fear of compassion from others	.054	.068	.070	.790	.431				

Table 7: Regressions predicting urge to self-injure with each flow of compassion from the CEAS (N=127)

	B	*SE B*	*β*	*t*	*p*	R^2	*Adj.* R^2	R^2 *Change*	*F*
Model 4 Step 3 Self-compassion						**.391**	**.350**	**.005**	**1.010**
Age	-.471	.174	-.204	-2.705	.008				
Gender	.766	1.217	.051	.629	.530				
Sexuality	.038	1.352	.002	.028	.978				
Ethnicity	-.655	1.309	-.038	-.501	.618				
Depression	.064	.072	.077	.880	.380				
Perceived burdensomeness	.341	.063	.488	5.419	< .001				
Thwarted Belongingness	.025	.066	.031	.386	.700				
Self-compassion	-.041	.041	-.082	-1.005	.317				
Model 5 Step 3 Compassion from others						**.386**	**.345**	**.000**	**.074**
Age	-.499	.173	-.216	-2.880	.005				
Gender	.872	1.219	.058	.715	.476				
Sexuality	-.233	1.364	-.013	-.163	.871				
Ethnicity	-.888	1.296	-.052	-.686	.494				
Depression	.055	.072	.067	.761	.448				
Perceived burdensomeness	.362	.059	.518	6.120	< .001				
Thwarted Belongingness	.021	.083	.025	.249	.804				
Compassion from others	-.010	.035	-.026	-.272	.786				
Model 6 Step 3 Compassion for others						**.391**	**.350**	**.005**	**.950**
Age	-.507	.173	-.220	-2.936	.004				
Gender	1.038	1.218	.069	.852	.396				
Sexuality	-.258	1.342	-.016	-.192	.848				
Ethnicity	-.698	1.303	-.014	-.536	.593				
Depression	.037	.073	.045	.511	.610				
Perceived burdensomeness	.371	.059	.531	6.273	< .001				
Thwarted belongingness	.050	.067	.060	.741	.460				
Compassion for others	.034	.035	.074	.975	.332				

Figure 1: Diagram illustrating the connection between the Interpersonal Theory of Suicide and the desire to harm oneself

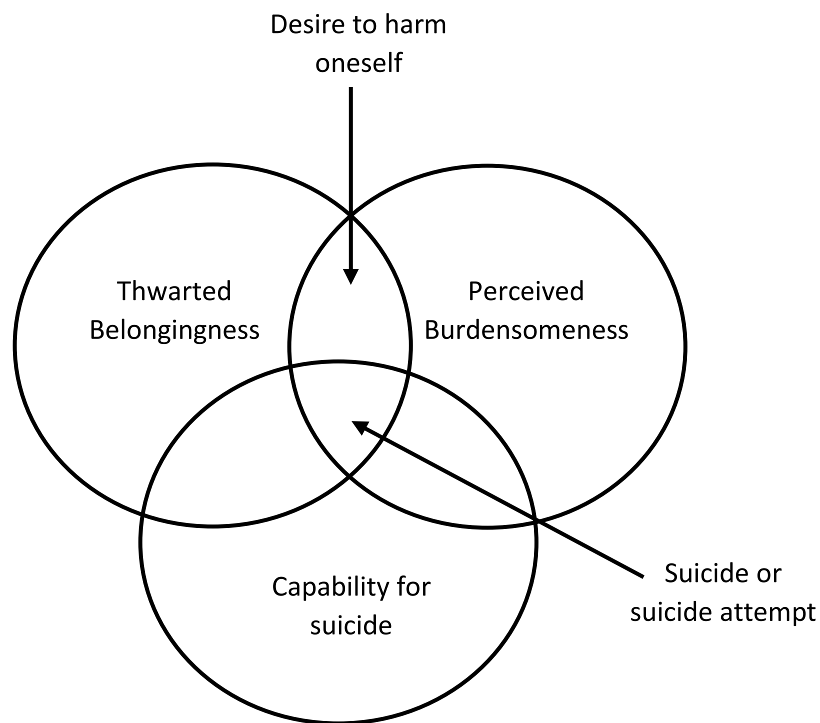


Figure 2: Mediation – Fear of self-compassion on Urge to self-injure, mediated by perceived burdensomeness (N=127)

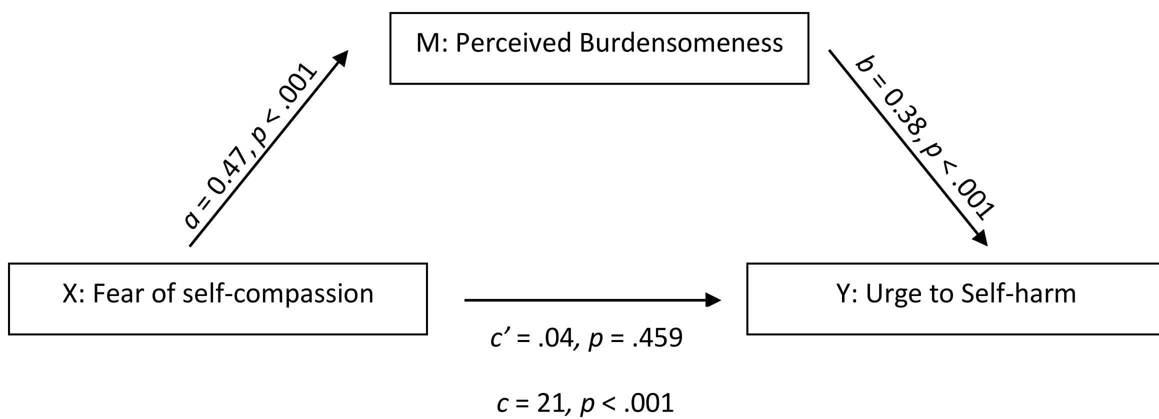
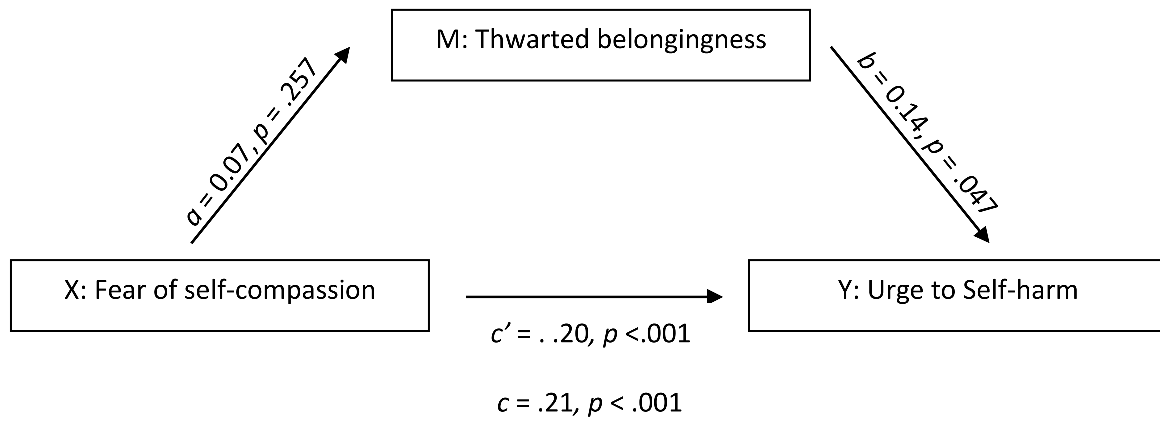


Figure 3: Mediation – Fear of self-compassion on Urge to self-injure, mediated by thwarted belongingness (N=127)



Appendices

Appendix 2-A: Guidelines for Publication for Archives of Suicide Research Journal

About the Journal

Archives of Suicide Research is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

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Preparing Your Paper

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits

Please include a word count for your paper.

A typical paper for this journal should be no more than 4000 (article)/4500 (review)/2000 (brief article) words

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   This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].

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Queries

If you have any queries, please visit our Author Services website or contact us here.

Updated 22nd February 2024

Appendix 2-B: Expert by Experience Involvement

PPI1 Consultation Feedback

Theory behind the research:

The researcher explained underlying research and theories behind the thesis project, and welcomed any feedback on this. PPI1 advised they felt this was worth looking into, however, wondered whether we had considered the element of control. They explained that they felt being in control and having control over behaviours was a motivating factor for acting on self-harm. The researcher discussed that the research was exploring factors which are linked to the urge to self-injure, and noted that control and a desire to be in control may be one factor which motivates people to act on this urge, which PPI1 agreed with.

Qualtrics Experience:

PPI1 reported frustration that there was no back button on the Qualtrics survey, as they had wished to go back at one point to check an answer but could not.

PPI1 felt that the Qualtrics survey felt 'cold', explaining that it did not feel personal and did not encourage and validate the user enough. When explored further, PPI1 felt that more recognition that the topic is difficult and people may struggle with this may validate anyone who feels an emotional response to any of the questions. PPI1 also felt more clear instructions that the user can stop the survey at any time were needed, with the information that they can return at a later time if they wish. PPI1 felt that a picture of the researcher with some information written by the researcher about the research might help users to feel the survey is more warm and personable.

PPI1 expressed they felt a free text entry box at the end of the survey for feedback may be a good idea to allow users to share their experience of completing the survey and any additional information they may wish to give. We discussed the risks involved in this, and the option to email the researcher with any feedback.

Debrief and Resources:

PPI1 felt that as all resources required reaching out to someone (or an organisation to speak with someone), that this was a barrier to users having options of coping with their self-harm if they do not want to talk to someone about this. PPI1 suggested including strategies to manage the urge to self-injure in addition to the existing resources.

Participant Information Sheet:

PPI1 suggested the participant information sheet felt cold and clinical due to it being a standard format. PPI1 suggested a more personable message prior to any required information may help to show empathy for the users of the survey in what they are experiencing.

Language in the measures

PPI1 felt that two statements in *the Center for Epidemiologic Studies Depression Scale* were difficult to respond to:

3. “I felt that I could not shake off the blues even with help from my family or friends.”

6. “I felt depressed.”

PPI1 felt that statement 3 was in a different tone than other questions which made it stand out. PPI1 also felt the language was too informal.

PPI1 felt that statement 6 was too subjective, and that people may not know what “depression” refers to. PPI1 felt that if we were to distinguish between low mood and clinical depression this may be helpful.

PPI1 felt that the *Self-Injurious Thoughts and Behaviours Interview Short Form - Non-Suicidal Self Injury Subscale* providing a check list of methods of self-harm methods may be triggering for some individuals, and could expose individuals to methods of self-harm they would otherwise not be aware of. PPI1 also expressed concern that some individuals with mental illnesses may view this as a

"bucket list" or "challenge" of methods to try. We discussed that it may be more appropriate to provide a free text box in place of the list, and allow users to self-describe their self-harm methods.

PPI2 Consultation Feedback

Theory behind the research:

The researcher explained underlying research and theories behind the thesis project, and welcomed any feedback on this. PPI2 expressed that they could see compassion or a lack of compassion being one influence on self-harming urges and behaviours.

Qualtrics Experience:

PPI2 reported feeling the Qualtrics Survey took a long time and required effort. PPI2 recommended more reminders that the survey can be paused and returned to. PPI2 suggested better headings could be used to make it clearer that some of the questions are similar and use the same response scales.

Adverts:

PPI2 commented that the language on the advert was too absolute in saying "We hope this will help us to understand why people have thoughts of self-harming.". Language such as "better understand some of the reasons" was discussed.

Debrief and Resources:

PPI2 suggested options such a SHOUT text line be added to the resources, and that strategies or materials which do not involve reaching out for support from a person or organisation would be a good addition also.

PPI2 suggested sharing the CalmHarm APP as they have found this to be useful in the past.

Participant Information Sheet:

PPI2 suggested more recognition that the task might be difficult for some people and that if they are already feeling emotionally vulnerable now might not be the right time to take part.

Language in the measures

PPI2 felt that one statement in *the Center for Epidemiologic Studies Depression Scale (CEDS)* was condescending:

3. “I felt that I could not shake off the blues even with help from my family or friends.”

PPI2 felt one statement from the *Compassionate Engagement and Action Scales (CEAS)* was difficult to respond to:

Self-compassion, section 2, statement 3. “I don’t know how to help myself”.

PPI2 explained this is because they feel when they are feeling good they do know, but they aren’t *able* to do this when distressed, rather than not knowing how.

PPI2 felt that the *Interpersonal Needs Questionnaire (INQ)* should not be so near the end of the survey, and that the *Fears of Compassion Scales* would feel more therapeutic to end on. The order of the scales was discussed and agreed to allow a better flow of questions. PPI2 also wanted to share that the *Fears of Compassion Scales* have provided helpful journaling prompts for them, and they are grateful to have read the statements to prompt this thinking and allow opportunity to challenge negative thoughts regarding giving and receiving compassion.

Appendix 2-C: Debriefs

End of Survey Debrief

Thank you for taking part in the survey. Your responses have now been submitted. It is our hope that these responses will help us to better understand the reasons for people experiencing thoughts of harming themselves, and therefore better inform how we can best support people experiencing these thoughts.

If you are interested in knowing the outcome of the study, an accessible report will be shared via @SelfHarmStudy on Twitter following data collection and analysis.

Resources in the event of distress

Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance. These resources cover the entire United Kingdom, however, there may be additional charities and organisations in your local area who can also offer you support.

Strategies and Techniques

Mind have a webpage which includes tips to manage if you are feeling the urge to self-harm right now, including distraction techniques: https://www.mind.org.uk/information-support/types-of-mental-health-problems/self-harm/helping-yourself-now/

Calm Harm is an app which is full of distraction techniques and strategies to help you to feel calm and resist the urge to self-harm. The app gives you things to do right now to help 'ride the wave' until the urge to self-harm starts to pass. You can read more about the app and find a link to download it on their website: https://calmharm.co.uk/

SHOUT – Support via Text

You can text 'SHOUT' to 85258 for free to receive support, anytime.

If you want to find out more about how this works, you can read more on their website: https://giveusashout.org/get-help/how-shout-works/

Papyrus Hopeline

If you are having thoughts of suicide and aged up to 35 or are concerned for a young person who might be, you can contact HOPELINEUK for confidential support and practical advice from 9am until midnight every day.

Call: 0800 068 4141

Text: 07860 039 967

Email: pat@papyrus-uk.org

The Mix

The mix offers support for anyone up to age 25.

The mix run a crisis text messaging service which is available 24/7 by texting "THEMIX" to 85258. The mix also provide one-to-one support via webchat or on their helpline.

Helpline: 0808 808 4994 (4pm to 11pm every day)

Webiste: themix.org.uk

Childline

Childline is open 24 hours a day, 7 days a week for those aged up to 19.

There is a variety of support available, such as a helpline, 1-2-1 online chat and email support.

Helpline: 0800 1111

Website: Childline.org.uk

NHS Services

If you need non-urgent medical advice or treatment you are able to contact your GP practice directly.

If you are unable to contact your GP practice for any reason, you can visit NHS Direct online at: https://111.nhs.uk/ or contact the NHS by calling 111 for advice and support.

Emergency services

If you feel that you want to end your life, please call 999 to seek immediate help from the emergency services, or visit your nearest A&E department.

Did Not Consent Debrief

Thank you for showing interest in this study and taking the time to answer the consent questions. Your answers indicate that you do not provide informed consent to take part in this study at the present time.

Informed consent

We check that people understand what is involved in the study to make sure that we are gaining informed consent. This means that we want to make sure that people taking part in the study know what they are going to be asked to do, and what will happen to their data. If people do not consent, then this indicates that they are not happy with the statements included in the consent form and therefore are not happy with all aspects of the study to contribute to the project.

Thank you

We thank you for considering the study and for the time that you took to answer the questions on the previous page.

We welcome you to contact the researcher via email (b.gray3@lancaster.ac.uk) if you have any questions regarding the research.

If you are interested in knowing the outcome of the study, an accessible report will be shared via @SelfHarmStudy on Twitter following data collection and analysis.

Resources in the event of distress

Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance. These resources cover the entire United Kingdom, however, there may be additional charities and organisations in your local area who can also offer you support.

Strategies and Techniques

Mind have a webpage which includes tips to manage if you are feeling the urge to self-harm right now, including distraction techniques: https://www.mind.org.uk/information-support/types-of-mental-health-problems/self-harm/helping-yourself-now/

Calm Harm is an app which is full of distraction techniques and strategies to help you to feel calm and resist the urge to self-harm. The app gives you things to do right now to help 'ride the wave' until the urge to self-harm starts to pass. You can read more about the app and find a link to download it on their website: https://calmharm.co.uk/

SHOUT – Support via Text

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If you want to find out more about how this works, you can read more on their website: https://giveusashout.org/get-help/how-shout-works/

Papyrus Hopeline

If you are having thoughts of suicide and aged up to 35 or are concerned for a young person who might be, you can contact HOPELINEUK for confidential support and practical advice from 9am until midnight every day.

Call: 0800 068 4141

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The Mix

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Childline

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There is a variety of support available, such as a helpline, 1-2-1 online chat and email support.

Helpline: 0800 1111

Website: Childline.org.uk

NHS Services

If you need non-urgent medical advice or treatment you are able to contact your GP practice directly.

If you are unable to contact your GP practice for any reason, you can visit NHS Direct online at: https://111.nhs.uk/ or contact the NHS by calling 111 for advice and support.

Emergency services

If you feel that you want to end your life, please call 999 to seek immediate help from the emergency services, or visit your nearest A&E department.

Appendix 2-D: Demographics Questionnaire

About You

We ask these questions so that we can understand the types of people who have completed the study and use this to understand our data better.

Age (please enter as a number in years): [ ]

With what gender do you most identify?

- ☐ Male
- ☐ Female
- ☐ Non-binary
- ☐ Other (Please Specify): [ ]

Is your gender the same as assigned at birth?

- ☐ Yes
- ☐ No

Which of the following best describes your sexual orientation?

- ☐ Straight or Heterosexual
- ☐ Gay or Lesbian
- ☐ Bisexual
- ☐ Other (Please Specify): [ ]

What is your ethnicity:

White

- ☐ English/Welsh/Scottish/Northern Irish/British
- ☐ Irish

- ☐ Gypsy or Irish Traveller
- ☐ Any other White background, please describe: ☐

Mixed/Multiple ethnic groups

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other Mixed/Multiple ethnic background, please describe: ☐

Asian/Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background, please describe: ☐

Black/ African/Caribbean/Black British

- ☐ African
- ☐ Caribbean
- ☐ Any other Black/African/Caribbean background, please describe: ☐

Other ethnic group:

- ☐ Arab
- ☐ Any other ethnic group, please describe: ☐

Engagement in self-harm

You do not have to have acted on your thoughts or urges to self-harm to take part in this study, however, if you have then we would like to ask a few questions about this.

Have you ever engaged in self-harm?

- ☐ Yes
- ☐ No

How many times in the past year have you engaged in self-harm? [ ]

How many times in the past month? [ ]

How many times in the past week? [ ]

Please state what method(s), or thing(s) you have done to harm yourself in the past:

[ ]

Appendix 2-E: Center for Epidemiologic Studies Depression Scale (CES-D)

Center for Epidemiologic Studies Depression Scale (CES-D), NIMH

Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week.

	During the Past Week			
	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me.	☐	☐	☐	☐
2. I did not feel like eating; my appetite was poor.	☐	☐	☐	☐
3. I felt that I could not shake off the blues even with help from my family or friends.	☐	☐	☐	☐
4. I felt I was just as good as other people.	☐	☐	☐	☐
5. I had trouble keeping my mind on what I was doing.	☐	☐	☐	☐
6. I felt depressed.	☐	☐	☐	☐
7. I felt that everything I did was an effort.	☐	☐	☐	☐
8. I felt hopeful about the future.	☐	☐	☐	☐
9. I thought my life had been a failure.	☐	☐	☐	☐
10. I felt fearful.	☐	☐	☐	☐
11. My sleep was restless.	☐	☐	☐	☐
12. I was happy.	☐	☐	☐	☐
13. I talked less than usual.	☐	☐	☐	☐
14. I felt lonely.	☐	☐	☐	☐
15. People were unfriendly.	☐	☐	☐	☐
16. I enjoyed life.	☐	☐	☐	☐
17. I had crying spells.	☐	☐	☐	☐
18. I felt sad.	☐	☐	☐	☐
19. I felt that people dislike me.	☐	☐	☐	☐
20. I could not get "going."	☐	☐	☐	☐

Appendix 2-F: Compassionate Engagement and Action Scales (CEAS)

THE COMPASSIONATE ENGAGEMENT AND ACTION SCALES

Self-compassion

When things go wrong for us and we become distressed by setbacks, failures, disappointments or losses, we may cope with these in different ways. We are interested in the degree to which people can **be compassionate with themselves**. We define compassion as "a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it." This means there are two aspects to compassion. The *first* is the ability to be motivated to engage with things/feelings that are difficult as opposed to trying to avoid or supress them. The *second* aspect of compassion is the ability to focus on what is helpful to us. Just like a doctor with his/her patient. The first is to be motivated and able to pay attention to the pain and (learn how to) make sense of it. The second is to be able to take the action that will be helpful. Below is a series of questions that ask you about these two aspects of compassion. Therefore read each statement carefully and think about how it applies to you if you become distressed. Please rate the items using the following rating scale:

Never **Always**
1 2 3 4 5 6 7 8 9 10

Section 1 – These are questions that ask you about how motivated you are, and able to engage with distress when you experience it. So:

When I'm distressed or upset by things…

1. I am *motivated* to engage and work with my distress when it arises.
Never **Always**
1 2 3 4 5 6 7 8 9 10

2. I *notice,* and am *sensitive* to my distressed feelings when they arise in me.
Never **Always**
1 2 3 4 5 6 7 8 9 10

(r)3. I avoid thinking about my distress and try to distract myself and put it out of my mind.
Never **Always**
1 2 3 4 5 6 7 8 9 10

4. I am *emotionally moved* by my distressed feelings or situations.
Never **Always**
1 2 3 4 5 6 7 8 9 10

5. I *tolerate* the various feelings that are part of my distress.
Never **Always**
1 2 3 4 5 6 7 8 9 10

1

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6. I *reflect on* and *make sense* of my feelings of distress.

Never **Always**
1 2 3 4 5 6 7 8 9 10

(r)7 I do not tolerate being distressed.

Never **Always**
1 2 3 4 5 6 7 8 9 10

8. I am *accepting, non-critical and non-judgemental* of my feelings of distress.

Never **Always**
1 2 3 4 5 6 7 8 9 10

Section 2 – These questions relate to how you actively cope in compassionate ways with emotions, thoughts and situations that distress you. So:

When I'm distressed or upset by things…

1. I direct my *attention* to what is likely to be helpful to me.

Never **Always**
1 2 3 4 5 6 7 8 9 10

2. I *think* about and come up with helpful ways to cope with my distress.

Never **Always**
1 2 3 4 5 6 7 8 9 10

(r)3. I don't know how to help myself.

Never **Always**
1 2 3 4 5 6 7 8 9 10

4. I take the *actions* and do the things that will be helpful to me.

Never **Always**
1 2 3 4 5 6 7 8 9 10

5. I create inner feelings of *support, helpfulness and encouragement*.

Never **Always**
1 2 3 4 5 6 7 8 9 10

NOTE FOR USERS: REVERSE ITEMS (r) ARE NOT INCLUDED IN THE SCORING

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Compassion to others

When things go wrong for other people and they become distressed by setbacks, failures, disappointments or losses, we may cope with their distress in different ways. We are interested in the degree to which people can be **compassionate to others**. We define compassion as "a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it." This means there are two aspects to compassion. The *first* is the ability to be motivated to engage with things/feelings that are difficult as opposed to trying to avoid or supress them. The *second* aspect of compassion is the ability to focus on what is helpful. Just like a doctor with his/her patient. The first is to be motivated and able to pay attention to the pain and (learn how to) make sense of it. The second is to be able to take the action that will be helpful. Below is a series of questions that ask you about these two aspects of compassion. Therefore read each statement carefully and think about how it applies to you when **people in your life** become distressed. Please rate the items using the following rating scale:

Never **Always**
1 2 3 4 5 6 7 8 9 10

Section 1 – These are questions that ask you about how motivated you are, and able to engage with other people's distress when they are experiencing it. So:

When others are distressed or upset by things…

1. I am *motivated* to engage and work with other peoples' distress when it arises.
Never **Always**
1 2 3 4 5 6 7 8 9 10

2. I *notice* and *am sensitive* to distress in others when it arises.
Never **Always**
1 2 3 4 5 6 7 8 9 10

(r)3. I avoid thinking about other peoples' distress, try to distract myself and put it out of my mind.
Never **Always**
1 2 3 4 5 6 7 8 9 10

4. I am *emotionally moved* by expressions of distress in others.
Never **Always**
1 2 3 4 5 6 7 8 9 10

5. I *tolerate* the various feelings that are part of other people's distress.
Never **Always**
1 2 3 4 5 6 7 8 9 10

3

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6. I *reflect on* and *make sense* of other people's distress.

Never									Always
1	2	3	4	5	6	7	8	9	10

(r)7 I do not tolerate other peoples' distress.

Never									Always
1	2	3	4	5	6	7	8	9	10

8. I am *accepting, non-critical and non-judgemental* of others people's distress.

Never									Always
1	2	3	4	5	6	7	8	9	10

Section 2 – These questions relate to how you actively respond in compassionate ways when other people are distressed. So:

When others are distressed or upset by things…

1. I direct *attention* to what is likely to be helpful to others.

Never									Always
1	2	3	4	5	6	7	8	9	10

2. I *think about and come up* with helpful ways for them to cope with their distress.

Never									Always
1	2	3	4	5	6	7	8	9	10

(r)3. I don't know how to help other people when they are distressed.

Never									Always
1	2	3	4	5	6	7	8	9	10

4. I take the *actions* and *do the things* that will be helpful to others.

Never									Always
1	2	3	4	5	6	7	8	9	10

5. I express feelings of *support, helpfulness and encouragement* to others.

Never									Always
1	2	3	4	5	6	7	8	9	10

NOTE FOR USERS: REVERSE ITEMS (r) ARE NOT INCLUDED IN THE SCORING

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Compassion from others

When things go wrong for us and we become distressed by setbacks, failures, disappointments or losses, others may cope with our distress in different ways. We are interested in the degree to which you feel that **important people in your life can be compassionate to your distress**. We define compassion as "a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it." This means there are two aspects to compassion. The *first* is the ability to be motivated to engage with things/feelings that are difficult as opposed to trying to avoid or supress them. The *second* aspect of compassion is the ability to focus on what is helpful to us or others. Just like a doctor with his/her patient. The first is to be motivated and able to pay attention to the pain and (learn how to) make sense of it. The second is to be able to take the action that will be helpful. Below is a series of questions that ask you about these two aspects of compassion. Therefore read each statement carefully and think about how it applies to the **important people in your life** when you become distressed. Please rate the items using the following rating scale:

Never **Always**
1 2 3 4 5 6 7 8 9 10

Section 1 – These are questions that ask you about how motivated you think others are, and how much they engage with your distress when you experience it. So:

When I'm distressed or upset by things…

1. Other people are actively *motivated* to engage and work with my distress when it arises.

Never **Always**
1 2 3 4 5 6 7 8 9 10

2. Others *notice* and *are sensitive* to my distressed feelings when they arise in me.

Never **Always**
1 2 3 4 5 6 7 8 9 10

(r)3 Others avoid thinking about my distress, try to distract themselves and put it out of their mind.

Never **Always**
1 2 3 4 5 6 7 8 9 10

4. Others are *emotionally moved* by my distressed feelings.

Never **Always**
1 2 3 4 5 6 7 8 9 10

5. Others *tolerate* my various feelings that are part of my distress.

Never **Always**
1 2 3 4 5 6 7 8 9 10

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6. Others *reflect on* and *make sense* of my feelings of distress.

Never 1 2 3 4 5 6 7 8 9 10 **Always**

(r)7. Others do not tolerate my distress.

Never 1 2 3 4 5 6 7 8 9 10 **Always**

8. Others are *accepting, non-critical and non-judgemental* of my feelings of distress.

Never 1 2 3 4 5 6 7 8 9 10 **Always**

Section 2 – These questions relate to how others actively cope in compassionate ways with emotions and situations that distress you. So:

When I'm distressed or upset by things…

1. Others direct their *attention* to what is likely to be helpful to me.

Never 1 2 3 4 5 6 7 8 9 10 **Always**

2. Others *think about* and come up with helpful ways for me to cope with my distress.

Never 1 2 3 4 5 6 7 8 9 10 **Always**

(r)3. Others don't know how to help me when I am distressed

Never 1 2 3 4 5 6 7 8 9 10 **Always**

4. Others take the *actions* and do the things that will be helpful to me.

Never 1 2 3 4 5 6 7 8 9 10 **Always**

5. Others treat me with feelings of *support, helpfulness and encouragement*.

Never 1 2 3 4 5 6 7 8 9 10 **Always**

NOTE FOR USERS: REVERSE ITEMS (r) ARE NOT INCLUDED IN THE SCORING

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Appendix 2-G: Fears of Compassion Scales

FEARS OF COMPASSION SCALES

Different people have different views of compassion and kindness. While some people believe that it is important to show compassion and kindness in all situations and contexts, others believe we should be more cautious and can worry about showing it too much to ourselves and to others. We are interested in your thoughts and beliefs in regard to kindness and compassion in three areas of your life:

1. Expressing compassion for others
2. Responding to compassion from others
3. Expressing kindness and compassion towards yourself

Below are a series of statements that we would like you to think carefully about and then circle the number that best describes how each statement fits you.

SCALE

Please use this scale to rate the extent that you agree with each statement

Don't agree at all	0	1	2	3	4	Completely agree
			Somewhat agree			

Scale 1: Expressing compassion for others

1.	People will take advantage of me if they see me as too compassionate	0	1	2	3	4
2.	Being compassionate towards people who have done bad things is letting them off the hook	0	1	2	3	4
3.	There are some people in life who don't deserve compassion	0	1	2	3	4
4.	I fear that being too compassionate makes people an easy target	0	1	2	3	4
5.	People will take advantage of you if you are too forgiving and compassionate	0	1	2	3	4
6.	I worry that if I am compassionate, vulnerable people can be drawn to me and drain my emotional resources	0	1	2	3	4
7.	People need to help themselves rather than waiting for others to help them	0	1	2	3	4
8.	I fear that if I am compassionate, some people will become too dependent upon me	0	1	2	3	4
9.	Being too compassionate makes people soft and easy to take advantage of	0	1	2	3	4
10.	For some people, I think discipline and proper punishments are more helpful than being compassionate to them	0	1	2	3	4

Appendix 2-H: Interpersonal Needs Questionnaire (INQ)

INQ

The following questions ask you to think about yourself and other people. Please respond to each question by using your own current beliefs and experiences, NOT what you think is true in general, or what might be true for other people. Please base your responses on how you've been feeling recently. Use the rating scale to find the number that best matches how you feel and circle that number. There are no right or wrong answers: we are interested in what you think and feel.

		Not at all true for me			Somewhat true for me			Very true for me
1.	These days, the people in my life would be better off if I were gone	1	2	3	4	5	6	7
2.	These days, the people in my life would be happier without me	1	2	3	4	5	6	7
3.	These days, I think I am a burden on society	1	2	3	4	5	6	7
4.	These days, I think my death would be a relief to the people in my life	1	2	3	4	5	6	7
5.	These days, I think the people in my life wish they could be rid of me	1	2	3	4	5	6	7
6.	These days, I think I make things worse for the people in my life	1	2	3	4	5	6	7
7.	These days, other people care about me	1	2	3	4	5	6	7
8.	These days, I feel like I belong	1	2	3	4	5	6	7
9.	These days, I rarely interact with people who care about me	1	2	3	4	5	6	7
10.	These days, I am fortunate to have many caring and supportive friends	1	2	3	4	5	6	7
11.	These days, I feel disconnected from other people	1	2	3	4	5	6	7
12.	These days, I often feel like an outsider in social gatherings	1	2	3	4	5	6	7
13.	These days, I feel that there are people I can turn to in times of need	1	2	3	4	5	6	7
14.	These days, I am close to other people	1	2	3	4	5	6	7
15.	These days, I have at least one satisfying interaction every day	1	2	3	4	5	6	7

Note: Items 7, 8, 10, 13, 14, and 15 are reverse coded.

Van Orden, K. A., Cukrowicz, K. C., Witte, T. K., & Joiner, T. E. (2012). Thwarted belongingness and perceived burdensomeness: Construct validity and psychometric properties of the Interpersonal Needs Questionnaire. *Psychological Assessment, 24*(1), 197-215.

Appendix 2-I: Alexian Brothers Urge to Self-Injure Scale (ABUSI)

Alexian Brothers Urge to Self-Injure Scale (ABUSI)

The questions below apply to **the last week**. Place an "X" in the box next to the most appropriate statement

1. **How often have you thought about injuring yourself or about how you want to injure yourself?**
   - ☐ **Never**, 0 times in the last week
   - ☐ **Rarely**, 1 -2 times in the last week
   - ☐ **Occasionally**, 3 – 4 times in the last week
   - ☐ **Sometimes**, 5 – 10 times in the last week, or 1 -2 times a day
   - ☐ **Often**, 11 – 20 times in the last week, or 2 – 3 times a day
   - ☐ **Most of the time**, 20 – 40 times in the last week, or 3 – 6 times a day
   - ☐ **Nearly all of the time**, more that 40 times in the last week, or more than 6 times a day
2. **At the most severe point, how strong was your urge to self-injure in the last week?**
   - ☐ **None** at all.
   - ☐ **Slight**, that is, a very mild urge.
   - ☐ **Mild** Urge.
   - ☐ **Moderate** Urge.
   - ☐ **Strong** Urge, but **easily** controlled.
   - ☐ **Strong** Urge, but **difficult** to control.
   - ☐ **Strong** Urge **and would have self-injured if able to.**
3. **How much time have you spent thinking about injuring yourself or about how you want to injure yourself?**

☐	☐	☐	☐	☐	☐	☐
None.	Less than 20 min.	21-45 min.	46-90 min.	90 min to 3 hrs.	3-6 hrs.	More than 6 hrs.

4. **How difficult was it to resist injuring yourself in the last week?**

☐	☐	☐	☐	☐	☐	☐
Not difficult at all	Very mildly difficult	Mildly difficult	Moderately difficult	Very difficult	Extremely difficult	Was not able to resist

5. **Keeping in mind your responses to the previous questions, please rate your *overall average* urge or desire to injure yourself in the last week.**
   - ☐ **Never** thought about it and **never** had the urge to self-injure.
   - ☐ **Rarely** thought about it and **rarely** had the urge to self-injure.
   - ☐ **Occasionally** thought about it and **occasionally** had the urge to self-injure.
   - ☐ **Sometimes** thought about it and **sometimes** had the urge to self-injure.
   - ☐ **Often** thought about it and **often** had the urge to self-injure.
   - ☐ Thought about self-injury **most** of the time and had the urge to do it **most** of the time.
   - ☐ Thought about self-injury **nearly all** the time and had the urge to do it **nearly all** the time.

Section Three: Critical Appraisal

Critical Reflection on a Research Project Exploring Self-Injury in Adolescents, Young Adults, and LGBTQ+ Individuals

Bethan Gray

Doctorate in Clinical Psychology

Division of Health Research

Lancaster University

Word Count: 3957

Excluding references, tables, figures and appendices

All correspondence should be addressed to:

Bethan Gray

c/o Doctorate in Clinical Psychology

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4AT

b.gray3@lancaster.ac.uk

The previous sections within this thesis have explored factors and experiences related to self-injury. The first section presented a meta-synthesis of qualitative research exploring LGBTQ+ experiences of self-harm. The second section was an empirical study with a non-clinical sample of adolescents and young adults, investigating factors which explained variance in the urge to self-injure.

This critical appraisal explores the relationships between the systematic literature review and the empirical paper, while highlighting the key challenges and processes that were considered during the process of the thesis. An overview of the findings is given, before considering the epistemological position that was taken throughout the thesis. Considerations around the use of language and the power this holds are explored, followed by key ethical considerations which were explored in the planning of the empirical paper. Finally, key clinical implications are discussed.

Overview of Findings

The literature review aimed to present a synthesis of the qualitative research exploring LGBTQ+ individual's experiences of and relating to self-harm. The papers were analysed and conceptualised using a meta-ethnographic approach (Noblit & Hare, 1988). In synthesising nine papers, the review found themes of discrimination, making sense of self-harming, experiences underlying self-harm engagement, and a developing identity. The theme of discrimination was central to the experience of self-harm within this group. Discrimination also impacted LGBTQ+ individuals' daily lives and their ability to discover and accept their sexual and gender identities. Not having the language or safety to express their identity was also linked to self-harm for LGBTQ+ individuals, as it led to a lack of self-understanding and self-acceptance. The papers reviewed discussed developing the language and understanding of LGBTQ+ identity as a process with multiple barriers due to a lack of gender and sexuality diversity education and representation. Participants explored the distress that accompanied a lack of self-understanding and self-acceptance due to these barriers, and related this to self-harm engagement. Positive factors which supported development of self-acceptance and connecting with the LGBTQ+ community were also explored.

The empirical paper employed a quantitative approach, aiming to investigate whether the fear of self-compassion explained unique variance in urge to self-injure, after the variance accounted for by perceived burdensomeness and thwarted belongingness. The study recruited 127 adolescents and young adults (aged 16 to 25 years old) with thoughts or urges to self-injure in the past six months. Regression analyses were used to analyse the data, with results showing that perceived burdensomeness and participant age significantly predicted the urge to self-injure, but that fear of self-compassion and thwarted belongingness did not. The variance explained by perceived burdensomeness was a particular interest in this study, as it was comparatively higher than found in previous research. This suggested a significance of the participant's interpretation of interactions with others, which impacted their view of themselves as a burden, as one factor which underlies the urge to self-injure.

Interesting parallels emerged in the participant demographics across the papers. The literature review methodology included only papers with LGBTQ+ participants; however, despite no targeted efforts to recruit from the LGBTQ+ community, the majority of the sample recruited for the empirical paper also identified as non-heterosexual (75.6%). There is a relative lack of research into the experiences of LGBTQ+ individuals who self-harm, despite self-harm being highly prevalent within this population (Liu et al., 2019). The high prevalence of non-heterosexual identities in the empirical paper highlights that self-harming behaviours are a key issue within this population, and indicates a willingness for LGBTQ+ individuals to be involved in research to better understand self-harm. The representation of LGBTQ+ individuals in the empirical paper may also reflect the demographics of chosen recruitment channels, i.e. social media sites such as Instagram and Reddit.

Epistemological Position and Reflexivity

Reflecting on our experiences and perceptions of the world is important, as our understanding of the data we analyse is guided by our own experiences. This thesis was written from a critical realist position. Critical realism acknowledges there is a difference between the 'real' world and the

‘observable’ world, and that we can only observe the world through our perceptions, interpretations, and constructions (Bhaskar, 2013). A critical realist perspective assumes that an individual’s world is constructed based on their experiences.

A meta-ethnographic approach aligns with the critical realist perspective that data does not seek to discover some ‘truth’. A meta-ethnographic approach seeks to understand the experience of the participants, acknowledges that information is interpreted by authors during research, and that subjectivity is essential to the production of knowledge (Madill et al., 2000). Therefore, a meta-ethnographic approach was chosen for the review, as it allowed the participant’s voices, views, and subjective interpretations of events to be maintained in the findings, while recognising that these are the participant’s interpretations of events. The importance of participant’s voices and experiences of events being maintained was particularly crucial as the researcher does not hold an LGBTQ+ identity. Researching a group to which a researcher does not belong risks assumptions and biases influencing the data analysis and interpretations. However, the meta-ethnographic approach, alongside engagement in reflective discussions and supervision, supported the researcher’s desire to honour the views and interpretations of participants’ own stories, while acknowledging that these views are their own interpretations which are subject to their own subjectivity.

A critical realist position also respected the theories which underpinned the empirical paper. The Interpersonal Theory of Suicide (ITS; Joiner, 2005; Van Orden et al., 2012; Van Orden et al., 2010) posits two interpersonal factors which underlie suicidality and self-injury – thwarted belongingness and perceived burdensomeness. However, both constructs are inherently concerned with an individual’s perceptions, interpretations and constructions of their interactions and relationships with others, and themselves. A critical realist perspective recognises the importance of how we experience the world over and above a supposed ‘true’ or ‘real’ account of our interactions.

As the researcher does not identify as a sexual or gender minority, and is employed as part of the mental health system, this places the researcher in a position of privilege and power. Therefore, it

was important to consider positionality in relation to identity, power, and language. It is the position of the researcher that those in positions of relative power should actively seek and create space for the views of those in positions of a relative lack of power, to challenge, and work towards reducing, the power imbalance. The researcher believes that all individuals are deserving of respect, autonomy, and choice about the ways in which they identify and the associated language they employ to reflect this. In line with this position, consideration was given to the power of language, and the impact of the narratives we create and perpetuate about ourselves and others.

The Power of Language

The language we use around different mental health conditions and behaviours is constantly evolving, alongside changes in diagnostic terminology and classifications (Stein et al., 2020). It is key that we continue to reflect on the language used within the field of mental health, as stigma affects engagement with services, treatment and the care provided to individuals who are struggling (Ozer et al., 2017).

Self-harm

In the United Kingdom, we discuss self-harm, as defined by the National Institute for Health and Care Excellence (NICE; NICE, 2022), as any act of self-poisoning or self-injury by an individual, irrespective of motivation. This definition and terminology replaced the previously used 'Deliberate Self-Harm' (DSH), a now outdated term, referring to the intent of the individual to cause harm to themselves. DSH was removed from clinical guidance in the UK following concerns that the term is judgemental and stigmatising (Kapur et al., 2013). Therefore, self-harm refers to any behaviour which causes oneself harm, including suicidal behaviours and suicide attempts.

In the United States, the terminology of Non-Suicidal Self-Injury (NSSI) is used. NSSI is described as intentional injury to one's own body tissue in the absence of suicidal intent (American Psychiatric Association, 2013). NSSI as a criterion allows for distinction between an individual with suicidal intent, versus the intent to harm oneself without ending one's life. However,

it is arguably difficult for an individual to articulate their motivation for self-harm due to the associated distress experienced (Kapur et al., 2013). Furthermore, the NSSI definition does not include acts of self-poisoning, which risks a group of individuals falling between diagnostic categories due to this terminology and definition.

Therefore, the different terminologies and definitions of these behaviours used across different countries informs how we understand and categorise these behaviours. Certainly, in the United States there is an attempt to separate the intent of self-harm. Distinguishing acts of self-harm from suicide attempts prevents confounding these two sets of behaviours, reducing the risk of inappropriate and potentially fatal errors in treatment and care (Zetterqvist, 2015). However, self-harm behaviours and suicidal behaviours may be more of a continuum than dichotomous categories (Kapur et al., 2013), making it extremely difficult for participants, researchers, clients and clinicians to clarify whether a behaviour is exclusively NSSI or a suicidal behaviour.

The empirical paper in this thesis uses the term "urge to self-injure" as this aligns with both the measure used, the Alexian Brothers Urge to Self-Injure Scale (Washburn et al., 2010), and with the language preferences of those with lived experience (Hasking et al., 2021). Participants in the empirical paper were able to self-identify whether they engaged in self-harming behaviours, and use a free-text box to describe the method of self-harm utilised. Participant descriptions fit best with the definition of self-harm, as they included self-poisoning, other methods of self-harm that do not cause tissue damage as detailed in the non-suicidal self-injury definition. Furthermore, the intent behind engaging in self-harming was not measured in the empirical study.

The literature review section of this thesis uses the term "self-harm" throughout, as this best reflected the language used by participants in the original research papers, with the majority of the primary researching having been conducted in the United Kingdom. The search criteria were designed to capture studies which included all definitions of self-harming behaviours, including self-injury and non-suicidal self-injury. This was to allow all studies exploring the broad definition of self-

harming to be included in the review. Some papers in the review employed a definition of self-harm and associated inclusion criteria which excluded self-harm with suicidal intent (Jackman et al., 2018), or methods they classified as “self-destructive”, such as substance abuse or sexual risk-taking (Alexander & Clare, 2004, p. 72), while others includes self-destructive behaviours alongside self-harming behaviours (McDermott et al., 2008). By employing an inclusive search strategy and inclusion criteria the review explores experiences across the continuum of self-harming behaviours and notes shared experiences and themes across these. This prevented unnecessary exclusion of papers exploring self-harming behaviours due to differences in the language and definitions employed by researchers, ensuring all relevant research was included (Meline, 2006; Robey & Dalebout, 1998).

LGBTQ+

The history of language used towards and regarding LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and any other minority gender or sexual identity) individuals and groups is fraught with hate speech and discrimination (Shafer, 2015), negatively affecting the safety and wellbeing of LGBTQ+ individuals (Zochniak et al., 2023) and societal attitudes (Soral et al., 2018). The use of language which centres “heterocisnormativity”, the assumption that heterosexual and cisgender identities are the norm, is a microaggression which has negative consequences for LGBTQ+ individuals, including increasing symptoms of traumatic stress and lowering self-esteem (Nadal et al., 2016; Soled et al., 2022).

Given the negative impacts of hate speech on LGBTQ+ individuals (Keighley, 2022; Zochniak et al., 2023), it is essential we work towards the use of appropriate language. Appropriate use of language creates an inclusive environment, whether this be for those seeking healthcare (Rossi & Lopez, 2017), those participating in or conducting research studies, or in general society. Given the unjust historic, and oftentimes current, use of language to discriminate against LGBTQ+ individuals, it is essential that research and practice work to ensure appropriate and inclusive language is used.

The process of learning the appropriate terminology and definitions of the various gender and sexual identities which exist requires intentional and conscious engagement and effort (Squires & Thompson, 2021). By reflecting on the ways in which we may unintentionally cause harm to others through our language use and behaviours, we create the opportunity for challenging our biases and stigma, creating behaviour change which will positively impact others. Furthermore, in order to challenge the systemic discrimination faced by LGBTQ+ individuals, it is important we are aware of our own positionality and relationships to systems and power (Altman et al., 2021).

An important consideration in the navigation of LGBTQ+ terminology is that "identities are adjectives that should qualify a noun" (Soled et al., 2022, p. 6). The sexual and gender identities are used to further describe the individual(s), rather than replacing the humanness of their identity – for example, "lesbian women" as opposed to "lesbians" (Soled et al., 2022). Much of stigmatising language has been rooted in the use of identities as a put-down, and this has primarily been achieved through use of language, by removing the adjectives of identities from the nouns of people. Allowing LGBTQ+ individuals to self-describe their identity and using their preferred language provides the opportunity for the power of language to be returned to the community. Respectful language can then be guided by the individuals who the language impacts the most.

The *Publication Manual of the American Psychological Association (7th Edition)* recommends the acronym "LGBTQ+" to refer to those who identify outside of the gender and sexual norms, as "bias-free language" and an inclusive term which represents the variety of gender and sexual identities present in society (American Psychological Association, 2020). Therefore, the literature review in this thesis uses the term LGBTQ+ to encapsule those who identify with a minoritised gender and/or sexual identity, and refers to 'LGBTQ+ individuals' to keep the adjective with the noun.

Ethical Considerations

Participant Engagement

Involving those with lived experience in self-harm research has a positive impact, both for the individual in their own perception of their self-harm (Corrigan et al., 2013), and for the research to be relevant and include the voice of experience (Lewis & Hasking, 2019).

Participant engagement was sought in this project to explore the concern around self-harm research having the potential to be distressing for participants, and to ensure the research was relevant to the experiences of those lived experience of self-harming behaviours and was not stigmatising. Consulting individuals with lived experience of self-harm during the design phase of the empirical project allowed for discussion of the relevancy of the research as well as the language used and allowed space for amendments to the research project to be adequately considered. The feedback gained during participant engagement was vital in guiding the collection of demographics. Most notably, the demographics questions regarding self-harming were discussed in-depth, with particular attention being paid to the questions adapted from the Self-Injurious Thoughts and Behaviours Interview Short Form (SITBI-SF; Nock et al., 2007). Question 69 from the SITBI-SF (Appendix 3-A) details a list of methods of self-harm, which requires the respondant to indicate whether they have ever utilsied each method. Participant feedback indicated that providing a list of self-harm methods was triggering, raising concerns that some individuals may be vulnerable to seeing alternative methods of self-harm which they were not previously engaged in. An agreed solution of adapting the question to an open text box balanced the desire to collect data on the methods of self-harm employed by participants to allow a fuller understanding of the sample, while minimising the risk of additional distress.

Recruitment Age Range

The empirical paper in this thesis invited adolescents and young adults aged 16 to 25 to participate in the study. This age range was selected as young adults (13.4%) and adolescents (17.2%) have the highest prevalence rates of NSSI (Swannell et al., 2014).

Research has indicated that experience of urges to self-harm may change over time, as the individual engages in repeated self-harm and can develop into a 'vicious cycle' which drives further engagement in the behaviours (Miller et al., 2021). Furthermore, longitudinal research shows that in adulthood a higher percentage of individuals report their self-harm having multiple functions than in adolescence, indicating that over time additional functions and motivations for self-harm may be discovered (Gardner et al., 2021). Therefore, a focus on the age range of 16 to 25 allows for the sample to include those who may have recently initiated engagement in self-harm, as well as those with a longer history, in the populations with the highest prevalence of the behaviour. This allows for investigation of whether the mechanisms and constructs explored are relevant across these key stages of self-harm initiation and maintenance.

There have been reports of a high prevalence of self-harm in under 16s (Morgan et al., 2017; Plener et al., 2015), and certainly inclusion of those with recent first episode self-harm engagement adds a valuable perspective and experience to the data. However, the legal age for informed consent in the United Kingdom is 16-years-old (Heath et al., 2007). Informed consent is the voluntary agreement of an individual of legal age to participate in research. Under 16s are able to assent to participate in research in place of giving consent. Assent is the agreement of someone not of legal age to provide informed consent, and is based on the individual understanding the proposed research and the risks and potential benefits (Levine, 1988). However, informed consent must still be sought from the individual's parent or guardian to allow an under 16-year-old to participate in psychological research ethically.

The issue of consent poses an ethical dilemma in self-harm research, as in the United Kingdom, it requires under 16-year-olds to disclose their self-harm to parents or carers if they wish to participate in self-harm research. If the individual wishing to assent has not previously disclosed engagement in self-harming behaviours to their parent or guardian, then requiring parental consent risks causing distress to interested participants (Demuthova et al., 2020), or otherwise unfairly excludes this population due to their inability to provide consent.

Therefore, including the age range of 16 to 25 balanced the need to recruit from the populations with the highest self-harm prevalence to address a significant clinical need, with the desire to ensure this research is being completed ethically with a population who can provide informed consent.

Clinical Implications

The Urge to Self-Injure

Thoughts and urges to self-injure are reported to present more frequently than self-injurious behaviours in adolescence (Stallard et al., 2013). The thought or urge to self-injure precedes the behaviour of self-injury; however, there are many factors which complicate engagement in self-harm following the urge to self-injure. Indeed, in those that experience thoughts and urges to self-injure, there are differences between those that act on the thoughts and those who do not (O'Connor et al., 2012). O'Connor et al. (2012) found that those who have a close contact with someone who has self-harmed previously, believe that their peers self-harm, and are significantly more impulsive are more likely to engage in self-harm, while those who do not are more likely to remain at the stage of ideation. By exploring predictors of the urge to self-injury we are able to progress our knowledge and understanding of the underlying factors in experiencing these urges, benefitting our ability to understand and support both those who ideate and engage in self-injury. This allows for informing of prevention strategies as well as interventions.

Importance of Improved Self-Harm Treatment and Care

There is a need for improved care for those presenting with self-harm in health settings. There are high levels of variation in management of self-harm presentations across hospital settings (Arensman et al., 2018; Cooper et al., 2013). Despite psychological assessments being recommended for presentations of self-harm in England (NICE, 2022), this happens between 28% and 91% of the time, depending on the hospital (Cooper et al., 2015). Furthermore, national guidelines in the short-term management of self-harm have been found to be implemented less than 50% of the time (M = 43.89%, SD = 38.79; Leather et al., 2020). Psychological assessment for those presenting at hospital with self-inflicted injuries allows delivery of person-centred care and exploration of how the individual is feeling. This provides the individual with a positive therapeutic interaction, resulting in the individual feeling hopeful for the future and that they matter as a person (Xanthopoulou et al., 2021). Ensuring the care experiences of those who self-harm are positive may protect against further perceived burdensomeness in this population.

How care is experienced by those who self-harm directly impacts the risk of further engagement in self-harming behaviours. In a recent study, individuals who experienced hospital support as supportive and compassionate did not engage in self-harm in the time between presenting at hospital and follow-up interview, while those who experienced care as superficial or unsupportive engaged in repeat episodes of self-harming behaviours (Cully et al., 2022). Furthermore, those who felt unsupported did not seek medical support following subsequent self-harm episodes, and reported significantly higher levels of hopelessness and the perception that their future seemed dark. This highlights the lasting impact of interpersonal interactions for these individuals. The current study highlighted a link between perceived burdensomeness and urges to self-harm, which combined with the findings of Cully et al. (2022) may suggest that feeling a burden when seeking medical care may contribute to further engagement in NSSI behaviours.

Working with LGBTQ+ Individuals

The systematic literature review highlighted the importance of discrimination in LGBTQ+ experiences of self-harm, as well as everyday life. This discrimination negatively impacts the mental health of LGBTQ+ individuals and acts as a barrier to services (Gonzales & Henning-Smith, 2017; Macapagal et al., 2016).

Healthcare services should work towards improving access and care for LGBTQ+ individuals (Furness et al., 2020). Training to support development of knowledge of LGBTQ+ identities and associated terminology should be provided to all staff working in healthcare services (Caceres et al., 2020). This will support staff in navigating discussions regarding gender and sexuality, including appropriate and non-offensive ways to explore an individual's pronouns to ensure these are respected throughout all contact with and discussions regarding the individual. Training will ultimately directly and indirectly address the risk of discrimination faced by LGBTQ+ individuals when accessing services.

Furthermore, clinical staff who understand the importance of discrimination in the mental health of LGBTQ+ individuals can explore these experiences as they relate to the formulation of presenting difficulties, better informing clinical interventions (Dunlop & Lea, 2023; Meyer, 2003).

Conclusion

LGBTQ+ individuals and those that self-harm are at risk of receiving sub-standard care due to a lack of understanding of their unique experiences by professionals. This project contributes to an understanding of the interpersonal, intrapersonal and contextual factors and experiences which relate to self-harm. The mechanisms discussed are based on interpersonal interactions and relationships which are not experienced positively by the individual, largely due to the social context in which we live. The relationship between discrimination, stigma and language is important to consider within research and clinical practice. Therefore, this critical appraisal explored the power and importance of appropriate and respectful language in research and clinical practice. Clinical implications and recommendations related to the key findings of the previous two papers are made,

which I hope will improve the experience of accessing support for those who self-harm, and those who identify as LGBTQ+.

References

Altman, M. R., Kantrowitz-Gordon, I., Moise, E., Malcolm, K., Vidaković, M., Barrington, W., O'Connor, M. R., & de Castro, A. (2021). Addressing positionality within case-based learning to mitigate systemic racism in health care. *Nurse educator*, *46*(5), 284-289.

American Psychological Association. (2020). *Publication manual of the american psychological association (7th ed.)*.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (Vol. 5). American psychiatric association Washington, DC.

Arensman, E., Griffin, E., Daly, C., Corcoran, P., Cassidy, E., & Perry, I. J. (2018). Recommended next care following hospital-treated self-harm: Patterns and trends over time. *PLoS ONE*, *13*(3), e0193587.

Bhaskar, R. (2013). *A realist theory of science*. Routledge.

Caceres, B. A., Travers, J., Primiano, J. E., Luscombe, R. E., & Dorsen, C. (2020). Provider and LGBT individuals' perspectives on LGBT issues in long-term care: A systematic review. *The Gerontologist*, *60*(3), e169-e183.

Cooper, J., Steeg, S., Bennewith, O., Lowe, M., Gunnell, D., House, A., Hawton, K., & Kapur, N. (2013). Are hospital services for self-harm getting better? An observational study examining management, service provision and temporal trends in England. *BMJ open*, *3*(11).

Cooper, J., Steeg, S., Gunnell, D., Webb, R., Hawton, K., Bennewith, O., House, A., & Kapur, N. (2015). Variations in the hospital management of self-harm and patient outcome: a multi-site observational study in England. *Journal of Affective Disorders*, *174*, 101-105.

Corrigan, P. W., Kosyluk, K. A., & Rüsch, N. (2013). Reducing self-stigma by coming out proud. *American Journal of Public Health*, *103*(5), 794-800.

Cully, G., Leahy, D., Shiely, F., & Arensman, E. (2022). Patients' experiences of engagement with healthcare services following a high-risk self-harm presentation to a hospital emergency department: A mixed methods study. *Archives of Suicide Research*, *26*(1), 91-111.

Demuthova, S., Vaclavikova, I., Selecka, L., & Blatny, M. (2020). The Problem of Self-Disclosure of Self-Harming Behaviour in Adolescence. *Postmodern Openings*, *11*(4), 01-19.

Dunlop, B. J., & Lea, J. (2023). Clinical formulation. In *Sexual minorities and mental health: Current perspectives and new directions* (pp. 165-191). Springer.

Furness, B. W., Goldhammer, H., Montalvo, W., Gagnon, K., Bifulco, L., Lentine, D., & Anderson, D. (2020). Transforming primary care for lesbian, gay, bisexual, and transgender people: a collaborative quality improvement initiative. *The Annals of Family Medicine*, *18*(4), 292-302.

Gardner, K. J., Paul, E., Selby, E. A., Klonsky, E. D., & Mars, B. (2021). Intrapersonal and interpersonal functions as pathways to future self-harm repetition and suicide attempts. *Frontiers in Psychology*, *12*, 688472.

Gonzales, G., & Henning-Smith, C. (2017). Barriers to care among transgender and gender nonconforming adults. *The Milbank Quarterly*, *95*(4), 726-748.

Hasking, P., & Boyes, M. (2018). Cutting words: A commentary on language and stigma in the context of nonsuicidal self-injury. *The Journal of nervous and mental disease*, *206*(11), 829-833.

Hasking, P. A., Boyes, M. E., & Lewis, S. P. (2021). The language of self-injury: A data-informed commentary. *The Journal of nervous and mental disease*, *209*(4), 233-236.

Heath, S., Charles, V., Crow, G., & Wiles, R. (2007). Informed consent, gatekeepers and go-betweens: negotiating consent in child-and youth-orientated institutions. *British Educational Research Journal*, *33*(3), 403-417.

Joiner, T. E. (2005). *Why people die by suicide*. Harvard University Press.

Kapur, N., Cooper, J., O'Connor, R. C., & Hawton, K. (2013). Non-suicidal self-injury v. attempted suicide: new diagnosis or false dichotomy? *The British Journal of Psychiatry*, *202*(5), 326-328.

Keighley, R. (2022). Hate hurts: Exploring the impact of online hate on LGBTQ+ young people. *Women & Criminal Justice*, *32*(1-2), 29-48.

Leather, J. Z., O'Connor, R. C., Quinlivan, L., Kapur, N., Campbell, S., & Armitage, C. J. (2020). Healthcare professionals' implementation of national guidelines with patients who self-harm. *Journal of Psychiatric Research*, *130*, 405-411.

Levine, R. J. (1988). *Ethics and regulation of clinical research*. Yale University Press.

Lewis, S. P., & Baker, T. G. (2011). The possible risks of self-injury web sites: a content analysis. *Archives of Suicide Research*, *15*(4), 390-396.

Lewis, S. P., & Hasking, P. (2019). Putting the "self" in self-injury research: Inclusion of people with lived experience in the research process. *Psychiatric Services*, *70*(11), 1058-1060.

Liu, R. T., Sheehan, A. E., Walsh, R. F. L., Sanzari, C. M., Cheek, S. M., & Hernandez, E. M. (2019). Prevalence and correlates of non-suicidal self-injury among lesbian, gay, bisexual, and transgender individuals: A systematic review and meta-analysis. *Clinical Psychology Review*, *74*. https://doi.org/10.1016/j.cpr.2019.101783

Macapagal, K., Bhatia, R., & Greene, G. J. (2016). Differences in healthcare access, use, and experiences within a community sample of racially diverse lesbian, gay, bisexual, transgender, and questioning emerging adults. *LGBT Health*, *3*(6), 434-442.

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British journal of psychology*, *91*(1), 1-20.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological bulletin*, *129*(5), 674.

Miller, M., Redley, M., & Wilkinson, P. O. (2021). A qualitative study of understanding reasons for self-harm in adolescent girls. *International journal of environmental research and public health*, *18*(7), 3361.

Morgan, C., Webb, R. T., Carr, M. J., Kontopantelis, E., Green, J., Chew-Graham, C. A., Kapur, N., & Ashcroft, D. M. (2017). Incidence, clinical management, and mortality risk following self harm among children and adolescents: cohort study in primary care. *bmj*, *359*.

Nadal, K. L., Whitman, C. N., Davis, L. S., Erazo, T., & Davidoff, K. C. (2016). Microaggressions toward lesbian, gay, bisexual, transgender, queer, and genderqueer people: A review of the literature. *The journal of sex research*, *53*(4-5), 488-508.

National Institute for Health and Care Excellence (NICE). (2022). *Self-harm: Assessment, management and preventing recurrence.* Retrieved from https://www.nice.org.uk/guidance/ng225

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing qualitative studies* (Vol. 11). sage.

Nock, M. K., Holmberg, E. B., Photos, V. I., & Michel, B. D. (2007). Self-Injurious Thoughts and Behaviors Interview: development, reliability, and validity in an adolescent sample.

O'Connor, R. C., Rasmussen, S., & Hawton, K. (2012). Distinguishing adolescents who think about self-harm from those who engage in self-harm. *The British Journal of Psychiatry*, *200*(4), 330-335.

Ozer, U., Varlik, C., Ceri, V., Ince, B., & Arslan Delice, M. (2017). Change starts with us: Stigmatizing attitudes towards mental illnesses and the use of stigmatizing language among mental health professionals. *Dusunen Adam The Journal of Psychiatry and Neurological Sciences*, *30*(3), 224.

Plener, P. L., Schumacher, T. S., Munz, L. M., & Groschwitz, R. C. (2015). The longitudinal course of non-suicidal self-injury and deliberate self-harm: a systematic review of the literature. *Borderline personality disorder and emotion dysregulation*, *2*(1), 1-11.

Rossi, A. L., & Lopez, E. J. (2017). Contextualizing competence: language and LGBT-based competency in health care. *Journal of Homosexuality*, *64*(10), 1330-1349.

Shafer, G. (2015). Language, Hegemony, and LGBT Rights. *Language Arts Journal of Michigan*, *30*(2), 7.

Soled, K. R., Clark, K. D., Altman, M. R., Bosse, J. D., Thompson, R. A., Squires, A., & Sherman, A. D. (2022). Changing language, changes lives: Learning the lexicon of LGBTQ+ health equity. *Research in nursing & health*, *45*(6), 621.

Soral, W., Bilewicz, M., & Winiewski, M. (2018). Exposure to hate speech increases prejudice through desensitization. *Aggressive behavior*, *44*(2), 136-146.

Squires, A., & Thompson, R. (2021). Learning the language of health equity. In (Vol. 44, pp. 869-871): Wiley Online Library.

Stallard, P., Spears, M., Montgomery, A. A., Phillips, R., & Sayal, K. (2013). Self-harm in young adolescents (12–16 years): onset and short-term continuation in a community sample. *BMC Psychiatry*, *13*(1), 1-14.

Stein, D. J., Szatmari, P., Gaebel, W., Berk, M., Vieta, E., Maj, M., De Vries, Y. A., Roest, A. M., De Jonge, P., & Maercker, A. (2020). Mental, behavioral and neurodevelopmental disorders in the ICD-11: an international perspective on key changes and controversies. *BMC medicine*, *18*(1), 1-24.

Swannell, S. V., Martin, G. E., Page, A., Hasking, P., & St John, N. J. (2014). Prevalence of nonsuicidal self-injury in nonclinical samples: Systematic review, meta-analysis and meta-regression. *Suicide and Life-Threatening Behavior*, *44*(3), 273-303.

Van Orden, K. A., Cukrowicz, K. C., Witte, T. K., & Joiner Jr, T. E. (2012). Thwarted belongingness and perceived burdensomeness: construct validity and psychometric properties of the Interpersonal Needs Questionnaire. *Psychological Assessment*, *24*(1), 197.

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner Jr, T. E. (2010). The interpersonal theory of suicide. *Psychological review*, *117*(2), 575.

Washburn, J. J., Juzwin, K., Styer, D. M., & Aldridge, D. (2010). Measuring the urge to self-injure: Preliminary data from a clinical sample. *Psychiatry Research*, *178*(3), 540-544.

Xanthopoulou, P., Ryan, M., Lomas, M., & McCabe, R. (2021). Psychosocial assessment in the emergency department: The experiences of people presenting with self-harm and suicidality. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*.

Zetterqvist, M. (2015). The DSM-5 diagnosis of nonsuicidal self-injury disorder: a review of the empirical literature. *Child and Adolescent Psychiatry and Mental Health*, *9*(1), 1-13.

Zochniak, K., Lewicka, O., Wybrańska, Z., & Bilewicz, M. (2023). Homophobic Hate Speech Affects Well-Being of Highly Identified LGBT People. *Journal of Language and Social Psychology*, 0261927X231174569.

Appendices

Appendix 3-A: Self-Injurious Thoughts and Behaviours Interview Short Form (Nock et al., 2007), Non-Suicidal Self-Injury Section

Thoughts of Non-Suicidal Self-Injury

51) Have you ever had thoughts of purposely hurting yourself without wanting to die? (for example, cutting or burning) 51)_____________
0) no 1) yes

We will refer to this as non-suicidal self-injury.

52) How old were you the first time you thought about engaging in NSSI? (*age*) 52)_____________

53) How old were you the last time? (*age*) 53)_____________

54) During how many separate times in your life have you thought about engaging in NSSI? 54)_____________

55) How many separate times in the past year? 55)____________

56) How many separate times in the past month? 56)____________

57) How many separate times in the past week? 57)____________

58) On the scale of 0 to 4, at the worst point, how intense were your thoughts about engaging in NSSI? 58)_____________

59) On average, how intense were these thoughts? 59)_____________

60) When you have had these thoughts, how long have they usually lasted? 60)_____________
0) 0 seconds
1) 1-60 seconds
2) 2-15 minutes
3) 16-60 minutes
4) less than one day
5) 1-2 days
6) more than 2 days
7) wide range (spans > 2 responses)
88) not applicable
99) unknown

61) On the scale of 0 to 4, what do you think the likelihood is that you will have thoughts about engaging in NSSI in the future? 61)_____________

Section Four: Ethics Proposal

Bethan Gray

Doctorate in Clinical Psychology

Division of Health Research

Lancaster University

Word Count: 3825

Excluding references, tables, figures and appendices

All correspondence should be addressed to:

Bethan Gray

c/o Doctorate in Clinical Psychology

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4AT

b.gray3@lancaster.ac.uk

Research Ethics Application Form

Research Ethics Application Form v1.9.4

Research Ethics Application Form v1.9.5 RECR

Fear of Compassion and Non-Suicidal Self-Injury - Approved

Information Regarding this Research Project

Are you conducting a research project?
(for more information on research projects please see our ethics pages)

- (•) Yes
- ( ) No

Does your research only involve animals?

- ( ) Yes
- (•) No

Are you undertaking this research as/are you filling this form out as:

- ( ) Academic/Research Staff
- ( ) Non Academic Staff
- ( ) Staff Undertaking a Programme of Study
- (•) PhD or DClinPsy student
- ( ) Undergraduate, Masters, Master by Research, MPhil or other taught postgraduate programme

Which Faculty are you in?

Faculty of Health and Medicine

Which department are you in?

Health Research

Will your project require NHS REC approval? (If you are not sure please read the guidance in the information button)

○ Yes ◉ No

Do you need Health Research Authority (HRA) approval? (Please read the guidance in the information button)

○ Yes ◉ No

Have you already obtained, or will you be applying for ethical approval, from another institution outside of Lancaster University? (For example, an external institution such as: another University's Research Ethics Committee, the NHS or an institution abroad (eg an IRB in the USA)? Please select one of the following:

◉ No, I do not need ethical approval from an external institution.
○ Yes, I have already received ethical approval from an external institution.
○ Yes, I will be applying for ethical approval from an external institution after I have received confirmation of ethical approval from my Faculty Research Ethics Committee (FREC) at Lancaster University, if the FREC grants approval.

Is this an amendment to a project previously approved by Lancaster University?

○ Yes ◉ No

Will your research involve any of the following? (Multiple selections are possible, please see i icon for details)

- [x] Human Participants
- [ ] Data relating to humans (Secondary/Pre-existing data only)
- [ ] Data collection from online sources such as social media platforms, discussion forums, online chat-rooms
- [ ] Human Tissue
- [ ] None of the above

Project Information

Please confirm/amend the title of this project.

Fear of Compassion and Non-Suicidal Self-Injury

Estimated Project Start Date 03/04/2023

Estimated End Date 31/03/2024

Is this a funded Project?

○ Yes ◉ No

Research Site(s) Information

Will you be recruiting participants from research sites outside of Lancaster University? *(E.g. Schools, workplaces, etc; please read the guidance in the information button for more information)*

○ Yes ◉ No

Applicant Details

Are you the named Principal Investigator at Lancaster University?

◉ Yes ○ No

Please check your contact details are correct. You can update these fields via the personal details section located in the top right of the screen. Click on your name and email address in the top right to access "Personal details". For more details on how to do this, please read the guidance in the information button.

First Name

Bethan

Surname

Gray

Department

Division of Health Research

Faculty

Faculty of Health and Medicine

Email

b.gray3@lancaster.ac.uk

Principal Investigator

You have stated that you are the Principal Investigator for this project.

First Name

Bethan

Surname

Gray

Department

Division of Health Research

Email

b.gray3@lancaster.ac.uk

Supervisor Details

Search for your supervisor's name. *If you cannot find your supervisor in the system please contact rso-systems@lancaster.ac.uk to have them added.*

First Name

James Andrew

Surname

Kelly

Department

Health Research

Faculty

Faculty of Health and Medicine

Email

j.a.kelly@lancaster.ac.uk

Do you need to add a second supervisor to sign off on this project?

- ○ Yes
- ● No

Additional Team Members

Other then those already added, please select which type of team members will be working on this project:

- ☐ I am not working with any other team members.
- ☐ Staff
- ☐ Student
- ☑ External

Please list all external contacts here:

First Name

Laura

Surname

Twist

Organisation

NHS

Details about the participants

As you are conducting research with Human Participants/Tissue you will need to answer the following questions before your application can be reviewed.

If you have any queries about this please contact your Ethics Officer before proceeding.

What's the minimum number of participants needed for this project?

114

What's the maximum number of expected participants?

127

Do you intend to recruit participants from online sources such as social media platforms, discussion forums, or online chat rooms?

(•) Yes ( ) No

Will you get written consent and give a participant information sheet with a written description of your research to all potential participants?

(•) Yes ( ) No ( ) I don't know

Will any participants be asked to take part in the study without their consent or knowledge at the time or will deception of any sort be involved?

( ) Yes (•) No ( ) I don't know

Is your research with any vulnerable groups?

(Vulnerable group as defined by Lancaster University Guidelines)

(•) Yes ( ) No ( ) I don't know

Is your research with any adults (aged 18 or older)?

(•) Yes ( ) No

Is your research data collected with completely anonymous adult (aged 18 or older) participants, with no contact details or other uniquely identifying information (e.g. date of birth) being recorded?

(•) Yes ( ) No

Is your research with adult participants (aged 18 years, or older) in private interactions (for example, one to one interviews, online questionnaires)?

(•) Yes ( ) No

Is your research with any young people (under 18 years old)?

(•) Yes ( ) No ( ) I don't know

Does your research involve discussion of personally sensitive subjects which the participant might not be willing to otherwise talk about in public (e.g. medical conditions)?

(•) Yes ( ) No ( ) I don't know

Could the study induce psychological stress or anxiety, or produce humiliation or cause harm or negative consequences beyond the risks encountered in a participant's usual, everyday life?

(•) Yes ( ) No ( ) I don't know

Is there a risk that the nature of the research topic might lead to disclosures from the participant concerning either:

- Their own or others involvement in illegal activities
- Other activities that represent a threat to themselves or others (e.g. sexual activity, drug use, or professional misconduct)?

( ) Yes (•) No ( ) I don't know

Does the study involve any of the following:

- Physically intrusive procedures including touching or attaching equipment to participants
- Administration of substances
- Ultrasound or sources of non-ionising radiation (e.g. lasers)
- Sources of ionising radiation, (e.g. X-rays)
- Collection or use of samples of Human Tissue (e.g. Saliva, skin cells, blood etc.)

( ) Yes (•) No ( ) I don't know

Details about Participant relationships

Do you have a current or prior relationship with potential participants? For example, teaching or assessing students or managing or influencing staff (this list is not exhaustive).

- ○ Yes
- ● No
- ○ I don't know

If you need written permission from a senior manager in an organisation where research will take place (e.g. school, business) will you gain this in advance of undertaking your research?

- ○ Yes
- ● No
- ○ I don't know
- ○ N/A

Will you be using a gatekeeper to access participants?

- ○ Yes
- ● No
- ○ I don't know if I will be using a gatekeeper

Will participants be subjected to any undue incentives to participate?

- ○ Yes
- ● No
- ○ I don't know

Will you ensure that there is no perceived pressure to participate?

- ● Yes
- ○ No
- ○ I don't know

Participant data

Will you be using video recording or photography as part of your research or publication of results?

- ○ Yes
- ● No

Will you be using audio recording as part of your research?

- ○ Yes
- ● No

Will you be using portable devices to record participants (e.g. audio, video recorders, mobile phone, etc)?

- (•) No
- ( ) Yes, and all portable devices will be encrypted as per the Lancaster University ISS standards, in particular where they are used for recording identifiable data
- ( ) Yes, but these cannot be encrypted because they do not have encryption functionality. Therefore I confirm that any identifiable data (including audio and video recordings of participants) will be deleted from the recording device(s) as quickly as possible (e.g. when it has been transferred to a secure medium, such as a password protected and encrypted laptop or stored in OneDrive) and that the device will be stored securely in the meantime

Will you be using other portable storage devices in particular for identifiable data (e.g. laptop, USB drive, etc)? (Please read the help text)

- (•) No
- ( ) Yes, and they will be encrypted as per the Lancaster University ISS standards in particular where they are used for recording identifiable data

Will anybody external to the research team be transcribing the research data?

( ) Yes (•) No

Online Sources

Does your research comply with the site(s) terms and conditions? Before completing the section below please read the 'Social Media Guidance for Researchers'

(•) Yes ( ) No ( ) It's unclear in the terms and conditions

Is there a reasonable expectation of privacy?

(•) Yes ( ) No

Because there is a reasonable expectation of privacy, you must obtain consent from site users. Therefore you will need to upload a copy of the Participant Information Sheet & Consent form that you intend to use to obtain their informed consent.

General Queries

Does any member of the research team, or their families and friends, have any links to the funder or organisations involved in the research?

○ Yes ● No ○ I don't know

Can the research results be freely disseminated?

● Yes ○ No ○ I don't know

Will you use data from potentially illicit, illegal, or unethical sources (e.g. pornography, related to terrorism, dark web, leaked information)?

○ Yes ● No ○ I don't know

Will you be gathering/working with any special category personal data?

○ Yes ● No ○ I don't know

Are there any other ethical considerations which haven't been covered?

○ Yes ● No ○ I don't know

REC Review Details

Based on the answers you have given so far you will need to answer some additional questions to allow reviewers to assess your application.

It is recommended that you do not proceed until you have completed **all of the previous questions**.

Please confirm that you have finished answering the previous questions and are happy to proceed.

☑ I confirm that I have answered all of the previous questions, and am happy to proceed with the application.

Questions for REC Review

Summarise your research protocol in lay terms (indicative maximum length 150 words).

Note: The summary of the protocol should concisely but clearly tell the Ethics Committee (in simple terms and in a way which would be understandable to a general audience) what you are broadly planning to do in your study. Your study will be reviewed by colleagues from different disciplines who will not be familiar with your specific field of research and it may also be reviewed by the lay members of the Research Ethics Committee; therefore avoid jargon and use simple terms. A helpful format may include a sentence or two about the background/ "problem" the research is addressing, why it is important, followed by a description of the basic design and target population. Think of it as a snapshot of your study.

Non-suicidal self-injury is the act of harming oneself without the desire to end one's life. Non-suicidal self-injury is highly prevalent in clinical and non-clinical populations and predicts future suicide risk.

This study will involve 16 to 25-year-olds, based on findings that non-suicidal self-injury engagement is highest in this age range; therefore, addressing a significant clinical need in the population.

Self-compassion is an awareness of one's own suffering and a drive to resolve this. Those with high self-compassion are less likely to engage in non-suicidal self-injury. Lower self-compassion is also linked with feeling isolated from others and feeling like you do not belong. These feelings of not belonging are linked with engagement in non-suicidal self-injury.

Fears, blocks and resistances to compassion are suggested as possible reasons an individual may have difficulty engaging in compassion. However, the relationship between feeling that you do not belong, feeling you are a burden, and fears, blocks and resistances to compassion have not been explored alongside non-suicidal self-injury yet. This reserach may allow us some further understanding of the underlying drivers of the behaviour.

An online questionnaire design will be used to gather information on whether fear of self-compassion, fear of receiving compassion from others and fear of giving compassion to others, feeling you are a burden, and feeling that you do not belong with others influence engagement in non-suicide self-injury.

State the Aims and Objectives of the project in Lay persons' language.

The aim of the study is to explore whether feeling that you do not belong with others, feeling that you are a burden and a fear of compassion all impact on engagement in non-suicidal self-injury.

Participant Information

Please explain the number of participants you intend to include in your study and explain your rationale in detail (eg who will be recruited, how, where from; and expected availability of participants). If your study contains multiple parts eg interviews, focus groups, online questionnaires) please clearly explain the numbers and recruitment details for each of these cohorts (see help text).

Recruitment will be completed by a range of means. Advertisement posters will be distributed at physical locations, such as Lancaster University, as well as distributed via online platforms as part of social media posts and to relevant forums.

The online study will be designed so that it does not allow for missing or partial data as all questions will be mandatory, meaning that all data collected will be complete data and will count towards the number of participants indicated in the calculations b. Data will be tested for normality of distribution, linearity, outliers and multicollinearity.

A forced entry multiple regression model will be used with the Alexian Brothers Urge to Self-Injure scale as the dependent variable, and will include 8 total predictor variables (age, gender, sexuality, ethnicity, depression, fear of compassion (total score), thwarted belongingness, perceived burdensomeness, with one of these being a tested predictor (Fear of Compassion). This will give details of the significant predictors of self-harm from the variables explored.

As there is a lack of research which encompasses both compassion literature and Joiner's concepts of thwarted belongingness and perceived burdensomeness, there is no directly comparable literature to explore expected percentages of variance to be explained by each construct to inform our power calculation as is suggested by Lakens (2022). However, studies exploring similar constructs (including perceived burdensomeness and thwarted belonging) in the emerging adult age group have reported 79% of the variance in NSSI remains unexplained by their model (La Guardia et al., 2020).

Using a conservative calculation suggesting that the tested variable will explain 5% of the variance in the model, G*Power was used to calculate an estimated effect size (Cohen's f2) of 0.06. A G*Power calculation states that, to explore whether fear of compassion explains unique variance over and above an established model (R2 increase), 127 participants will be required to detect an effect size of 0.06 at 80% power in this model's regression analysis with a 0.05 level of significance.

A commonly used 'Rule of Thumb' suggests a sample size where N > 50 + 8m (where m is the number of IVs) for testing the multiple correlation and N > 104 + m for testing individual predictors, using the larger of the two numbers (Green, 1991). This would equate to 114 participants.

A further three exploratory models will be completed with the 7 predictor variables of age, gender, sexuality, ethnicity, depression, fear of compassion, thwarted belongingness, and perceived burdensomeness remaining the same, and one of each sub-scale of the fear of compassion scales being included in each model (fear of self-compassion, fear of compassion from others, fear of compassion for others).

A further regression model will be completed with the 7 predictor variables of age, gender, sexuality, ethnicity, depression, fear of compassion, thwarted belongingness, and perceived burdensomeness, however, this model will include the total score from the flows of compassion scale in place of the fear of compassion scale total. This will allow validation of the fear of compassion scales to see if they behave similarly to the flows of compassion scales which are less well-validated in this age group.
A mediation analysis will be also completed to explore the hypothesis that Fear of Compassion remains independently significantly related to urge to Self-Harm even whilst accounting for the mediated effects of Interpersonal Needs (thwarted belonging and perceived burdensomeness total score) on urge to self-harm.

A sample of 127 will have sufficient power to detect a medium effect size of both the alpha and beta path in a mediation model, where the minimum sample needed would be 78. A medium effect size has been chosen as mediation of small effect sizes are less likely to be important clinically.

Therefore, the aim is to end data collection when either a) 127 participants have fully completed the study or b) once 114 participants have completed the study within the data collection window, whichever occurs first.

As you have indicated that you are working with a vulnerable group please describe the intended participants, and why they are needed for this research.

I have identified the participants as a vulnerable group as we will be seeking to gain responses from individuals who have experienced thoughts of or urges to engage in non-suicidal self-injury in the past 6 months. This is required for the research as we are looking to explore the factors which influence the urge to engage in self-harm, with the hope that a better understanding of this can guide our support of these individuals.

As you have indicated that you are working with young people (under 18 years old), please describe the intended participants, and why they are needed for this research.

Participants will consist of emergening adults (aged 16 to 25), who self-identify as experiencing thoughts or urges to self-harm, or who have experienced NSSI thoughts, urges or behaviours within the preceding 6 months. Some research considering emerging adults consider this from 18 to 25 years of age, however the age range of participants in this study is based on research highlighting rates of NSSI engagement are highly prevalent in the age group of 16 to 24 (McManus et al., 2019), as well as a recent study evaluating the interaction between age and NSSI found that NSSI was most prevalent between ages 16 and 19 (Wilkinson et al., 2022).
There is also evidence of a high prevalence of self-harm in those under the age of 16; however, including the age range of 16 to 25 balances the need to recruit from the populations with the highest self-harm prevalence to address a significant clinical need, with our desire to ensure this research is being completed ethically with this potentially vulnerable population.

Please indicate how this group will be recruited.

Social media advertising will be used to recruit, inviting participants to consider whether they wish to participate by following a link to a Qualtrics study.

Websites identified to advertise online include: Twitter (using a study-specific Twitter account @selfharmstudy); Facebook groups such as "truly twenties" and other groups identified as accepting research advertisements; Reddit Forums such as "R/AdultSelfharm", "R/SampleSize", "R/Psychology" in the research studies sharing thread.

Charities such as Harm Less and Battle Scars will be contacted to inquire about sharing the advertisement for the study.

There will also be physical adverts placed at locations across Lancaster University with a web link and QR code to allow people to gain further information and access the study if desired.

Please indicate how this group will be recruited.

Social media advertising will be used to recruit, inviting participants to consider whether they wish to participate by following a link to a Qualtrics study.

Websites identified to advertise online include: Twitter (using a study-specific Twitter account @selfharmstudy); Facebook groups such as "truly twenties" and other groups identified as accepting research advertisements; Reddit Forums such as "R/AdultSelfharm", "R/SampleSize", "R/Psychology" in the research studies sharing thread. Other suitable forums and groups will be searched for.

Charities such as Harm Less and Battle Scars will be contacted to enquire about the sharing of the advertisement for the study.

There will also be physical adverts placed at locations across Lancaster University with a web link and QR code to allow people to gain further information and access the study if desired.

You have selected that the research may involve personal sensitive topics that participants may not be willing to otherwise talk about. Please indicate what discomfort, inconvenience or harm could be caused to the participant and what steps you will take to mitigate or manage these situations.

The study will contain questions regarding self-harm, including whether the individual thinks about harming themselves and experiences urges to harm themselves. This is potentially distressing for participants who both do and do not engage in self-harm, as it can be an upsetting topic to consider. Many people who have thoughts of self-harm and/or engage in self-harming behaviours do not talk about this with those in their life and may consider this a personal and sensitive topic.

To ensure participants are fully aware that this will be included in the survey, we will disclose this in our advertising. This will ensure that any participants that do opt-in are prepared for this topic to be discussed. Advertising will disclose that participants do not need to take part if they are in any way concerned about responding to questions surrounding this topic. We will also ensure we provide signposting for support both within the participant information sheet and in the debrief.

Prior to recruitment, participant involvement will be sought to evaluate the language used in the questionnaires and advertisement to minimise any potential distress caused to participants. Language in the demographic questions will be discussed, especially relating to the questions selected from the SITBI, which have been reworded with the aim of reducing any experience of perceived judgement by the participants.

You stated that the study could induce psychological stress or anxiety, or produce humiliation or cause harm or negative consequences beyond the risks encountered in a participant's usual, everyday life. Please describe the question(s) and situation(s) that could lead to these outcomes and explain how you will mitigate this.

The study will contain questions regarding self-harm including whether the individual thinks about harming themselves and experiences urges to harm themselves and questions discussing methods of self-harm, frequency, and recent incidents. This is potentially distressing for participants who both do and do not engage in self-harm, as it can be an upsetting topic to consider and may present as a reminder or prompt to think about this beyond what the individual may be exposed to in everyday life.

To ensure participants are fully aware that this will be included in the survey, we will disclose this in our advertising. This will ensure that any participants that do opt-in are prepared for this topic to be discussed. We include the experience of thoughts of self-harm or self-harming behaviours as an inclusion criterion, so we are aware that this is something that the individuals will already experience regardless of whether they choose to engage in the study. We will also ensure we provide signposting for support both within the participant information sheet and in the debrief.

Information about the Research

What are your dissemination plans? E.g publishing in PhD thesis, publishing in academic journal, presenting in a conference (talk or poster).

We will look to publish our findings in an academic journal, potentially 'Crisis' or 'Suicide and Life Threatening Behaviour', as well as using the data as part of the Doctoral Thesis.
We will also create a lay summary of our findings to distribute to charities and across recruitment sites.

Online Sources

You have indicated site users have a reasonable expectation of privacy and therefore you will need to obtain consent to use their data for this project. Please explain how you propose to obtain consent.

All participants will be provided with an information sheet which explains the purpose of the study, what the study will entail and how their data will be used. This will be written in clear language to make it accessible and will not include any jargon. The survey will include a consent form which guides the individual through a set of questions to ensure they know how their data will be used and can consent/decline consent to each individual statement. Declining consent to any one statement will redirect the participant to a 'did not consent' page which will explain that they have not indicated that they are happy with how the study will utilise the data.

Data Storage

How long will you retain the research data?

Data will be retained for 10 years.

How long and where will you store any personal and/or sensitive data?

The data collected for this study will be stored on University approved secure cloud storage and only the researchers conducting this study will have access to this data.

Please explain when and how you will anonymise data and delete any identifiable record?

We will collect personal and demographic information (such as age, gender, sexuality and ethnicity) to inform our understanding of the data.
We will not ask for any identifiable information in the survey, ensuring the data collected is anonymous. No individual data points will be reported in the analyses or the reporting of the statistics.

Project Documentation*

Important Notice about uploaded documents:

When your application has been reviewed if you are asked to make any changes to your uploaded documents please highlight the changes on the updated document(s) using the highlighter so that they are easy to see.

Please confirm that you have read and applied, where appropriate, the guidance on completing the Participant Information Sheet, Consent Form, and other related documents and that you followed the guidance in the help button for a quality check of these documents. For information and guidance, please use the relevant link below:

FST Ethics Webpage

FHM Ethics Webpage

FASS-LUMS Ethics Webpage

REAMS Webpage

- [x] I confirm that I have followed the guidance.

In addition to completing this form you must submit all supporting materials.

Please indicate which of the following documents are appropriate for your project:

- [x] Research Proposal (DClinPsy)
- [x] Advertising materials (posters, emails)
- [ ] Letters/emails of invitation to participate
- [x] Consent forms
- [x] Participant information sheet(s)
- [ ] Interview question guides
- [ ] Focus group scripts
- [x] Questionnaires, surveys, demographic sheets
- [ ] Workshop guide(s)
- [x] Debrief sheet(s)
- [ ] Transcription (confidentiality) agreement
- [x] Other
- [ ] None of the above.

Please upload the documents in the correct sections below:

Please ensure these are the latest version of the documents to prevent the application being returned for corrections you have already made.

As you are in a DClinPsy course please upload your Research Proposal for this project.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Research Proposal	Thesis Proposal Form	Thesis Proposal Form.docx	03/03/2023	3	494.7 KB

Please upload all consent forms to be used in this project.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Consent Form	Consent Form	Consent Form.docx	06/04/2023	2	60.7 KB

Please upload all Participant Information Sheets:

Documents

Type	Document Name	File Name	Version Date	Version	Size
Participant Information Sheet	Participant Information Sheet	Participant Information Sheet.docx	06/04/2023	2	272.2 KB

Please upload all advertising materials (posters, emails)

Documents

Type	Document Name	File Name	Version Date	Version	Size
Advertising materials	Advertisements	Advertisements.docx	06/04/2023	2	680.7 KB

Please upload all Questionnaires, surveys, demographic sheets

Documents

Type	Document Name	File Name	Version Date	Version	Size
Questionnaires, surveys, demographic sheets	Questionnaires^J Surveys^J Demographic Sheets	Questionnaires^J Surveys^J Demographic Sheets.pdf	06/04/2023	2	1.7 MB

Please upload a copy of your Debrief sheet.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Debrief sheet	Debrief	Debrief.docx	06/04/2023	2	62.7 KB

Please upload any other relevant documentation related to this project.

Documents

Type	Document Name	File Name	Version Date	Version	Size
Other	REC Cover Letter for Changes	REC Cover Letter for Changes.pdf	06/04/2023	1	174.8 KB
Other	Ethics Protocol	Ethics Protocol.docx	06/04/2023	2	3.6 MB

Declaration

Please Note

Research Services monitors projects entered into the online system, and may select projects for quality control.

All research at Lancaster university must comply with the LU data storage and governance guidance as well as the General Data Protection Regulation (GDPR) and the UK Data Protection Act 2018. (Data Protection Guidance webpage)

☑ I confirm that I have read and will comply with the LU Data Storage and Governance guidance and that my data use and storage plans comply with the General data Protection Regulation (GDPR) and the UK Data Protection Act 2018.

Have you that you have undertaken a health and safety risk assessment for your project through your departmental process? (Health and Safety Guidance)

☑ I have undertaken a health and safety assesment for your project through my departmental process, and where required will follow the appropriate guidance for the control and management of any foreseeable risks.

When you are satisfied that this application has been completed please click "Request" below to send this application to your supervisor for approval.

Signed: This form was signed by Dr James Kelly (j.a.kelly@lancaster.ac.uk) on 13/04/2023 17:51

Please read the terms and conditions below:

- You have read and will abide by Lancaster University's Code of Practice and will ensure that all staff and students involved in the project will also abide by it.
- If appropriate a confidentiality agreement will be used.
- You will complete a data management plan with the Library if appropriate. Guidance from Library.
- You will provide your contact details, as well as those of either your supervisor (for students) or an appropriate person for complaints (such as HoD) to any participants with whom you interact, so they know whom to contact in case of questions or complaints?
- That University policy will be followed for secure storage of identifiable data on all portable devices and if necessary you will seek guidance from ISS.
- That you have completed the ISS Information Security training and passed the assessment.
- That you will abide by Lancaster University's lone working policy for field work if appropriate.
- On behalf of the institution you accept responsibility for the project in relation to promoting good research practice and the prevention of misconduct (including plagiarism and fabrication or misrepresentation of results).
- To the best of your knowledge the information you have provided is correct at the time of submission.
- If anything changes in your research project you will submit an amendment.

Applicant Only: To complete and submit this application please click "Sign" below:

Signed: This form was signed by Bethan Gray (b.gray3@lancaster.ac.uk) on 06/04/2023 19:53

Appendices

Appendix 4-A: Research Protocol

Title: Fear of Compassion and Non-Suicidal Self-Injury

Applicant: Bethan Gray

Research Supervisor: Dr James Kelly

Version Number: 2

Introduction/Background

Non-suicidal self-injury (NSSI) is the infliction of damage to one's own body without the intent to die (Nock, 2009). NSSI is a global public health concern due to its high prevalence in clinical and non-clinical populations (Chan et al., 2016). NSSI is a significant predictor of future suicide attempts (McManus et al., 2019).

A recent cross-sectional general population study in England suggested engagement in NSSI has risen from the year 2000 compared to data in 2014 (McManus et al., 2019). The study included 7243 individuals ages 16 to 74 and found that NSSI is most highly prevalent in females aged 16 to 24, with 1 in 5 reported to engage in NSSI (McManus et al., 2019). Therefore, NSSI is an increasing concern in society currently.

The Interpersonal Theory of Suicide (Joiner, 2005; Van Orden et al., 2010) suggests that suicidal ideation and the desire to harm oneself develop based on the presence of two interpersonal constructs – thwarted belongingness and perceived burdensomeness. Thwarted belongingness is concerned with social isolation, loneliness, and an absence of reciprocal care – the individual's view that support is neither given nor received from others. Perceived burdensomeness is the individual's perception that they are flawed and thus have a negative impact on others and the presence of self-hatred. Research suggests that perceived burdensomeness may be a better predictor of suicidality than thwarted belongingness (Chu et al., 2016). However, thwarted belongingness was shown to

have a significant relationship to NSSI in undergraduate students, while perceived burdensomeness was non-significant (Assavedo & Anestis, 2016). This suggests a relationship between thwarted belongingness and NSSI.

Compassion theory offers one understanding of fundamental human motivation systems which may provide insight into the emergence of thwarted belonging and perceived burdensomeness, aiding understanding of the development and maintenance of NSSI behaviours. Compassion can be defined as a sensitivity to the suffering of oneself and others, with a motivation to try and alleviate this (Gilbert, 2014), a factor that influences an individual's relationship with themselves and others. Self-compassion is associated with psychological well-being, and reduced mental health difficulties (MacBeth & Gumley, 2012). Individuals with higher levels of self-compassion are more likely to engage in adaptive coping strategies (Allen & Leary, 2010), while those with higher levels of self-criticism are more likely to engage in maladaptive coping strategies, including NSSI (Nock, 2010). This suggests self-compassion as a protective factor for NSSI.

Gilbert (2010) details three flows of compassion; self-to-other, other-to-self, and self-to-self (self-compassion. Research shows that self-compassion negatively correlates with NSSI (Abdelraheem et al., 2019; Cleare et al., 2019; Suh & Jeong, 2021), meaning that those with higher self-compassion are less likely to engage in NSSI. Self-compassion is negatively associated with thwarted belongingness and perceived burdensomeness (Umphrey et al., 2020), and thwarted belongingness and perceived burdensomeness positively relate to NSSI (Assavedo & Anestis, 2016; Chu et al., 2016).

Gilbert (2010) details fears, blocks and resistances which impact these flows of compassion by preventing compassion motivation. Fear of compassion is described as an individual's active resistance to engaging in compassionate experiences and behaviours (Gilbert et al., 2011). Therefore, fear of compassion may be a reason why others cannot engage in compassionate processes with themselves and others, creating difficulty in connecting with others, which may be

related to feelings of thwarted belongingness. Fear of compassion has been shown as related to NSSI (Jiang et al., 2020; Xavier et al., 2016). However, there is a lack of research into the relationships between the three flows of compassion, difficulties engaging in compassion, and thwarted belongingness and perceived burdensomeness. Theory may indicate that thwarted belongingness and perceived burdensomeness are related to the flows of self-to-other and other-to-self compassion, as they are related to our ability to connect with others and experience others as supportive, respectively. A lack of research encompassing these two key theories, which have both independently been shown to be related to NSSI, may be limiting our full understanding of the underlying mechanisms for engagement in NSSI.

Therefore, research indicates correlations between compassion and thwarted belonging, compassion and NSSI, and thwarted belonging and NSSI. However, no one study has covered all three of compassion, thwarted belonging and NSSI. Furthermore, no study has connected fear of compassion, thwarted belongingness and NSSI to determine the relationship between these. This thesis will aim to build on the current body of research by testing the hypothesis that compassion and thwarted belongingness interact in their relation to NSSI. Specifically, a study exploring whether fear of compassion accounts for unique variance on NSSI after the variance accounted for by thwarted belongingness will be undertaken.

Method

Participants

Participants will consist of emergent adults (aged 16 to 25), who self-identify as experiencing thoughts or urges to self-harm, or who have experienced NSSI thoughts, urges or behaviours within the preceding 6 months. This time frame is based on the methodology of a recently published study (Dunlop et al., 2021) exploring a similar research topic. Some research considering emergent adults consider this from 18 to 25 years of age, however the age range of participants in this study is based on research highlighting rates of NSSI engagement are highly prevalent in the age group of 16 to 24

(McManus et al., 2019), as well as a recent study evaluating the interaction between age and NSSI found that NSSI was most prevalent between ages 16 and 19 (Wilkinson et al., 2022).

We recognise that there has been a high prevalence of self-harm reported in under 16s (Morgan et al., 2017; Plener et al., 2015). However, we consider the requirement for parental consent in this group a complex ethical concern as many teenagers who engage in self-harm do not discuss this with their parents or caregivers, and as such would either be unintentionally excluded or put at risk of intense emotional distress if seeking parental consent to participate. Therefore, including the age range of 16 to 25 balances the need to recruit from the populations with the highest self-harm prevalence to address a significant clinical need, with our desire to ensure this research is being completed ethically with an adult population who can provide informed consent.

Participants will reside in the United Kingdom to ensure that signposting provided is relevant to them and they are able to seek support if required or desired.

Design

The study will be quantitative with a correlational cross-sectional design. It will consist of five validated and reliable questionnaires which measure depression, flows of compassion (including compassion for self, compassion from others and compassion for others), fear of compassion (including fear of compassion, fear of compassion from others, fear of compassion for others), thwarted belongingness, perceived burdensomeness and urges to self-harm. It will also include a demographics questionnaire. The predictor variables will be depression, the flows of compassion, fear of compassion, thwarted belongingness and perceived burdensomeness. The dependent variable will be the urge to self-harm.

Materials

Center for Epidemiologic Studies Depression Scale (CES-D; Appendix G). This is a 20-item measure using a 4-point Likert scale to assess the presence of negative symptoms and the absence of positive symptoms associated with depression (Radloff, 1977).

Compassionate Engagement and Action Scales (CEAS; Appendix H). These three scales have 13 items each, measuring compassion for others, compassion from others and compassion for self (Gilbert et al., 2017). The responses are all measured on a 10-point Likert scale from 1 (Never) to 10 (Always).

Fears of compassion scales (Appendix J). This is a 38-item measure consisting of three subscales measuring fear of compassion, fear of compassion from others and fear of compassion for others (Gilbert et al., 2011). Responses are measured on a 5-point Likert scale ranging from 0 (Don't agree at all) to 4 (Completely agree). Higher scales on each subscale indicate higher fears of compassion

Interpersonal Needs Questionnaire (INQ; Appendix I). This is a 15-item measure using a 7-point Likert scale to measure thwarted belongingness and perceived burdensomeness (Van Orden et al., 2012).

Alexian Brothers Urge to Self-Injure Scale (ABUSI; Appendix F). This is a 5-item measure using 7-point Likert scales to measure the urge to self-harm (Washburn et al., 2010).

Self-Injurious Thoughts and Behaviours Interview Short Form (SITBI-short form; Appendix K). This is a structured interview which assesses the presence, frequency and characteristics of self-injurious thoughts and behaviours (Nock et al., 2007). Questions 62, 66, 67, 68 and 69 from the SITBI-Short Form will be employed as part of the demographics to measure the frequency and method of self-harm the participant engages in, if they currently or historically have engaged in self-harm behaviours. Question 69 will be provided as an open text box for free text entry in response to participant involvement (Appendix N).

Procedure

Prior to recruitment, participant involvement will be sought to evaluate the language used in the questionnaires and advertisement to minimise any potential distress caused to participants. Language in the demographic questions will be discussed, especially relating to the questions selected from the SITBI, which have been reworded with the aim of reducing any experience of perceived judgement by the participants.

Recruitment will be completed by a range of means. Advertisement posters (Appendix A) will be distributed at physical locations, such as Lancaster University, as well as being distributed via online platforms as part of social media posts.

A dedicated Twitter account has been created for the purpose of the project (@SelfHarmStudy) which will be used to tweet information about the project, including the advert and the survey link. The Twitter account will be used to request that others share the information widely.

Other social media platforms which have been identified to be used in a similar way are Facebook, Reddit, and Online Forums.

Participants can access further information regarding the study by following the link of the advertisements (Appendix A). Once participants read that information, they will be able to proceed to the next page, the participant information sheet, which will detail what they are consenting to once they continue to complete the survey (Appendix B).

Participants will then be taken to a consent form page (Appendix C). If participants do not agree with all statements, and therefore provide consent, they will be taken to the debrief page for those not providing consent (Appendix D).

If participants agree with all statements and provide consent, participants will be directed to the measures in the following order:

1. Demographics (including the stated questions from the Self-Injurious Thoughts and Behaviours Interview; SITBI)
2. Alexian Brothers Urge to Self-Injure Scale (ABUSI)
3. Center for Epidemiologic Studies Depression Scale (CES-D)
4. Compassionate Engagement and Action Scales (CEAS)
5. Interpersonal Needs Questionnaire (INQ)
6. Fears of compassion scales

Participants will then be directed to the completion debrief page (Appendix L), including signposting and resources.

Proposed analysis

The online study will be designed so that it does not allow for missing or partial data as all questions will be mandatory. Data will be tested for normality of distribution, linearity, outliers and multicollinearity.

The data will be examined using correlational analysis to first identify relationships between variables (depression, compassion for self, compassion from others and compassion for others, fear of compassion, fear of compassion from others, fear of compassion for others, thwarted belongingness, perceived burdensomeness and urges to self-harm). Regression analysis will be utilised to further explore the relationship between the variables, with urges to self-harm as the dependent variable.

A forced entry multiple regression model will be used with the Alexian Brothers Urge to Self-Injure scale as the dependent variable, and will include 8 total predictor variables (age, gender, sexuality, ethnicity, depression, fear of compassion (total score), thwarted belongingness, perceived burdensomeness, with one of these being a tested predictor (Fear of Compassion). This will give details of the significant predictors of self-harm from the variables explored.

As there is a lack of research which encompasses both compassion literature and Joiner's concepts of thwarted belongingness and perceived burdensomeness, there is no directly comparable literature to explore expected percentages of variance to be explained by each construct to inform our power calculation as is suggested by Lakens (2022). However, studies exploring similar constructs (including perceived burdensomeness and thwarted belonging) in the emerging adult age group have reported 79% of the variance in NSSI remains unexplained by their model (La Guardia et al., 2020).

Using a conservative calculation suggesting that the tested variable will explain 5% of the variance in the model, G*Power was used to calculate an estimated effect size (Cohen's $f2$) of 0.06. A G*Power calculation states that, to explore whether fear of compassion explains unique variance over and above an established model (R*2* increase), 127 participants will be required to detect an effect size of 0.06 at 80% power in this model's regression analysis with a 0.05 level of significance.

A commonly used 'Rule of Thumb' suggests a sample size where $N > 50 + 8m$ (where m is the number of IVs) for testing the multiple correlation and $N > 104 + m$ for testing individual predictors, using the larger of the two numbers (Green, 1991). This would equate to 114 participants.

Therefore, the aim is to end data collection when either a) 127 participants have fully completed the study or b) once 114 participants have completed the study within the data collection window, whichever occurs first.

A further three exploratory models will be completed with the 7 predictor variables of age, gender, sexuality, ethnicity, depression, fear of compassion, thwarted belongingness, and perceived burdensomeness remaining the same, and one of each sub-scale of the fear of compassion scales being included in each model (fear of self-compassion, fear of compassion from others, fear of compassion for others).

A further regression model will be completed with the 7 predictor variables of age, gender, sexuality, ethnicity, depression, fear of compassion, thwarted belongingness, and perceived burdensomeness, however, this model will include the total score from the flows of compassion scale in place of the fear of compassion scale total. This will allow validation of the fear of compassion scales to see if they behave similarly to the flows of compassion scales which are less well-validated in this age group.

A mediation analysis will be also completed to explore the hypothesis that Fear of Compassion remains independently significantly related to urge to Self-Harm even whilst accounting for the mediated effects of Interpersonal Needs (thwarted belonging and perceived burdensomeness total score) on urge to self-harm.

A sample of 127 will have sufficient power to detect a medium effect size of both the alpha and beta path in a mediation model, where the minimum sample needed would be 78. A medium effect size has been chosen as mediation of small effect sizes are less likely to be important clinically.

Practical issues

Data Storage

The data will initially be collected through the Qualtrics website (www.qualtrics.com) and will then be securely stored on University approved secure cloud storage. Only the researchers conducting this study will have access to this data. The data will be destroyed after 10 years. Refer to the data manage plan (Appendix M).

Dissemination of Findings

The results will be summarised and reported as a Lancaster University doctoral thesis and through presentations to the Doctorate in Clinical Psychology staff and peers at the university. The study will be submitted for publication in an academic or professional journal.

Ethical concerns

The main ethical concern regarding this research is surrounding the potential distress which participants may experience when thinking about their experience of urges to self-harm and any accompanied behaviours. However, the individuals completing the study will have self-identified that they already experience thoughts of self-harm, and as such will have decided as to whether they feel able to contribute to the project safely. The advertisements for the study, and information sheet, will both reflect that participants do not need to take part if they are concerned they will find this distressing and that they can exit the study at any time if desired.

While research has shown that trigger warnings do not significantly impact whether the individual finds the material distressing, those who have experience of trigger warnings report a belief that they are important and necessary when considering potentially triggering topics (Boysen et al., 2021). Therefore, advertisements for the study will include a content warning noting clearly that the study will ask about self-harm thoughts and behaviours and allow potential participants to make an informed decision.

Participant involvement has been undertaken to allow two individuals with either historic or current engagement in self-harming behaviours to provide input regarding the study materials. Consultations were held with these individuals, feedback collected and amendments have been made to the project as appropriate (Appendix N).

Timescale

The study is expected to being recruitment of participants in April 2023, with an aim of completing recruitment by September 2023. The data collection period would only be extended if the minimum number of participants required is not reached by September 2023.

The below is an expected timeline of the study:

- May 2022 – March 2023 – Prepare and submit a proposal to ethics

- January 2023 – March 2023– Creation of online questionnaire and stakeholder involvement
- March 2023 – Submit ethics application
- April 2023 – September 2023 – Data Collection and begin draft of empirical paper
- October 2023 – November 2023 – Data Analysis
- November 2023 - January 2024 – Complete draft of empirical paper
- January 2024 - Submit draft of research paper to supervisor(s)
- February 2024 – Make revisions
- March 2024 – Thesis Submission
- June 2024 - Viva

References

Abdelraheem, M., McAloon, J., & Shand, F. (2019). Mediating and moderating variables in the prediction of self-harm in young people: A systematic review of prospective longitudinal studies. *Journal of Affective Disorders*, *246*, 14-28. https://doi.org/10.1016/j.jad.2018.12.004

Allen, A. B., & Leary, M. R. (2010). Self-Compassion, stress, and coping. *Social and personality psychology compass*, *4*(2), 107-118.

Assavedo, B. L., & Anestis, M. D. (2016). The relationship between non-suicidal self-injury and both perceived burdensomeness and thwarted belongingness. *Journal of Psychopathology and Behavioral Assessment*, *38*(2), 251-257. https://doi.org/10.1007/s10862-015-9508-8

Boysen, G. A., Isaacs, R. A., Tretter, L., & Markowski, S. (2021). Trigger warning efficacy: The impact of warnings on affect, attitudes, and learning. *Scholarship of Teaching and Learning in Psychology*, *7*(1), 39.

Chan, M. K., Bhatti, H., Meader, N., Stockton, S., Evans, J., O'Connor, R. C., Kapur, N., & Kendall, T. (2016). Predicting suicide following self-harm: systematic review of risk factors and risk scales. *The British Journal of Psychiatry*, *209*(4), 277-283.

Chu, C., Rogers, M. L., & Joiner, T. E. (2016). Cross-sectional and temporal association between non-suicidal self-injury and suicidal ideation in young adults: The explanatory roles of thwarted belongingness and perceived burdensomeness. *Psychiatry Research*, *246*, 573-580. https://doi.org/10.1016/j.psychres.2016.07.061

Cleare, S., Gumley, A., & O'Connor, R. C. (2019). Self-compassion, self-forgiveness, suicidal ideation, and self-harm: A systematic review. *Clinical Psychology & Psychotherapy*, *26*(5), 511-530. https://doi.org/10.1002/cpp.2372

Dunlop, B. J., Coleman, S. E., Hartley, S., Carter, L. A., & Taylor, P. J. (2021). Self-injury in young bisexual people: A microlongitudinal investigation (sibl) of thwarted belongingness and self-esteem on non-suicidal self-injury. *Suicide and Life-Threatening Behavior*. https://doi.org/10.1111/sltb.12823

Gilbert, P. (2010). *Compassion focused therapy: Distinctive features*. Routledge.

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology*, *53*(1), 6-41. https://doi.org/10.1111/bjc.12043

Gilbert, P., Catarino, F., Duarte, C., Matos, M., Kolts, R., Stubbs, J., Ceresatto, L., Duarte, J., Pinto-Gouveia, J., & Basran, J. (2017). The development of compassionate engagement and action scales for self and others. *Journal of Compassionate Health Care*, *4*(1), 1-24.

Gilbert, P., McEwan, K., Matos, M., & Rivis, A. (2011). Fears of compassion: Development of three self-report measures. *Psychology and Psychotherapy: Theory, Research and Practice*, *84*(3), 239-255.

Green, S. B. (1991). How many subjects does it take to do a regression analysis. *Multivariate behavioral research*, *26*(3), 499-510.

Jiang, Y., Ren, Y., Zhu, J., & You, J. (2020). Gratitude and hope relate to adolescent nonsuicidal self-injury: Mediation through self-compassion and family and school experiences. *Current Psychology: A Journal for Diverse Perspectives on Diverse Psychological Issues*. https://doi.org/10.1007/s12144-020-00624-4

Joiner, T. E. (2005). *Why people die by suicide*. Harvard University Press.

La Guardia, A. C., Cramer, R. J., Bryson, C. N., & Emelianchik-Key, K. (2020). Analysis of personality, suicide, and self-injury in emerging adulthood. *Journal of College Counseling*, *23*(1), 57-70.

Lakens, D. (2022). Sample size justification. *Collabra: Psychology*, *8*(1), 33267.

MacBeth, A., & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review*, *32*(6), 545-552.

McManus, S., Gunnell, D., Cooper, C., Bebbington, P. E., Howard, L. M., Brugha, T., Jenkins, R., Hassiotis, A., Weich, S., & Appleby, L. (2019). Prevalence of non-suicidal self-harm and service contact in England, 2000–14: repeated cross-sectional surveys of the general population. *The Lancet Psychiatry*, *6*(7), 573-581.

Morgan, C., Webb, R. T., Carr, M. J., Kontopantelis, E., Green, J., Chew-Graham, C. A., Kapur, N., & Ashcroft, D. M. (2017). Incidence, clinical management, and mortality risk following self harm among children and adolescents: cohort study in primary care. *bmj*, *359*.

Nock, M. K. (2009). Why do people hurt themselves? New insights into the nature and functions of self-injury. *Current Directions in Psychological Science*, *18*(2), 78-83.

Nock, M. K. (2010). Self-injury. *Annual review of clinical psychology*, *6*(1), 339-363.

Nock, M. K., Holmberg, E. B., Photos, V. I., & Michel, B. D. (2007). Self-Injurious Thoughts and Behaviors Interview: development, reliability, and validity in an adolescent sample.

Plener, P. L., Schumacher, T. S., Munz, L. M., & Groschwitz, R. C. (2015). The longitudinal course of non-suicidal self-injury and deliberate self-harm: a systematic review of the literature. *Borderline personality disorder and emotion dysregulation*, *2*(1), 1-11.

Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied psychological measurement*, *1*(3), 385-401.

Suh, H., & Jeong, J. (2021). Association of self-compassion with suicidal thoughts and behaviors and non-suicidal self injury: A meta-analysis. *Frontiers in Psychology*, *12*, 633482.

Umphrey, L. R., Sherblom, J. C., & Swiatkowski, P. (2020). Relationship of Self-Compassion, Hope, and Emotional Control to Perceived Burdensomeness, Thwarted Belongingness, and Suicidal Ideation. *Crisis: The Journal of Crisis Intervention & Suicide Prevention*, 1-7. https://doi.org/10.1027/0227-5910/a000697

Van Orden, K. A., Cukrowicz, K. C., Witte, T. K., & Joiner Jr, T. E. (2012). Thwarted belongingness and perceived burdensomeness: construct validity and psychometric properties of the Interpersonal Needs Questionnaire. *Psychological Assessment*, *24*(1), 197.

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner Jr, T. E. (2010). The interpersonal theory of suicide. *Psychological review*, *117*(2), 575.

Washburn, J. J., Juzwin, K., Styer, D. M., & Aldridge, D. (2010). Measuring the urge to self-injure: Preliminary data from a clinical sample. *Psychiatry Research*, *178*(3), 540-544.

Wilkinson, P. O., Qiu, T., Jesmont, C., Neufeld, S. A., Kaur, S. P., Jones, P. B., & Goodyer, I. M. (2022). Age and gender effects on non-suicidal self-injury, and their interplay with psychological distress. *Journal of Affective Disorders*, *306*, 240-245.

Xavier, A., Pinto Gouveia, J., & Cunha, M. (2016). Non-suicidal self-injury in adolescence: The role of shame, self-criticism and fear of self-compassion. *Child & Youth Care Forum*, *45*(4), 571-586. https://doi.org/10.1007/s10566-016-9346-1

Appendix 4-B: Amendments to Proposed Analysis

Thesis Proposal – Analysis Proposal Version 1.2

Summary of Updates to the Proposed Analysis

In the original analysis, we proposed the use of the Fear of Compassion (total score) as the tested predictor in the following model. This was an error, as the Fear of Compassion comprises of three sub-scales that are not intended to compound into a single total score, due to measuring different constructs. The regression model has been amended to show Fear of Self-Compassion as the tested predictor, and the exploratory analysis proposal has been amended on the basis of this.

The use of Fear of Self-Compassion as the tested predictor is based on the theory that a block in the flow of compassion towards oneself is related to engagement in self-harming behaviours, as to show oneself compassion is to be kind towards oneself, and the act of self-harm is in opposition with this.. Research highlights that higher self-compassion is related to lower levels of engagement in NSSI (Suh & Jeong, 2021).

Furthermore, past research has highlighted Fear of Self-compassion as related to NSSI (Jiang et al., 2021; Xavier et al., 2016) . By expanding on this research, we are able to test the relationships between Fear of Self-Compassion, Thwarted Belongingness, Perceived Burdensomeness and NSSI.

As the number of variables in the model is unchanged, the following power analysis still applies.

Updated Research Question

Does fear of self-compassion account for unique variance on NSSI after the variance accounted for by thwarted belongingness and perceived burdensomeness?

Main Data Analysis

The data will be examined using correlational analysis to first identify relationships between variables (depression, compassion for self, compassion from others and compassion for others, fear of compassion, fear of compassion from others, fear of compassion for others, thwarted belongingness, perceived burdensomeness and urges to self-harm).

Regression analysis will be utilised to further explore the relationship between the variables, with urges to self-harm as the dependent variable.

A forced entry multiple regression model will be used with the Alexian Brothers Urge to Self-Injure scale as the dependent variable, and will include 8 total predictor variables (age, gender, sexuality, ethnicity, depression, thwarted belongingness, perceived burdensomeness, and fear of self-compassion, with one of these being a tested predictor (Fear of Self-Compassion). This will give details of the significant predictors of self-harm from the variables explored.

Power Calculation

As there is a lack of research which encompasses both compassion literature and Joiner's concepts of thwarted belongingness and perceived burdensomeness, there is no directly comparable literature to explore expected percentages of variance to be explained by each construct to inform our power calculation as is suggested by Lakens (2022). However, studies exploring similar constructs (including perceived burdensomeness and thwarted belonging) in the emerging adult age group have reported 79% of the variance in NSSI remains unexplained by their model (La Guardia et al., 2020).

Using a conservative calculation suggesting that the tested variable will explain 5% of the variance in the model, G*Power was used to calculate an estimated effect size (Cohen's $f2$) of 0.06. A G*Power calculation states that, to explore whether fear of compassion explains unique variance over and above an established model (R*2* increase), 127 participants will be required to detect an effect size of 0.06 at 80% power in this model's regression analysis with a 0.05 level of significance.

A commonly used 'Rule of Thumb' suggests a sample size where N > 50 + 8m (where m is the number of IVs) for testing the multiple correlation and N > 104 + m for testing individual predictors, using the larger of the two numbers (Green, 1991). This would equate to 114 participants.

Therefore, the aim is to end data collection when either a) 127 participants have fully completed the study or b) once 114 participants have completed the study within the data collection window, whichever occurs first.

Exploratory Analyses

Further exploratory models will be completed, amending the main model by investigating the remaining two Fear of Compassion sub-scales, Fear of Compassion to Others and Fear of Compassion from Others:

1. A forced entry multiple regression model will be used with the Alexian Brothers Urge to Self-Injure scale as the dependent variable, and will include 8 total predictor variables (age, gender, sexuality, ethnicity, depression, thwarted belongingness, perceived burdensomeness, and fear of Compassion to Others, with one of these being a tested predictor (Fear of Compassion to Others).
2. A forced entry multiple regression model will be used with the Alexian Brothers Urge to Self-Injure scale as the dependent variable, and will include 8 total predictor variables (age, gender, sexuality, ethnicity, depression, thwarted belongingness, perceived burdensomeness, and fear of Compassion from Others, with one of these being a tested predictor (Fear of Compassion from Others).

To test the use of the Fear of Compassion Scales with this population, as it has not been validated for use with adolescents, a further three regressions will be completed. This will allow comparison of the Compassionate Engagement and Action Scales (Which have been validated in adolescent

populations) with the Fear of Compassion scales (Which have not been validated with participants under 18 years old):

1. A forced entry multiple regression models will be used with the 7 predictor variables of age, gender, sexuality, ethnicity, depression, thwarted belongingness, and perceived burdensomeness, and CEAS Self-Compassion
2. A forced entry multiple regression models will be used with the 7 predictor variables of age, gender, sexuality, ethnicity, depression, thwarted belongingness, and perceived burdensomeness, and CEAS Compassion to Others
3. A forced entry multiple regression models will be used with the 7 predictor variables of age, gender, sexuality, ethnicity, depression, thwarted belongingness, and perceived burdensomeness, and CEAS Compassion from Others

This will allow validation of the fear of compassion scales to see if they behave similarly to the flows of compassion scales which are less well-validated in this age group.

Two mediation analysis will be also completed to explore the hypothesis that Fear of Self-Compassion remains independently significantly related to urge to Self-Harm even whilst accounting for the mediated effects of Interpersonal Needs (thwarted belonging and perceived burdensomeness total score) on urge to self-harm.

A sample of 127 will have sufficient power to detect a medium effect size of both the alpha and beta path in a mediation model, where the minimum sample needed would be 78. A medium effect size has been chosen as mediation of small effect sizes are less likely to be important clinically.

References

Abdelraheem, M., McAloon, J., & Shand, F. (2019). Mediating and moderating variables in the prediction of self-harm in young people: A systematic review of prospective longitudinal studies. *Journal of Affective Disorders*, *246*, 14-28. https://doi.org/10.1016/j.jad.2018.12.004

Abramson, L. Y., & Sackheim, H. A. (1977). A paradox in depression: uncontrollability and self-blame. *Psychological bulletin*, *84*(5), 838.

Al-Sharifi, A., Krynicki, C. R., & Upthegrove, R. (2015). Self-harm and ethnicity: A systematic review. *International Journal of Social Psychiatry*, *61*(6), 600-612.

Alexander, E., Lyne, R., Mottaghi-Taromssari, Y. S., & Lever, I. (2020). The representation of LGBTQ+ people in medical assessment and teaching scenarios. *Future Healthcare Journal*, *7*(Suppl 1), s87.

Alexander, N., & Clare, L. (2004). You still feel different: The experience and meaning of women's self-injury in the context of a lesbian or bisexual identity. *Journal of Community & Applied Social Psychology*, *14*(2), 70-84. https://doi.org/10.1002/casp.764

Allan, N. P., Boffa, J. W., Raines, A. M., & Schmidt, N. B. (2018). Intervention related reductions in perceived burdensomeness mediates incidence of suicidal thoughts. *Journal of Affective Disorders*, *234*, 282-288.

Allen, A. B., & Leary, M. R. (2010). Self-Compassion, stress, and coping. *Social and personality psychology compass*, *4*(2), 107-118.

Altman, M. R., Kantrowitz-Gordon, I., Moise, E., Malcolm, K., Vidaković, M., Barrington, W., O'Connor, M. R., & de Castro, A. (2021). Addressing positionality within case-based learning to mitigate systemic racism in health care. *Nurse educator*, *46*(5), 284-289.

American Psychological Association. (2020). *Publication manual of the american psychological association (7th ed.)*.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (Vol. 5). American psychiatric association Washington, DC.

Arensman, E., Griffin, E., Daly, C., Corcoran, P., Cassidy, E., & Perry, I. J. (2018). Recommended next care following hospital-treated self-harm: Patterns and trends over time. *PLoS ONE*, *13*(3), e0193587.

Aronfreed, J. (1964). The origin of self-criticism. *Psychological review*, *71*(3), 193.

Assavedo, B. L., & Anestis, M. D. (2016). The relationship between non-suicidal self-injury and both perceived burdensomeness and thwarted belongingness. *Journal of Psychopathology and Behavioral Assessment*, *38*(2), 251-257. https://doi.org/10.1007/s10862-015-9508-8

Baloyi, M. E. (2020). Black self-hatred: regaining self-worth-from decolonisation towards reconciliation in South Africa-a practical theological appraisal. *Theologia Viatorum*, *44*(1), 1-8.

Banerjee, D., & Nair, V. S. (2020). “The untold side of COVID-19”: Struggle and perspectives of the sexual minorities. *Journal of Psychosexual Health*, *2*(2), 113-120.

Bartoș, S. E., & Langdridge, D. (2019). LGBQ resilience: A thematic meta-synthesis of qualitative research. *Psychology & Sexuality*, *10*(3), 234-247.

Bhaskar, R. (2013). *A realist theory of science*. Routledge.

Bianchini, G., & Bodell, L. P. (2024). An open trial of a brief, self-compassion intervention targeting thwarted belongingness and perceived burdensomeness. *Archives of Suicide Research*, 1-13.

Bird, K., Arcelus, J., Matsagoura, L., O'Shea, B., & Townsend, E. (2024). Risk and protective factors for self-harm thoughts and behaviours in transgender and gender diverse people: A systematic review. *Heliyon*.

Bleckmann, C., Leyendecker, B., & Busch, J. (2023). Sexual and gender minorities facing the Coronavirus pandemic: A systematic review of the distinctive psychosocial and health-related impact. *Journal of Homosexuality*, *70*(12), 2741-2762.

Blodgett, J. M., Lachance, C. C., Stubbs, B., Co, M., Wu, Y.-T., Prina, M., Tsang, V. W., & Cosco, T. D. (2021). A systematic review of the latent structure of the Center for Epidemiologic Studies Depression Scale (CES-D) amongst adolescents. *BMC Psychiatry*, *21*, 1-8.

Bowen, H. P., & Wiersema, M. F. (1999). Matching method to paradigm in strategy research: limitations of cross-sectional analysis and some methodological alternatives. *Strategic management journal*, *20*(7), 625-636.

Boysen, G. A., Isaacs, R. A., Tretter, L., & Markowski, S. (2021). Trigger warning efficacy: The impact of warnings on affect, attitudes, and learning. *Scholarship of Teaching and Learning in Psychology*, *7*(1), 39.

Brach, T. (2004). *Radical acceptance: Embracing your life with the heart of a Buddha*. Bantam.

Brandes, A. (2014). The negative effect of stigma, discrimination, and the health care system on the health of gender and sexual minorities. *Tul. JL & Sexuality*, *23*, 155.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative research in sport, exercise and health*, *11*(4), 589-597.

Brown, A. C., Latham, C., Danquah, A. N., Dunlop, B. J., & Taylor, P. J. (2022). "Cover up your arms, you're triggering people": A Mixed-Methods Investigation of Shame in those who Self-Injure. *Psychology and Psychotherapy: Theory, Research and Practice*, *95*(3), 701-716.

Buitron, V., Hill, R. M., Pettit, J. W., Green, K. L., Hatkevich, C., & Sharp, C. (2016). Interpersonal stress and suicidal ideation in adolescence: An indirect association through perceived burdensomeness toward others. *Journal of Affective Disorders*, *190*, 143-149.

Caceres, B. A., Travers, J., Primiano, J. E., Luscombe, R. E., & Dorsen, C. (2020). Provider and LGBT individuals' perspectives on LGBT issues in long-term care: A systematic review. *The Gerontologist*, *60*(3), e169-e183.

Cadorna, G., Vera San Juan, N., Staples, H., Johnson, S., & Appleton, R. (2023). Systematic review and metasynthesis of qualitative literature on young people's experiences of going to A&E/emergency departments for mental health support. *Child and adolescent mental health*.

Camacho, G., Reinka, M. A., & Quinn, D. M. (2020). Disclosure and concealment of stigmatized identities. *Current Opinion in Psychology*, *31*, 28-32.

Campbell, R., Pound, P., Morgan, M., Daker-White, G., Britten, N., Pill, R., Yardley, L., Pope, C., & Donovan, J. (2012). Evaluating meta ethnography: systematic analysis and synthesis of qualitative research.

Carr, E. R., & Miller, R. (2017). Expanding our reach: Increasing the role of psychologists in public and community mental health. *Psychological Services*, *14*(3), 352.

CASP. (2018). *CASP systematic review checklist*. Retrieved from https://casp-uk.net/casp-tools-checklists/

Cawley, R., Pontin, E. E., Touhey, J., Sheehy, K., & Taylor, P. J. (2019). What is the relationship between rejection and self-harm or suicidality in adulthood? *Journal of Affective Disorders*, *242*, 123-134. https://doi.org/10.1016/j.jad.2018.08.082

Chan, M. K., Bhatti, H., Meader, N., Stockton, S., Evans, J., O'Connor, R. C., Kapur, N., & Kendall, T. (2016). Predicting suicide following self-harm: systematic review of risk factors and risk scales. *The British Journal of Psychiatry*, *209*(4), 277-283.

Chávez-Flores, Y. V., Hidalgo-Rasmussen, C. A., & Yanez-Peñúñuri, L. Y. (2019). Assessment tools of non-suicidal self-injury in adolescents 1990-2016: a systematic review. *Ciência & Saúde Coletiva*, *24*, 2871-2882.

Cheek, S. M., Reiter-Lavery, T., & Goldston, D. B. (2020). Social rejection, popularity, peer victimization, and self-injurious thoughts and behaviors among adolescents: A systematic review and meta-analysis. *Clinical Psychology Review*, *82*, 101936.

Cheng, Y., Zhou, X., & Yao, K. (2023). LGBT-inclusive representation in entertainment products and its market response: evidence from field and lab. *Journal of Business Ethics*, *183*(4), 1189-1209.

Christie, C. (2021). What is hidden can still hurt: Concealable stigma, psychological well-being, and social support among LGB college students. *Sexuality Research and Social Policy*, *18*, 693-701.

Chu, C., Rogers, M. L., & Joiner, T. E. (2016). Cross-sectional and temporal association between non-suicidal self-injury and suicidal ideation in young adults: The explanatory roles of thwarted belongingness and perceived burdensomeness. *Psychiatry Research*, *246*, 573-580. https://doi.org/10.1016/j.psychres.2016.07.061

Cleare, S., Gumley, A., & O'Connor, R. C. (2019). Self-compassion, self-forgiveness, suicidal ideation, and self-harm: A systematic review. *Clinical Psychology & Psychotherapy*, *26*(5), 511-530. https://doi.org/10.1002/cpp.2372

Cohen, J., Cohen, P., West, S. G., & Aiken, L. S. (2013). *Applied multiple regression/correlation analysis for the behavioral sciences*. Routledge.

Cooper, J., Steeg, S., Bennewith, O., Lowe, M., Gunnell, D., House, A., Hawton, K., & Kapur, N. (2013). Are hospital services for self-harm getting better? An observational study examining management, service provision and temporal trends in England. *BMJ open*, *3*(11).

Cooper, J., Steeg, S., Gunnell, D., Webb, R., Hawton, K., Bennewith, O., House, A., & Kapur, N. (2015). Variations in the hospital management of self-harm and patient outcome: a multi-site observational study in England. *Journal of Affective Disorders*, *174*, 101-105.

Cooper, K., Hards, E., Moltrecht, B., Reynolds, S., Shum, A., McElroy, E., & Loades, M. (2021). Loneliness, social relationships, and mental health in adolescents during the COVID-19 pandemic. *Journal of Affective Disorders*, *289*, 98-104.

Copeland, M., Siennick, S. E., Feinberg, M. E., Moody, J., & Ragan, D. T. (2019). Social ties cut both ways: self-harm and adolescent peer networks. *Journal of Youth and Adolescence*, *48*, 1506-1518.

Corrigan, P. W., Kosyluk, K. A., & Rüsch, N. (2013). Reducing self-stigma by coming out proud. *American Journal of Public Health*, *103*(5), 794-800.

Corrigan, P. W., Markowitz, F. E., & Watson, A. C. (2004). Structural levels of mental illness stigma and discrimination. *Schizophrenia bulletin*, *30*(3), 481-491.

Cosley, B. J., McCoy, S. K., Saslow, L. R., & Epel, E. S. (2010). Is compassion for others stress buffering? Consequences of compassion and social support for physiological reactivity to stress. *Journal of experimental social psychology*, *46*(5), 816-823.

Cully, G., Leahy, D., Shiely, F., & Arensman, E. (2022). Patients' experiences of engagement with healthcare services following a high-risk self-harm presentation to a hospital emergency department: A mixed methods study. *Archives of Suicide Research*, *26*(1), 91-111.

Cunha, M., Galhardo, A., Gilbert, P., Rodrigues, C., & Matos, M. (2023). The flows of compassion in adolescents as measured by the compassionate engagement and action scales. *Current Psychology*, *42*(9), 7737-7751.

Cybulski, L., Ashcroft, D. M., Carr, M. J., Garg, S., Chew-Graham, C. A., Kapur, N., & Webb, R. T. (2021). Temporal trends in annual incidence rates for psychiatric disorders and self-harm among children and adolescents in the UK, 2003–2018. *BMC Psychiatry*, *21*, 1-12.

Daly, M., Sutin, A. R., & Robinson, E. (2022). Longitudinal changes in mental health and the COVID-19 pandemic: Evidence from the UK Household Longitudinal Study. *Psychological Medicine*, *52*(13), 2549-2558.

Darawsheh, W. (2014). Reflexivity in research: Promoting rigour, reliability and validity in qualitative research. *International journal of therapy and rehabilitation*, *21*(12), 560-568.

Day, J. K., Perez-Brumer, A., & Russell, S. T. (2018). Safe schools? Transgender youth's school experiences and perceptions of school climate. *Journal of Youth and Adolescence*, *47*, 1731-1742.

Demuthova, S., Vaclavikova, I., Selecka, L., & Blatny, M. (2020). The Problem of Self-Disclosure of Self-Harming Behaviour in Adolescence. *Postmodern Openings*, *11*(4), 01-19.

Department for Education. (2019). *Relationships, Education Relationships and Sex Education*. Retrieved from https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education

Doyle, L., Sheridan, A., & Treacy, M. (2017). Motivations for adolescent self-harm and the implications for mental health nurses. *Journal of Psychiatric and Mental Health Nursing*, *24*(2-3), 134-142.

Dunlop, B. J., Coleman, S. E., Hartley, S., Carter, L. A., & Taylor, P. J. (2021). Self-injury in young bisexual people: A microlongitudinal investigation (sibl) of thwarted belongingness and self-esteem on non-suicidal self-injury. *Suicide and Life-Threatening Behavior*. https://doi.org/10.1111/sltb.12823

Dunlop, B. J., Coleman, S. E., Hartley, S., Carter, L. A., Taylor, P. J., & Carter, L.-A. (2022). Self-injury in young bisexual people: A microlongitudinal investigation (SIBL) of thwarted belongingness and self-esteem on non-suicidal self-injury. *Suicide & Life-Threatening Behavior*, *52*(2), 317-328. https://doi.org/10.1111/sltb.12823

Dunlop, B. J., Hunter, C., Shafti, M., Coleman, S. E., Hartley, S., & Taylor, P. J. (2022). 'Why is it so different now I'm bisexual?': young bisexual people's experiences of identity, belonging, self-injury, and COVID19. *Psychology & Sexuality*, *13*(3), 756-773. https://doi.org/10.1080/19419899.2021.1924241

Dunlop, B. J., & Lea, J. (2023). Clinical formulation. In *Sexual minorities and mental health: Current perspectives and new directions* (pp. 165-191). Springer.

Eades, A., Segal, D. L., & Coolidge, F. L. (2019). Suicide risk factors among older adults: Exploring thwarted belongingness and perceived burdensomeness in relation to personality and self-esteem. *The International Journal of Aging and Human Development*, *88*(2), 150-167.

Edwards-Bailey, L., Cartwright, T., Smyth, N., & Mackenzie, J.-M. (2023). A qualitative exploration of student self-harm and experiences of support-seeking within a UK university setting. *Counselling Psychology Quarterly*, *36*(4), 638-662.

Engelbrecht, A., & Jobson, L. (2020). Self-concept, post-traumatic self-appraisals and post-traumatic psychological adjustment: what are the relationships? *Behavioural and Cognitive Psychotherapy*, *48*(4), 463-480.

Erlangsen, A., Qin, P., & Mittendorfer-Rutz, E. (2018). Studies of suicidal behavior using national registers. In: Hogrefe Publishing.

Fässberg, M. M., Van Orden, K. A., Duberstein, P., Erlangsen, A., Lapierre, S., Bodner, E., Canetto, S. S., Leo, D. D., Szanto, K., & Waern, M. (2012). A systematic review of social factors and suicidal behavior in older adulthood. *International journal of environmental research and public health*, *9*(3), 722-745.

Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G* Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior research methods*, *39*(2), 175-191.

Field, A. (2018). Discovering Statistics Using IBM Statistics. 5th edn. Ed: J. Seaman. In: London: Sage Publications.

Fish, J. N., Salerno, J., Williams, N. D., Rinderknecht, R. G., Drotning, K. J., Sayer, L., & Doan, L. (2021). Sexual minority disparities in health and well-being as a consequence of the COVID-19 pandemic differ by sexual identity. *LGBT Health*, *8*(4), 263-272.

Flentje, A., Heck, N. C., Brennan, J. M., & Meyer, I. H. (2020). The relationship between minority stress and biological outcomes: A systematic review. *Journal of Behavioral Medicine*, *43*, 673-694.

Fliege, H., Lee, J.-R., Grimm, A., & Klapp, B. F. (2009). Risk factors and correlates of deliberate self-harm behavior: A systematic review. *Journal of psychosomatic research*, *66*(6), 477-493.

Forrester, R. L., Slater, H., Jomar, K., Mitzman, S., & Taylor, P. J. (2017). Self-esteem and non-suicidal self-injury in adulthood: A systematic review. *Journal of Affective Disorders*, *221*, 172-183.

France, E. F., Cunningham, M., Ring, N., Uny, I., Duncan, E. A., Jepson, R. G., Maxwell, M., Roberts, R. J., Turley, R. L., & Booth, A. (2019). Improving reporting of meta-ethnography: the eMERGe reporting guidance. *BMC medical research methodology*, *19*, 1-13.

France, E. F., Uny, I., Ring, N., Turley, R. L., Maxwell, M., Duncan, E. A., Jepson, R. G., Roberts, R. J., & Noyes, J. (2019). A methodological systematic review of meta-ethnography conduct to articulate the complex analytical phases. *BMC medical research methodology*, *19*(1), 1-18.

Frost, D. M., Fine, M., Torre, M. E., & Cabana, A. (2019). Minority stress, activism, and health in the context of economic precarity: Results from a national participatory action survey of lesbian, gay, bisexual, transgender, queer, and gender non-conforming youth. *American Journal of Community Psychology*, *63*(3-4), 511-526.

Furness, B. W., Goldhammer, H., Montalvo, W., Gagnon, K., Bifulco, L., Lentine, D., & Anderson, D. (2020). Transforming primary care for lesbian, gay, bisexual, and transgender people: a collaborative quality improvement initiative. *The Annals of Family Medicine*, *18*(4), 292-302.

Garcia, J., Vargas, N., Clark, J. L., Magaña Álvarez, M., Nelons, D. A., & Parker, R. G. (2020). Social isolation and connectedness as determinants of well-being: Global evidence mapping focused on LGBTQ youth. *Global Public Health*, *15*(4), 497-519. https://doi.org/10.1080/17441692.2019.1682028

Gardner, K. J., Paul, E., Selby, E. A., Klonsky, E. D., & Mars, B. (2021). Intrapersonal and interpersonal functions as pathways to future self-harm repetition and suicide attempts. *Frontiers in Psychology*, *12*, 688472.

Geulayov, G., Casey, D., Bale, L., Brand, F., Clements, C., Farooq, B., Kapur, N., Ness, J., Waters, K., & Tsiachristas, A. (2019). Suicide following presentation to hospital for non-fatal self-harm in the Multicentre Study of Self-harm: a long-term follow-up study. *The Lancet Psychiatry*, *6*(12), 1021-1030.

Gilbert, P. (1998). Evolutionary psychopathology: Why isn't the mind designed better than it is? *British Journal of Medical Psychology*, *71*(4), 353-373.

Gilbert, P. (2005). *Compassion: Conceptualisations, research and use in psychotherapy*. Routledge.

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment*, *15*(3), 199-208.

Gilbert, P. (2010). *Compassion focused therapy: Distinctive features*. Routledge.

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology*, *53*(1), 6-41. https://doi.org/10.1111/bjc.12043

Gilbert, P. (2020). Compassion: From its evolution to a psychotherapy. *Frontiers in Psychology*, *11*, 3123.

Gilbert, P., Catarino, F., Duarte, C., Matos, M., Kolts, R., Stubbs, J., Ceresatto, L., Duarte, J., Pinto-Gouveia, J., & Basran, J. (2017). The development of compassionate engagement and action scales for self and others. *Journal of Compassionate Health Care*, *4*(1), 1-24.

Gilbert, P., & Mascaro, J. (2017). Compassion: Fears, blocks, and resistances: An evolutionary investigation. *The Oxford handbook of compassion science*, 399-420.

Gilbert, P., McEwan, K., Matos, M., & Rivis, A. (2011). Fears of compassion: Development of three self-report measures. *Psychology and Psychotherapy: Theory, Research and Practice*, *84*(3), 239-255.

Gilbey, D., Perry, Y., Lin, A., & Ohan, J. (2022). “Shame, Doubt and Sadness”: A Qualitative Investigation of the Experience of Self-Stigma in Adolescents with Diverse Sexual Orientations. *Youth*, *2*(3), 352-365.

Goffman, E. (2009). *Stigma: Notes on the management of spoiled identity*. Simon and schuster.

Gonzales, G., & Henning-Smith, C. (2017). Barriers to care among transgender and gender nonconforming adults. *The Milbank Quarterly*, *95*(4), 726-748.

Gosling, H., Pratt, D., & Lea, J. (2022). Understanding self-harm urges and behavior amongst non-binary young adults: A grounded theory study. *Journal of Gay & Lesbian Mental Health*. https://doi.org/10.1080/19359705.2022.2073310

Green, S. B. (1991). How many subjects does it take to do a regression analysis. *Multivariate behavioral research*, *26*(3), 499-510.

Griep, S. K., & MacKinnon, D. F. (2022). Does nonsuicidal self-injury predict later suicidal attempts? A review of studies. *Archives of Suicide Research*, *26*(2), 428-446.

Harris, J. (2000). Self-harm: Cutting the bad out of me. *Qualitative Health Research*, *10*(2), 164-173.

Hasking, P., & Boyes, M. (2018). Cutting words: A commentary on language and stigma in the context of nonsuicidal self-injury. *The Journal of nervous and mental disease*, *206*(11), 829-833.

Hasking, P., Boyes, M. E., Finlay-Jones, A., McEvoy, P. M., & Rees, C. S. (2019). Common pathways to NSSI and suicide ideation: The roles of rumination and self-compassion. *Archives of Suicide Research*, *23*(2), 247-260. https://doi.org/10.1080/13811118.2018.1468836

Hasking, P. A., Boyes, M. E., & Lewis, S. P. (2021). The language of self-injury: A data-informed commentary. *The Journal of nervous and mental disease*, *209*(4), 233-236.

Hawton, K., & Harriss, L. (2007). Deliberate self-harm in young people: characteristics and subsequent mortality in a 20-year cohort of patients presenting to hospital.[CME]. *Journal of Clinical Psychiatry*, *68*(10), 1574.

Hayes, A. F. (2012). PROCESS: A versatile computational tool for observed variable mediation, moderation, and conditional process modeling. In: University of Kansas, KS.

Heath, S., Charles, V., Crow, G., & Wiles, R. (2007). Informed consent, gatekeepers and go-betweens: negotiating consent in child-and youth-orientated institutions. *British Educational Research Journal*, *33*(3), 403-417.

Hetrick, S. E., Subasinghe, A., Anglin, K., Hart, L., Morgan, A., & Robinson, J. (2020). Understanding the needs of young people who engage in self-harm: a qualitative investigation. *Frontiers in Psychology*, *10*, 2916.

Higa, D., Hoppe, M. J., Lindhorst, T., Mincer, S., Beadnell, B., Morrison, D. M., Wells, E. A., Todd, A., & Mountz, S. (2014). Negative and positive factors associated with the well-being of lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) youth. *Youth & Society*, *46*(5), 663-687.

Hill, R. M., Mellick, W., Alvis, L., Dodd, C. G., Do, C., Buitron, V., Sharp, C., Pettit, J. W., & Kaplow, J. B. (2020). Performance of the interpersonal needs questionnaire in adolescent clinical samples: Confirmatory factor analyses and evaluation of measurement invariance. *Suicide and Life-Threatening Behavior*, *50*(6), 1214-1222.

Hill, R. M., & Pettit, J. W. (2012). Suicidal ideation and sexual orientation in college students: The roles of perceived burdensomeness, thwarted belongingness, and perceived rejection due to sexual orientation. *Suicide and Life-Threatening Behavior*, *42*(5), 567-579.

Hill, R. M., Rey, Y., Marin, C. E., Sharp, C., Green, K. L., & Pettit, J. W. (2015). Evaluating the Interpersonal Needs Questionnaire: Comparison of the reliability, factor structure, and predictive validity across five versions. *Suicide and Life-Threatening Behavior*, *45*(3), 302-314.

Hinrichs, K. L., & Donaldson, W. (2017). Recommendations for use of affirmative psychotherapy with LGBT older adults. *Journal of Clinical Psychology*, *73*(8), 945-953.

Hooley, J. M., Fox, K. R., & Boccagno, C. (2020). Nonsuicidal self-injury: diagnostic challenges and current perspectives. *Neuropsychiatric disease and treatment*, 101-112.

Imran, N., Zeshan, M., & Pervaiz, Z. (2020). Mental health considerations for children & adolescents in COVID-19 Pandemic. *Pakistan journal of medical sciences*, *36*(COVID19-S4), S67.

Jackman, K., Edgar, B., Ling, A., Honig, J., & Bockting, W. (2018). Experiences of transmasculine spectrum people who report nonsuicidal self-injury: A qualitative investigation. *Journal of Counseling Psychology*, *65*(5), 586-597. https://doi.org/10.1037/cou0000304

Jadva, V., Guasp, A., Bradlow, J. H., Bower-Brown, S., & Foley, S. (2023). Predictors of self-harm and suicide in LGBT youth: The role of gender, socio-economic status, bullying and school

experience. *Journal of Public Health*, *45*(1), 102-108. https://doi.org/10.1093/pubmed/fdab383
Jahn, D. R., Cukrowicz, K. C., Linton, K., & Prabhu, F. (2011). The mediating effect of perceived burdensomeness on the relation between depressive symptoms and suicide ideation in a community sample of older adults. *Aging & Mental Health*, *15*(2), 214-220.
Jazaieri, H., McGonigal, K., Jinpa, T., Doty, J. R., Gross, J. J., & Goldin, P. R. (2014). A randomized controlled trial of compassion cultivation training: Effects on mindfulness, affect, and emotion regulation. *Motivation and emotion*, *38*, 23-35.
Jiang, Y., Ren, Y., Liu, T., & You, J. (2021). Rejection sensitivity and adolescent non-suicidal self-injury: Mediation through depressive symptoms and moderation by fear of self-compassion. *Psychology and Psychotherapy: Theory, Research and Practice*, *94*, 481-496.
Jiang, Y., Ren, Y., Zhu, J., & You, J. (2020). Gratitude and hope relate to adolescent nonsuicidal self-injury: Mediation through self-compassion and family and school experiences. *Current Psychology: A Journal for Diverse Perspectives on Diverse Psychological Issues*. https://doi.org/10.1007/s12144-020-00624-4
Jiang, Y., You, J., Hou, Y., Du, C., Lin, M.-P., Zheng, X., & Ma, C. (2016). Buffering the effects of peer victimization on adolescent non-suicidal self-injury: The role of self-compassion and family cohesion. *Journal of Adolescence*, *53*, 107-115. https://doi.org/10.1016/j.adolescence.2016.09.005
Joiner, T. E. (2005). *Why people die by suicide*. Harvard University Press.
Kapur, N., Cooper, J., O'Connor, R. C., & Hawton, K. (2013). Non-suicidal self-injury v. attempted suicide: new diagnosis or false dichotomy? *The British Journal of Psychiatry*, *202*(5), 326-328.
Keighley, R. (2022). Hate hurts: Exploring the impact of online hate on LGBTQ+ young people. *Women & Criminal Justice*, *32*(1-2), 29-48.
King, B., McIntyre, C., & Parker, K. (2020). The process of self-acceptance of transgender individuals through narratives and photos. *Journal of LGBT Issues in Counseling*, *14*(3), 228-247.
Kirby, J. N., Day, J., & Sagar, V. (2019). The ‘Flow’of compassion: A meta-analysis of the fears of compassion scales and psychological functioning. *Clinical Psychology Review*, *70*, 26-39.
Klemera, E., Brooks, F., Chester, K., Magnusson, J., Spencer, N., Brooks, F. M., & Chester, K. L. (2017). Self-harm in adolescence: protective health assets in the family, school and community. *International Journal of Public Health (Springer Nature)*, *62*(6), 631-638. https://doi.org/10.1007/s00038-016-0900-2
Klonsky, E. (2011). Non-suicidal self-injury in United States adults: prevalence, sociodemographics, topography and functions. *Psychological Medicine*, *41*(9), 1981-1986.
Kneale, D., & Bécares, L. (2020). The mental health and experiences of discrimination of LGBTQ+ people during the COVID-19 pandemic: initial findings from the Queerantine study. *MedRxiv*, 2020.2008. 2003.20167403.
La Guardia, A. C., Cramer, R. J., Bryson, C. N., & Emelianchik-Key, K. (2020). Analysis of personality, suicide, and self-injury in emerging adulthood. *Journal of College Counseling*, *23*(1), 57-70.
Lakens, D. (2022). Sample size justification. *Collabra: Psychology*, *8*(1), 33267.
Larkin, C., Di Blasi, Z., & Arensman, E. (2014). Risk factors for repetition of self-harm: a systematic review of prospective hospital-based studies. *PLoS ONE*, *9*(1), e84282.
Lathren, C. R., Rao, S. S., Park, J., & Bluth, K. (2021). Self-compassion and current close interpersonal relationships: A scoping literature review. *Mindfulness*, *12*, 1078-1093.
Laye-Gindhu, A., & Schonert-Reichl, K. A. (2005). Nonsuicidal self-harm among community adolescents: Understanding the “whats” and “whys” of self-harm. *Journal of Youth and Adolescence*, *34*, 447-457.
Leary, M. R., & Baumeister, R. F. (2000). The nature and function of self-esteem: Sociometer theory. In *Advances in experimental social psychology* (Vol. 32, pp. 1-62). Elsevier.

Leather, J. Z., O'Connor, R. C., Quinlivan, L., Kapur, N., Campbell, S., & Armitage, C. J. (2020). Healthcare professionals' implementation of national guidelines with patients who self-harm. *Journal of Psychiatric Research*, *130*, 405-411.

Legate, N., & Ryan, W. S. (2014). Autonomy support as acceptance for disclosing and developing a healthy lesbian, gay, bisexual or transgendered identity. In *Human motivation and interpersonal relationships: Theory, research, and applications* (pp. 191-212). Springer.

Levine, R. J. (1988). *Ethics and regulation of clinical research*. Yale University Press.

Lewis, S. P., & Baker, T. G. (2011). The possible risks of self-injury web sites: a content analysis. *Archives of Suicide Research*, *15*(4), 390-396.

Lewis, S. P., & Hasking, P. (2019). Putting the "self" in self-injury research: Inclusion of people with lived experience in the research process. *Psychiatric Services*, *70*(11), 1058-1060.

Lieberman, A., Gai, A. R., Rogers, M. L., Jobes, D. A., Rudd, M. D., Chalker, S. A., Brenner, J. T., & Joiner, T. E. (2023). Targeting perceived burdensomeness to reduce suicide risk. *Behavior Therapy*, *54*(4), 696-707.

Lindgren, B.-M., Svedin, C. G., & Werkö, S. (2018). A systematic literature review of experiences of professional care and support among people who self-harm. *Archives of Suicide Research*, *22*(2), 173-192.

Lindgren, B.-M., Wikander, T., Neyra Marklund, I., & Molin, J. (2022). A necessary pain: A literature review of young people's experiences of self-harm. *Issues in Mental Health Nursing*, *43*(2), 154-163.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual review of Sociology*, *27*(1), 363-385.

Liu, R. T., Sheehan, A. E., Walsh, R. F., Sanzari, C. M., Cheek, S. M., & Hernandez, E. M. (2019). Prevalence and correlates of non-suicidal self-injury among lesbian, gay, bisexual, and transgender individuals: A systematic review and meta-analysis. *Clinical Psychology Review*, *74*, 101783.

Lloyd-Richardson, E. E., Perrine, N., Dierker, L., & Kelley, M. L. (2007). Characteristics and functions of non-suicidal self-injury in a community sample of adolescents. *Psychological Medicine*, *37*(8), 1183-1192.

Lloyd, B., Blazely, A., & Phillips, L. (2018). Stigma towards individuals who self harm: Impact of gender and disclosure. *Journal of Public Mental Health*, *17*(4), 184-194.

Loades, M. E., Chatburn, E., Higson-Sweeney, N., Reynolds, S., Shafran, R., Brigden, A., Linney, C., McManus, M. N., Borwick, C., & Crawley, E. (2020). Rapid systematic review: the impact of social isolation and loneliness on the mental health of children and adolescents in the context of COVID-19. *Journal of the American Academy of Child & Adolescent Psychiatry*, *59*(11), 1218-1239. e1213.

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, *1*(1), 31-42.

Luong, V., Bearman, M., & MacLeod, A. (2023). Understanding Meta-Ethnography in Health Professions Education Research. *Journal of Graduate Medical Education*, *15*(1), 40-45.

Ma, J., Batterham, P. J., Calear, A. L., & Han, J. (2016). A systematic review of the predictions of the Interpersonal–Psychological Theory of Suicidal Behavior. *Clinical Psychology Review*, *46*, 34-45.

Macapagal, K., Bhatia, R., & Greene, G. J. (2016). Differences in healthcare access, use, and experiences within a community sample of racially diverse lesbian, gay, bisexual, transgender, and questioning emerging adults. *LGBT Health*, *3*(6), 434-442.

MacBeth, A., & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review*, *32*(6), 545-552.

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British journal of psychology*, *91*(1), 1-20.

Marco, J. H., Gallego-Hernández de Tejada, B., Guillén, V., Baños, R. M., & Pérez, S. (2021). Meaning in life buffers the association between perceived burdensomeness, thwarted belongingness, and frequency of non-suicidal self-injuries in Spanish adolescents. *Journal of clinical medicine*, *10*(21), 4867.

Marzetti, H., McDaid, L., & O'Connor, R. (2022). "Am I really alive?": Understanding the role of homophobia, biphobia and transphobia in young LGBT+ people's suicidal distress. *Social Science & Medicine*, *298*, 114860.

McCormick, M., & Barthelemy, R. S. (2021). Excluded from "inclusive" communities: LGBTQ youths' perception of "their" community. *Journal of Gay & Lesbian Social Services*, *33*(1), 103-122.

Mccrone, S. (2018). LGBT healthcare disparities, discrimination, and societal stigma: The mental and physical health risks related to sexual and/or gender minority status. *American Journal of Medical Research*, *5*(1), 91-96.

McDermott, E. (2015). Asking for help online: Lesbian, gay, bisexual and trans youth, self-harm and articulating the 'failed' self. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, *19*(6), 561-577. https://doi.org/10.1177/1363459314557967

McDermott, E., Roen, K., & Piela, A. (2015). Explaining self-harm: Youth cybertalk and marginalized sexualities and genders. *Youth & Society*, *47*(6), 873-889. https://doi.org/10.1177/0044118X13489142

McDermott, E., Roen, K., & Scourfield, J. (2008). Avoiding shame: young LGBT people, homophobia and self-destructive behaviours [Article]. *Culture, Health & Sexuality*, *10*(8), 815-829. https://doi.org/10.1080/13691050802380974

McManus, S., Gunnell, D., Cooper, C., Bebbington, P. E., Howard, L. M., Brugha, T., Jenkins, R., Hassiotis, A., Weich, S., & Appleby, L. (2019). Prevalence of non-suicidal self-harm and service contact in England, 2000–14: repeated cross-sectional surveys of the general population. *The Lancet Psychiatry*, *6*(7), 573-581.

Meline, T. (2006). Selecting studies for systemic review: Inclusion and exclusion criteria. *Contemporary issues in communication science and disorders*, *33*(Spring), 21-27.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological bulletin*, *129*(5), 674.

Meyer, I. H. (2015). Resilience in the study of minority stress and health of sexual and gender minorities. *Psychology of Sexual Orientation and Gender Diversity*, *2*(3), 209.

Meyer, I. H., Russell, S. T., Hammack, P. L., Frost, D. M., & Wilson, B. D. (2021). Minority stress, distress, and suicide attempts in three cohorts of sexual minority adults: A US probability sample. *PLoS ONE*, *16*(3), e0246827.

Miller, A. L., & Smith, H. L. (2008). Adolescent non-suicidal self-injurious behavior: The latest epidemic to assess and treat. *Applied and Preventive Psychology*, *12*(4), 178-188.

Miller, G. A., & Chapman, J. P. (2001). Misunderstanding analysis of covariance. *Journal of Abnormal Psychology*, *110*(1), 40.

Miller, M., Redley, M., & Wilkinson, P. O. (2021). A qualitative study of understanding reasons for self-harm in adolescent girls. *International journal of environmental research and public health*, *18*(7), 3361.

Mingelli, F., Perrone, D., Balducci, J., Sacchetti, A., Ferrari, S., Mattei, G., & Galeazzi, G. M. (2019). Minority stress and mental health among LGBT populations: An update on the evidence. *Minerva Psichiatrica*, *60*(1), 27-50.

Miranda-Mendizábal, A., Castellví, P., Parés-Badell, O., Almenara, J., Alonso, I., Blasco, M., Cebrià, A., Gabilondo, A., Gili, M., & Lagares, C. (2017). Sexual orientation and suicidal behaviour in adolescents and young adults: systematic review and meta-analysis. *The British Journal of Psychiatry*, *211*(2), 77-87.

Mitchell, S. M., Brown, S. L., Roush, J. F., Tucker, R. P., Cukrowicz, K. C., & Joiner, T. E. (2020). The Interpersonal Needs Questionnaire: Statistical considerations for improved clinical application. *Assessment*, *27*(3), 621-637.

Montano, G. T., Thoma, B. C., Paglisotti, T., Weiss, P. M., Shultz, M. K., McCauley, H. L., Miller, E., & Marshal, M. P. (2018). Disparities in parental support and parental attachment between heterosexual and sexual minority youth: A meta-analysis. *Journal of Adolescent Health*, *62*(2), S32-S33.

Moran, P. (2023). Do We Belong? Promoting a Sense of Belonging in LGBTQ Youth Through Artistic Community Engagement: A Literature Review.

Morey, Y., Mellon, D., Dailami, N., Verne, J., & Tapp, A. (2017). Adolescent self-harm in the community: an update on prevalence using a self-report survey of adolescents aged 13–18 in England. *Journal of Public Health*, *39*(1), 58-64.

Morgan, C., Webb, R. T., Carr, M. J., Kontopantelis, E., Green, J., Chew-Graham, C. A., Kapur, N., & Ashcroft, D. M. (2017). Incidence, clinical management, and mortality risk following self harm among children and adolescents: cohort study in primary care. *bmj*, *359*.

Muehlenkamp, J. J., Bagge, C. L., Tull, M. T., & Gratz, K. L. (2013). Body regard as a moderator of the relation between emotion dysregulation and nonsuicidal self-injury. *Suicide and Life-Threatening Behavior*, *43*(5), 479-493.

Muehlenkamp, J. J., Claes, L., Quigley, K., Prosser, E., Claes, S., & Jans, D. (2013). Association of training on attitudes towards self-injuring clients across health professionals. *Archives of Suicide Research*, *17*(4), 462-468.

Mughal, F., Troya, M. I., Dikomitis, L., Tierney, S., Evans, N., Townsend, E., & Chew-Graham, C. A. (2022). The experiences and needs of supporting individuals of young people who self-harm: A systematic review and thematic synthesis. *EClinicalMedicine*.

Nadal, K. L., Whitman, C. N., Davis, L. S., Erazo, T., & Davidoff, K. C. (2016). Microaggressions toward lesbian, gay, bisexual, transgender, queer, and genderqueer people: A review of the literature. *The journal of sex research*, *53*(4-5), 488-508.

Nalipay, M. J. N., & Ku, L. (2019). Indirect effect of hopelessness on depression symptoms through perceived burdensomeness. *Psychological Reports*, *122*(5), 1618-1631.

National Institute for Health and Care Excellence (NICE). (2022). *Self-harm: Assessment, management and preventing recurrence.* Retrieved from https://www.nice.org.uk/guidance/ng225

Neff, K. D. (2023). Self-compassion: Theory, method, research, and intervention. *Annual review of psychology*, *74*, 193-218.

NICE. (2022). Self-harm: assessment, management and preventing recurrence.

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing qualitative studies* (Vol. 11). sage.

Nock, M. K. (2009). Why do people hurt themselves? New insights into the nature and functions of self-injury. *Current Directions in Psychological Science*, *18*(2), 78-83.

Nock, M. K. (2010). Self-injury. *Annual review of clinical psychology*, *6*(1), 339-363.

Nock, M. K., Holmberg, E. B., Photos, V. I., & Michel, B. D. (2007). Self-Injurious Thoughts and Behaviors Interview: development, reliability, and validity in an adolescent sample.

Noyes, J., Booth, A., Flemming, K., Garside, R., Harden, A., Lewin, S., Pantoja, T., Hannes, K., Cargo, M., & Thomas, J. (2018). Cochrane Qualitative and Implementation Methods Group guidance series—paper 3: methods for assessing methodological limitations, data extraction and synthesis, and confidence in synthesized qualitative findings. *Journal of clinical epidemiology*, *97*, 49-58.

O'Connor, R. C., Rasmussen, S., & Hawton, K. (2012). Distinguishing adolescents who think about self-harm from those who engage in self-harm. *The British Journal of Psychiatry*, *200*(4), 330-335.

O'Shaughnessy, T., & Speir, Z. (2018). The state of LGBQ affirmative therapy clinical research: A mixed-methods systematic synthesis. *Psychology of Sexual Orientation and Gender Diversity*, *5*(1), 82.

O'Donoghue, K., & Guerin, S. (2017). Homophobic and transphobic bullying: Barriers and supports to school intervention. *Sex Education*, *17*(2), 220-234.

Octavius, G. S., Silviani, F. R., Lesmandjaja, A., Angelina, & Juliansen, A. (2020). Impact of COVID-19 on adolescents' mental health: a systematic review. *Middle East current psychiatry*, *27*, 1-8.

Odeh, L. E. (2010). A comparative analysis of global north and global south economies.

Office for National Statistics. (2023). *Sexual orientation, England and Wales: Census 2021*. https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualorientationenglandandwales/census2021

Ozer, U., Varlik, C., Ceri, V., Ince, B., & Arslan Delice, M. (2017). Change starts with us: Stigmatizing attitudes towards mental illnesses and the use of stigmatizing language among mental health professionals. *Dusunen Adam The Journal of Psychiatry and Neurological Sciences*, *30*(3), 224.

Pachankis, J. E. (2007). The psychological implications of concealing a stigma: a cognitive-affective-behavioral model. *Psychological bulletin*, *133*(2), 328.

Pachankis, J. E., Hatzenbuehler, M. L., Hickson, F., Weatherburn, P., Berg, R. C., Marcus, U., & Schmidt, A. J. (2015). Hidden from health: structural stigma, sexual orientation concealment, and HIV across 38 countries in the European MSM Internet Survey. *AIDS (London, England)*, *29*(10), 1239.

Pachankis, J. E., Hatzenbuehler, M. L., Rendina, H. J., Safren, S. A., & Parsons, J. T. (2015). LGB-affirmative cognitive-behavioral therapy for young adult gay and bisexual men: A randomized controlled trial of a transdiagnostic minority stress approach. *Journal of Consulting and Clinical Psychology*, *83*(5), 875.

Pachankis, J. E., Hatzenbuehler, M. L., & Starks, T. J. (2014). The influence of structural stigma and rejection sensitivity on young sexual minority men's daily tobacco and alcohol use. *Social Science & Medicine*, *103*, 67-75.

Pachankis, J. E., Mahon, C. P., Jackson, S. D., Fetzner, B. K., & Bränström, R. (2020). Sexual orientation concealment and mental health: A conceptual and meta-analytic review. *Psychological bulletin*, *146*(10), 831.

Pachankis, J. E., McConocha, E. M., Reynolds, J. S., Winston, R., Adeyinka, O., Harkness, A., Burton, C. L., Behari, K., Sullivan, T. J., & Eldahan, A. I. (2019). Project ESTEEM protocol: a randomized controlled trial of an LGBTQ-affirmative treatment for young adult sexual minority men's mental and sexual health. *BMC public health*, *19*(1), 1-12.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., & Brennan, S. E. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *International journal of surgery*, *88*, 105906.

Parsons, M. B., Rollyson, J. H., & Reid, D. H. (2012). Evidence-based staff training: A guide for practitioners. *Behavior analysis in practice*, *5*, 2-11.

Pate, A. R., & Anestis, M. D. (2020). Comparison of perceived burdensomeness, thwarted belongingness, capability for suicide, and suicidal ideation among heterosexual and sexual minority individuals in Mississippi. *Archives of Suicide Research*, *24*(sup2), S293-S309.

Peterson, C., Miller, G. F., Barnett, S. B. L., & Florence, C. (2021). Economic cost of injury—United States, 2019. *Morbidity and Mortality Weekly Report*, *70*(48), 1655.

Plener, P. L., Schumacher, T. S., Munz, L. M., & Groschwitz, R. C. (2015). The longitudinal course of non-suicidal self-injury and deliberate self-harm: a systematic review of the literature. *Borderline personality disorder and emotion dysregulation*, *2*(1), 1-11.

Porter, A. C., Zelkowitz, R. L., Gist, D. C., & Cole, D. A. (2019). Self-evaluation and depressive symptoms: A latent variable analysis of self-esteem, shame-proneness, and self-criticism. *Journal of Psychopathology and Behavioral Assessment*, *41*, 257-270.

Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied psychological measurement*, *1*(3), 385-401.

Rasmussen, S., Hawton, K., Philpott-Morgan, S., & O'Connor, R. C. (2016). Why do adolescents self-harm? *Crisis*.

Rayner, G. C., Bowling, G., Bluff, L., Wright, K., Ashworth-Lord, A., & Laird, C. (2022). A multi-method evaluation of a compassion-focused cognitive behavioural psychotherapy group for people who self-harm. *Counselling and Psychotherapy Research*, *22*(3), 569-582.

Riggle, E. D., Rostosky, S. S., Black, W. W., & Rosenkrantz, D. E. (2017). Outness, concealment, and authenticity: Associations with LGB individuals' psychological distress and well-being. *Psychology of Sexual Orientation and Gender Diversity*, *4*(1), 54.

Rivers, I. (2011). *Homophobic bullying: Research and theoretical perspectives*. Oxford University Press.

Robey, R. R., & Dalebout, S. D. (1998). A tutorial on conducting meta-analyses of clinical outcome research. *Journal of Speech, Language, and Hearing Research*, *41*(6), 1227-1241.

Rockett, I. R., Ali, B., Caine, E. D., Shepard, D. S., Banerjee, A., Nolte, K. B., Connery, H. S., Larkin, G. L., Stack, S., & White, F. M. (2023). Escalating costs of self-injury mortality in the 21st century United States: an interstate observational study. *BMC public health*, *23*(1), 285.

Rossi, A. L., & Lopez, E. J. (2017). Contextualizing competence: language and LGBT-based competency in health care. *Journal of Homosexuality*, *64*(10), 1330-1349.

Sattar, R., Lawton, R., Panagioti, M., & Johnson, J. (2021). Meta-ethnography in healthcare research: a guide to using a meta-ethnographic approach for literature synthesis. *BMC health services research*, *21*, 1-13.

Scourfield, J., Roen, K., & McDermott, L. (2008). Lesbian, gay, bisexual and transgender young people's experiences of distress: Resilience, ambivalence and self-destructive behaviour. *Health & Social Care in the Community*, *16*(3), 329-336. https://doi.org/10.1111/j.1365-2524.2008.00769.x (Health and social care needs of children and young people)

Seers, K. (2015). Qualitative systematic reviews: their importance for our understanding of research relevant to pain. *British journal of pain*, *9*(1), 36-40.

Shafer, G. (2015). Language, Hegemony, and LGBT Rights. *Language Arts Journal of Michigan*, *30*(2), 7.

Sheehy, K., Noureen, A., Khaliq, A., Dhingra, K., Husain, N., Pontin, E. E., Cawley, R., & Taylor, P. J. (2019). An examination of the relationship between shame, guilt and self-harm: A systematic review and meta-analysis. *Clinical Psychology Review*, *73*, 101779.

Silva, C., Chu, C., Monahan, K. R., & Joiner, T. E. (2015). Suicide risk among sexual minority college students: A mediated moderation model of sex and perceived burdensomeness. *Psychology of Sexual Orientation and Gender Diversity*, *2*(1), 22-33. https://doi.org/10.1037/sgd0000086

Simm, R., Roen, K., & Daiches, A. (2010). Primary school children and self harm: the emotional impact upon education professionals, and their understandings of why children self harm and how this is managed. *Oxford Review of Education*, *36*(6), 677-692.

Smith, P. N., Cukrowicz, K. C., Poindexter, E. K., Hobson, V., & Cohen, L. M. (2010). The acquired capability for suicide: A comparison of suicide attempters, suicide ideators, and non-suicidal controls. *Depression and Anxiety*, *27*(9), 871-877.

Soled, K. R., Clark, K. D., Altman, M. R., Bosse, J. D., Thompson, R. A., Squires, A., & Sherman, A. D. (2022). Changing language, changes lives: Learning the lexicon of LGBTQ+ health equity. *Research in nursing & health*, *45*(6), 621.

Solomon, R. L. (1980). The opponent-process theory of acquired motivation: the costs of pleasure and the benefits of pain. *American Psychologist*, *35*(8), 691.

Soral, W., Bilewicz, M., & Winiewski, M. (2018). Exposure to hate speech increases prejudice through desensitization. *Aggressive behavior*, *44*(2), 136-146.

Spillane, A., Matvienko-Sikar, K., Larkin, C., & Arensman, E. (2020). How do people experience a family member's high-risk self-harm? An interpretative phenomenological analysis. *Archives of Suicide Research*, *24*(sup1), 280-302.

Squires, A., & Thompson, R. (2021). Learning the language of health equity. In (Vol. 44, pp. 869-871): Wiley Online Library.

Stallard, P., Spears, M., Montgomery, A. A., Phillips, R., & Sayal, K. (2013). Self-harm in young adolescents (12–16 years): onset and short-term continuation in a community sample. *BMC Psychiatry*, *13*(1), 1-14.

Stein, D. J., Szatmari, P., Gaebel, W., Berk, M., Vieta, E., Maj, M., De Vries, Y. A., Roest, A. M., De Jonge, P., & Maercker, A. (2020). Mental, behavioral and neurodevelopmental disorders in the ICD-11: an international perspective on key changes and controversies. *BMC medicine*, *18*(1), 1-24.

Stockings, E., Degenhardt, L., Lee, Y. Y., Mihalopoulos, C., Liu, A., Hobbs, M., & Patton, G. (2015). Symptom screening scales for detecting major depressive disorder in children and adolescents: a systematic review and meta-analysis of reliability, validity and diagnostic utility. *Journal of Affective Disorders*, *174*, 447-463.

Suh, H., & Jeong, J. (2021). Association of self-compassion with suicidal thoughts and behaviors and non-suicidal self injury: A meta-analysis. *Frontiers in Psychology*, *12*, 633482.

Swannell, S. V., Martin, G. E., Page, A., Hasking, P., & St John, N. J. (2014). Prevalence of nonsuicidal self-injury in nonclinical samples: Systematic review, meta-analysis and meta-regression. *Suicide and Life-Threatening Behavior*, *44*(3), 273-303.

Taliaferro, L. A., McMorris, B. J., Rider, G. N., & Eisenberg, M. E. (2019). Risk and protective factors for self-harm in a population-based sample of transgender youth. *Archives of Suicide Research*, *23*(2), 203-221. https://doi.org/10.1080/13811118.2018.1430639

Taylor, P. J., Jomar, K., Dhingra, K., Forrester, R., Shahmalak, U., & Dickson, J. M. (2018). A meta-analysis of the prevalence of different functions of non-suicidal self-injury. *Journal of Affective Disorders*, *227*, 759-769.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC medical research methodology*, *8*(1), 1-10.

Thomassin, K., Guérin Marion, C., Venasse, M., & Shaffer, A. (2017). Specific coping strategies moderate the link between emotion expression deficits and nonsuicidal self-injury in an inpatient sample of adolescents. *Child and Adolescent Psychiatry and Mental Health*, *11*, 1-8.

Thorne, N., Yip, A. K.-T., Bouman, W. P., Marshall, E., & Arcelus, J. (2020). The terminology of identities between, outside and beyond the gender binary–A systematic review. *Non-Binary and Genderqueer Genders*, 20-36.

Travis, L. A., & Arizona, P. (2017). LGBT: What You Should Know About LGBT Older Adults. *ELDER CARE*.

Turecki, G., & Brent, D. A. (2016). Suicide and suicidal behaviour. *The Lancet*, *387*(10024), 1227-1239.

Umphrey, L. R., Sherblom, J. C., & Swiatkowski, P. (2020). Relationship of Self-Compassion, Hope, and Emotional Control to Perceived Burdensomeness, Thwarted Belongingness, and Suicidal Ideation. *Crisis: The Journal of Crisis Intervention & Suicide Prevention*, 1-7. https://doi.org/10.1027/0227-5910/a000697

Unthank, K. W. (2019). How self-blame empowers and disempowers survivors of interpersonal trauma: An intuitive inquiry. *Qualitative Psychology*, *6*(3), 359.

Van Orden, K. A., Cukrowicz, K. C., Witte, T. K., & Joiner Jr, T. E. (2012). Thwarted belongingness and perceived burdensomeness: construct validity and psychometric properties of the Interpersonal Needs Questionnaire. *Psychological Assessment*, *24*(1), 197.

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner Jr, T. E. (2010). The interpersonal theory of suicide. *Psychological review*, *117*(2), 575.

Vilagut, G., Forero, C. G., Barbaglia, G., & Alonso, J. (2016). Screening for depression in the general population with the Center for Epidemiologic Studies Depression (CES-D): a systematic review with meta-analysis. *PLoS ONE*, *11*(5), e0155431.

Vitaliano, P. P., Zhang, J., & Scanlan, J. M. (2003). Is caregiving hazardous to one's physical health? A meta-analysis. *Psychological bulletin*, *129*(6), 946.

Wang, L., Zou, H., Yang, Y., & Hong, J. (2023). Adolescents' attitudes toward non-suicidal self-injury (NSSI) and their perspectives of barriers to seeking professional treatment for NSSI. *Archives of Psychiatric Nursing*, *45*, 26-35.

Wang, S., Chen, L., Ran, H., Che, Y., Fang, D., Sun, H., Peng, J., Liang, X., & Xiao, Y. (2022). Depression and anxiety among children and adolescents pre and post COVID-19: A comparative meta-analysis. *Frontiers in Psychiatry*, *13*, 917552.

Washburn, J. J., Juzwin, K., Styer, D. M., & Aldridge, D. (2010). Measuring the urge to self-injure: Preliminary data from a clinical sample. *Psychiatry Research*, *178*(3), 540-544.

White, J., Trinh, M.-H., & Reynolds, C. A. (2023). Psychological distress, self-harm and suicide attempts in gender minority compared with cisgender adolescents in the UK. *BJPsych Open*, *9*(5), e138.

Whitlock, J., Muehlenkamp, J., Purington, A., Eckenrode, J., Barreira, P., Baral Abrams, G., Marchell, T., Kress, V., Girard, K., Chin, C., & Knox, K. (2011). Nonsuicidal self-injury in a college population: General trends and sex differences. *Journal of American College Health*, *59*(8), 691-698. https://doi.org/10.1080/07448481.2010.529626

Wilkinson, P. O., Qiu, T., Jesmont, C., Neufeld, S. A., Kaur, S. P., Jones, P. B., & Goodyer, I. M. (2022). Age and gender effects on non-suicidal self-injury, and their interplay with psychological distress. *Journal of Affective Disorders*, *306*, 240-245.

Williams, A. J., Arcelus, J., Townsend, E., & Michail, M. (2023). Understanding the processes underlying self-harm ideation and behaviors within LGBTQ+ young people: A qualitative study. *Archives of Suicide Research*, *27*(2), 380-396. https://doi.org/10.1080/13811118.2021.2003273

Williams, A. J., Jones, C., Arcelus, J., Townsend, E., Lazaridou, A., & Michail, M. (2021). A systematic review and meta-analysis of victimisation and mental health prevalence among LGBTQ+ young people with experiences of self-harm and suicide. *PLoS ONE*, *16*(1). https://doi.org/10.1371/journal.pone.0245268

Witt, K., Milner, A., Spittal, M. J., Hetrick, S., Robinson, J., Pirkis, J., & Carter, G. (2019). Population attributable risk of factors associated with the repetition of self-harm behaviour in young people presenting to clinical services: a systematic review and meta-analysis. *European Child & Adolescent Psychiatry*, *28*, 5-18.

Woodward, E. N., Wingate, L., Gray, T. W., & Pantalone, D. W. (2014). Evaluating thwarted belongingness and perceived burdensomeness as predictors of suicidal ideation in sexual minority adults. *Psychology of Sexual Orientation and Gender Diversity*, *1*(3), 234.

Wright, N., Hill, J., Sharp, H., & Pickles, A. (2020). Impact of COVID-19 on young adolescent mental health: comparison of depression, anxiety and behaviour problems in 12 year olds immediately before and during the pandemic in a UK birth cohort. *Anxiety and Behaviour Problems in*, *12*.

Wu, J., Liu, S., Luo, J., Li, X., & You, J. (2023). The effects of childhood abuse, depression, and self-compassion on adolescent nonsuicidal self-injury: A moderated mediation model. *Child Abuse & Neglect*, *136*, 105993.

Xanthopoulou, P., Ryan, M., Lomas, M., & McCabe, R. (2021). Psychosocial assessment in the emergency department: The experiences of people presenting with self-harm and suicidality. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*.

Xavier, A., Pinto Gouveia, J., & Cunha, M. (2016). Non-suicidal self-injury in adolescence: The role of shame, self-criticism and fear of self-compassion. *Child & Youth Care Forum*, *45*(4), 571-586. https://doi.org/10.1007/s10566-016-9346-1

Zelkowitz, R. L., & Cole, D. A. (2019). Self-Criticism as a Transdiagnostic Process in Nonsuicidal Self-Injury and Disordered Eating: Systematic Review and Meta-Analysis. *Suicide & Life-Threatening Behavior*, *49*(1), 310-327. https://doi.org/10.1111/sltb.12436

Zetterqvist, M. (2015). The DSM-5 diagnosis of nonsuicidal self-injury disorder: a review of the empirical literature. *Child and Adolescent Psychiatry and Mental Health*, *9*(1), 1-13.

Zochniak, K., Lewicka, O., Wybrańska, Z., & Bilewicz, M. (2023). Homophobic Hate Speech Affects Well-Being of Highly Identified LGBT People. *Journal of Language and Social Psychology*, 0261927X231174569.

Appendix 4-C: Participant Information Sheet

Participant Information Sheet

How we feel about ourselves and others

My name is Bethan, and I am conducting this research as a student in the Doctorate of Clinical Psychology program at Lancaster University. I am completing this research as I think it is important to understand what leads to people experiencing urges to self-harm, so that we can better support people experiencing this.

I understand that the topic of the research is extremely personal and may be upsetting for some people. If you feel you might be upset by this, then please do not feel that you need to take part. Looking after yourself is the most important thing.

All of the questions on each page need to be answered to allow you to continue to the next page. It may be difficult or upsetting for some people to answer some of the questions in the survey, so do not feel pressured to take part, or to complete all the questions in one go.

If you want to stop the survey at any time, please close the browser or tab you are using. If you decide to come back to the survey, as long as you use the link on the same device, the survey should continue from where you got up to (e.g. if you start on your mobile phone, and close the tab today, but click the link again on your mobile tomorrow to continue, you should start on the page you closed the survey on and will not need to repeat questions as long as you do this on the same mobile phone).

There is further information about the study below, please read through this information and think about whether you would like to take part.

What is the study about?

This study aims to see if different types of compassion (kindness and understanding for ourselves and others) are linked to experiencing the urge to self-harm.

Why have I been approached?

You are invited to take part if you:

- Are between the age of 16 and 25 years old
- Live in the United Kingdom, and
- have had thoughts of self-harming within the last six months

Do I have to take part?

No. It's completely up to you to decide if you want to take part. You can stop the survey at any point by closing the browser window or tab up until the last page. If you close the survey before the last page your responses will be automatically deleted. Once you have submitted your responses (by clicking submit on the last page) you will not be able to ask for your responses to be deleted as they are anonymous, so we will not know which response is yours.

What will I be asked to do if I take part?

If you decide you would like to take part, you would be asked to complete a short online survey, which should take up to 30 minutes.

You will be asked questions about what you think and feel about receiving compassion from others and being compassionate towards others and yourself, as well as about how often you have had urges to self-harm recently.

Will my data be Identifiable?

No, we will not be asking for any identifiable information in the survey. We will be asking for some demographic information such as your age and gender to help us to understand any differences between groups.

The data will initially be collected through the Qualtrics website (www.qualtrics.com) and will then be securely stored on University approved secure cloud storage. Only the researchers conducting this study will have access to this data. The data will be retained for 10 years.

What will happen to the results?

The results will be summarised and reported as a Lancaster University doctoral thesis and through presentations to the Doctorate in Clinical Psychology staff and peers at the university. The study will be submitted for publication in an academic or professional journal.

Are there any risks?

Due to the topic of the study, you may find certain questions within the survey upsetting or distressing. If you are concerned that you may find participating distressing, or you do not wish to take part in the study or any reason, you can close the survey now. We thank you for considering participation.

If you experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher: Bethan Gray (b.gray3@lancaster.ac.uk). You can also contact the research supervisor: Dr James Kelly (j.a.kelly@lancaster.ac.uk).

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Dr Ian Smith Tel: (01524) 592282

Research Director Senior Lecturer

Email: i.smith@lancaster.ac.uk

Tel: (01524) 592282

Clinical Psychology Training Programme

Lancaster University

Lancaster

LA1 4YW

If you wish to speak to someone outside of the Lancaster Doctorate Programme, you may also contact:

Dr Laura Machin Tel: +44 (0)1524 594973

Chair of FHM REC Email: l.machin@lancaster.ac.uk

Faculty of Health and Medicine

(Lancaster Medical School)

Lancaster University

Lancaster

LA1 4YG

Resources in the event of distress

Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance.

Strategies and Techniques

Mind have a webpage which includes tips to manage if you are feeling the urge to self-harm right now, including distraction techniques: https://www.mind.org.uk/information-support/types-of-mental-health-problems/self-harm/helping-yourself-now/

Calm Harm is an app which is full of distraction techniques and strategies to help you to feel calm and resist the urge to self-harm. The app gives you things to do right now to help 'ride the wave'

until the urge to self-harm starts to pass. You can read more about the app and find a link to download it on their website: https://calmharm.co.uk/

Support Services

SHOUT – Support via Text

You can text 'SHOUT' to 85258 for free to receive support, anytime.

If you want to find out more about how this works, you can read more on their website: https://giveusashout.org/get-help/how-shout-works/

If you are having thoughts of suicide and aged up to 35 or are concerned for a young person who might be, you can contact **HOPELINEUK** for confidential support and practical advice from 9am until midnight every day.

Call: 0800 068 4141

Text: 07860 039 967

Email: pat@papyrus-uk.org

Childline is open 24 hours a day, 7 days a week for those aged up to 19.

There is a variety of support available, such as a helpline, 1-2-1 online chat and email support.

Helpline: 0800 1111

Website: Childline.org.uk

NHS direct

If you need urgent medical help, contact the NHS on 111 for advice and support.

Emergency services

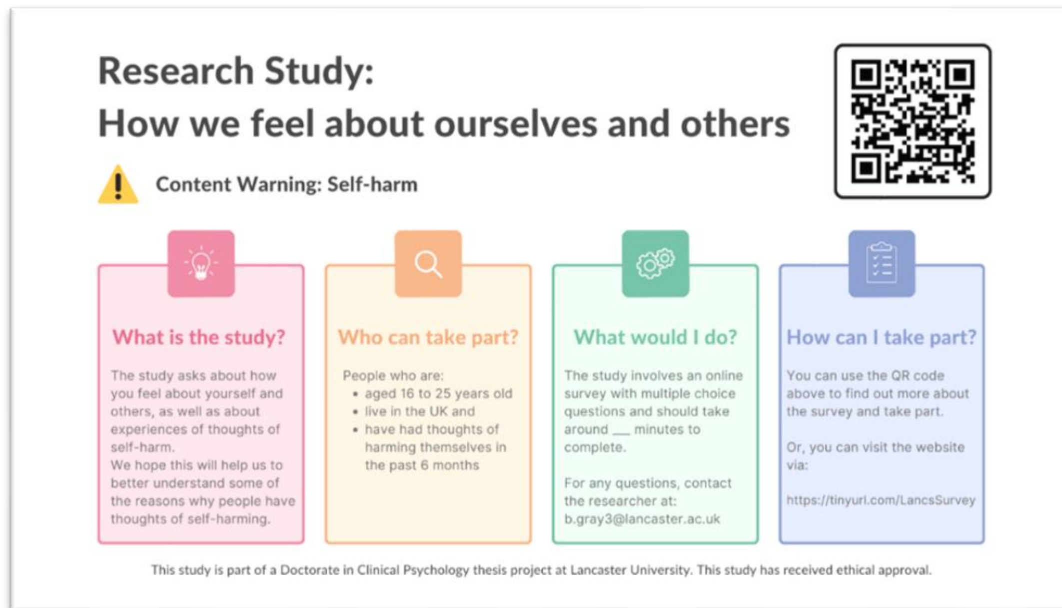
If you are in immediate danger, please contact the emergency services on 999.

Thank you for taking the time to read this information sheet. If you wish to continue to participate in the study, please continue to the next page using the buttons below.

Appendix 4-D: Example Advertisements

Advertisements

An example of a physical poster/shareable image has been designed as below:



*The time to complete the study will be added to the poster once our participant involvement is complete as we have a representative example of expected time to complete the survey.

A dedicated twitter account has been created for the project: @SelfHarmStudy. This account will be used to tweet out to organisations, and using hashtags to invite sharing of the study and to recruit participants.

Examples of tweets which will be used are as below (the above poster will also be attached to tweets):

- "Content warning: Self-harm:

  16 to 25? Had thoughts of harming yourself in the past 6 months? Want to help research understand why we have thoughts of self-harm, take part in our study here: https://tinyurl.com/LancsSurvey #selfharm #mentalhealth @(twitter account) pls RT"

- "Content warning: Self-harm:

16 to 25 and recent thoughts of harming yourself? You could help our understanding of why we experience thoughts and urges to self-harm. If you would like to know more, you can read about our study at https://tinyurl.com/LancsSurvey #mentalhealth #research @(twitter account) please share!"

- "Content warning: Self-harm:

  If you are interested in helpful us to understand why people have thoughts of self-harm, please read more about our research study in the attached image."

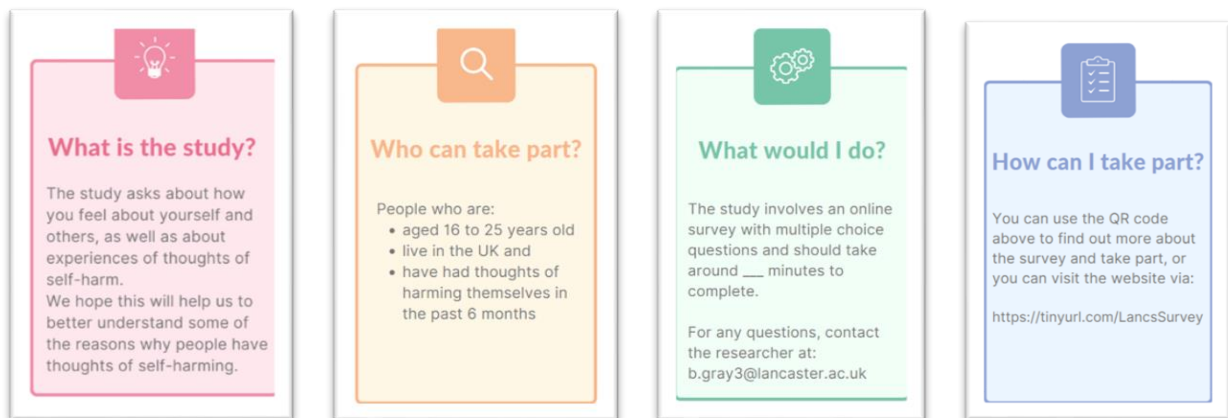
- "Content warning: Self-harm:

  We are interested in finding out more about why people have thoughts of harming themselves. If you are 16 to 25, live in the UK, and have had thoughts of harming yourself in the last 6 months you could help by completing our study: https://tinyurl.com/LancsSurvey

- "Content warning: Self-harm:

  1 in 5 females aged 16 to 24 in England currently self-harm according to recent findings. We are interested in why people have thoughts of self-harming. If you are aged 16 to 25, live in the UK and have had thoughts of self-harm in the past 6-months, you can read about our study here: https://tinyurl.com/LancsSurvey"

The Twitter account will also be able to share the infographics split into 4 images so that they can be chunked and be swiped through within one post, as shown below:



The post will include a text content warning for self-harm.

Reddit will also be used to post in relevant forums with a summary of the research study aims and criteria to invite people to find out more information, an example of this is as below:

- "Content warning: Self-harm:

  Thoughts and urges to self-harm are increasingly common. We are interested in finding out what causes people to experience these thoughts to help better our understanding of this and help professionals better support those who experience this. If you are aged 16 to 25, live in the UK, and are interested in taking part in an online survey to help research better understand self-harm, you can find out more here: https://tinyurl.com/LancsSurvey "

Facebook groups may also be identified to share the above advertisement poster in addition to the below text:

- "Content warning: Self-harm:

  We are interested in finding out more about why people have thoughts of harming themselves. If you are 16 to 25, live in the UK, and have had thoughts of harming yourself in the past 6 months you could help by completing our study: https://tinyurl.com/LancsSurvey

Appendix 4-E: Consent Form

Consent Form

We are asking if you would like to take part in a research project exploring whether how you feel about yourself and about other people is related to whether you experience an urge to self-harm.

Before agreeing to take part in the survey, we ask that you have read the previous information page fully as this tells you what is involved.

Once you are happy that you have read and understood the previous page, please read each statement below and indicate whether you agree or disagree with each in reference to this survey:

I have read the information sheet and fully understand what I will be asked to do if I do the survey	[ ] agree	[ ] disagree
I have asked any questions that I need to and have them answered	[ ] agree	[ ] disagree
I understand that it is my choice to do the survey, and that I do not have to do the survey if I do not want to	[ ] agree	[ ] disagree
I know that if I want to stop doing the survey I can exit the survey at any time by closing the tab or window, and my responses will be deleted	[ ] agree	[ ] disagree
I understand that as my data is anonymous, once I have completed the survey it will no longer be possible to withdraw my consent or have my answers deleted	[ ] agree	[ ] disagree
I consent to Lancaster University keeping the anonymised data for a period of 10 years after the study has finished	[ ] agree	[ ] disagree
I consent to participate in the survey	[ ] agree	[ ] disagree

Please click to the next page.