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Exploring the Lived Experiences of Hospitalised Women with a History of Childhood Abuse, Who Engage in Self-Harming Behaviour

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Abstract: *Background:* Adverse childhood experiences (ACEs) are linked to increased risk of deliberate self-harm (DSH), yet little is known about how women in forensic inpatient settings with histories of childhood abuse understand their self-harm. This study aimed to explore how such women make sense of their self-harm, including perceived contributing and protective factors. *Methods:* Semi-structured interviews were conducted with six female psychiatric inpatients (aged 22–38) detained in a low-secure forensic hospital in the north of England. All had a history of ACEs and DSH. Interpretative phenomenological analysis (IPA) was used to analyse the data. *Results:* Three overarching themes were identified: (1) Journey of self-harm, (2) reasons for self-harm, and (3) relationships and self-harm. Participants described self-harm as a method of emotional regulation, a way to regain control, or a means of feeling something. Protective factors included supportive relationships, self-awareness, and having meaningful goals. The findings reflect complex, evolving understandings of self-harm shaped by personal histories and relational dynamics. *Conclusions:* This study highlights the persistent and multifaceted nature of self-harm among women in forensic settings. The findings support the need for trauma-informed interventions that address emotion regulation, relational support, and personal empowerment. Implications for clinical practice and directions for future research are discussed.



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1. Introduction

The term deliberate self-harm (DSH) refers to non-fatal, intentional self-injury, regardless of whether it is motivated by suicidal or non-suicidal intent (Royal College of Psychiatrists, 2020). Research indicates that women are more likely than men to experience childhood adversity and abuse, with reviews consistently showing significantly higher rates of sexual and physical abuse among females (Vaswani, 2018). Among different forms of abuse, childhood sexual abuse (CSA) has been strongly associated with both the chronicity and severity of DSH, while childhood physical abuse is also a significant risk factor for future self-harm (Low et al., 1997; Swannell et al., 2012; Troya et al., 2021). Given these associations, women who have experienced childhood abuse, particularly violent and sexual abuse, are at increased risk for psychological health problems, including DSH.

1.1. Childhood Sexual Abuse, Mental Health Issues and Hospitalisation

Research indicates that childhood sexual abuse (CSA) is strongly associated with post-traumatic stress disorder (PTSD) in women, who are diagnosed with the condition

nearly twice as often as men (Hu et al., 2017). Globally, PTSD prevalence in women is estimated at 10–12% (Olff, 2017), with females more likely to experience relational traumas such as CSA, sexual assault, and intimate partner violence (Tolin & Foa, 2006). This may contribute to their heightened vulnerability to PTSD (McLean et al., 2011).

Studies of clinical populations suggest that female survivors of CSA are at greater risk of developing Emotionally Unstable Personality Disorder (EUPD) (Abrams & Stefan, 2012). CSA has also been linked to insecure or disorganised attachment styles, which increase susceptibility to depression and overwhelming feelings of fear and shame (Ensink et al., 2020). A core feature of EUPD includes impulsivity and self-destructive behaviours such as DSH, alongside significant interpersonal difficulties (American Psychiatric Association [APA], 2013). Additionally, CSA survivors often experience a negative self-image characterised by self-blame and self-disgust, further reinforcing patterns of self-harm (Ensink et al., 2020). It has been suggested that DSH may serve as a maladaptive coping mechanism to regulate these intense emotions (Lundh et al., 2011).

Women with a history of adverse childhood experiences (ACEs) appear particularly vulnerable to repeated self-harm (Cleare et al., 2018). Many of these individuals also present with complex trauma-related symptoms and personality difficulties. In severe cases, the level of psychological distress and associated risk behaviours necessitate psychiatric hospitalisation under legal frameworks for mental health care (MHA, 1983/2007). In high-secure psychiatric settings, self-harm is prevalent, with 70% of female inpatients engaging in DSH at some point in their lifetime (Swinton et al., 1998). Similarly, in forensic settings, high rates of DSH have been reported among incarcerated women, including those with no prior history of self-harm before imprisonment (Völm & Dolan, 2009).

Further research highlights the disproportionate risk of DSH among women in psychiatric care. A UK-based study found that 20–24% of female psychiatric patients engage in self-harm annually, compared with 5–6% of male patients (Hawton et al., 2014). In a female medium-secure setting, DSH prevalence among inpatients was as high as 54% (Holden et al., 2022). These findings underscore the high levels of self-harm among women with complex mental health needs requiring treatment in secure settings.

Beyond the increased rates of DSH, female psychiatric inpatients also have high rates of CSA histories. A review of 46 studies worldwide found that nearly half (48%) of female inpatients reported experiencing CSA (Read et al., 2007). Additionally, a U.S. study found that female psychiatric inpatients with a history of childhood abuse were nearly three times more likely to experience sexual violence as adults compared with inpatients without a history of abuse (Cloitre et al., 1996). These findings highlight the vulnerability of this population, not only in terms of their mental health difficulties and self-harm risk but also their heightened susceptibility to future victimisation.

1.2. Personal Support to Reduce DSH

While adverse childhood experiences (ACEs) are strongly linked to the development of deliberate self-harm (DSH), not all individuals with a history of childhood abuse engage in self-harm. Likewise, some individuals who previously engaged in DSH are able to reduce or cease this behaviour over time. Understanding the protective factors that mitigate the risk of self-harm is therefore essential.

Social support is widely recognised as a buffer against the negative psychological impact of adverse life events (Li et al., 2021; Uchino et al., 1999). Research suggests that social connectedness may also serve as a protective factor against DSH. One study compared individuals who continued to self-harm with those who had ceased self-harm and found that the latter group reported higher levels of perceived social support, stronger family connections, and a greater sense of belonging to a social group (Rotolone & Martin,

2012). Similarly, a mixed-methods study of university students with a history of self-harm identified professional and social support as key factors in discontinuing DSH. Participants emphasised the importance of having someone to talk to, with family and friends playing a crucial role in their recovery (Gelinas & Wright, 2013).

These findings highlight the significance of personal and professional support in reducing self-harm risk, reinforcing the need for interventions that foster social connectedness and access to support networks.

1.3. The Current Study

Research examining the link between childhood abuse and deliberate self-harm (DSH) has often been quantitative, focusing on statistical associations rather than the lived experiences of those affected. While quantitative research has informed evidence-based clinical practice, it has provided limited insight into service users' subjective experiences of self-harm (Biggerstaff & Thompson, 2008).

This study aimed to explore the experiences of self-harm in hospitalised women with a history of childhood abuse, as well as factors influencing their continued engagement in DSH. Given the high risk of repeated self-harm among psychiatric inpatients with childhood abuse histories, a deeper understanding of their perspectives is crucial. A qualitative approach was selected to capture the complexity of self-harm within this population. Although all participants had experienced childhood abuse, the study did not focus on their trauma histories but instead sought to understand their experiences of DSH in a forensic inpatient setting. The research questions were as follows:

1. How do hospitalised women with a history of childhood abuse make sense of their experiences of self-harm?
2. From their perspective, what factors affect their engagement in self-harming behaviours, particularly what has caused them to self-harm on some occasions but not others?

2. Materials and Methods

2.1. Design

This study aimed to gain an in-depth understanding of the lived experiences of hospitalised women with a history of childhood abuse who engage in self-harm. A qualitative approach was deemed most appropriate, with interpretative phenomenological analysis (IPA) selected for its focus on capturing participants' subjective experiences (Smith & Osborn, 2003). IPA is particularly suited for exploring complex, emotionally charged topics (Smith & Osborn, 2015) and has been recognised as a robust research approach (Smith et al., 2009).

Rooted in hermeneutics—the theory of interpretation—IPA acknowledges that individuals strive to make sense of their experiences. It employs a double hermeneutic process, wherein the researcher interprets how participants interpret their own experiences (Smith et al., 2022). IPA is idiographic, emphasising detailed exploration of individual experiences within a small sample to identify shared themes while preserving personal narratives (Alase, 2017). Semi-structured interviews were used to facilitate open, participant-led discussions, allowing for rich, detailed accounts (Smith et al., 2022).

2.2. Participants

To ensure sample homogeneity, six participants were selected based on predetermined inclusion and exclusion criteria. Inclusion criteria required that participants were adult women (aged 18–60) detained under the Mental Health Act (MHA, 1983/2007), with a history of childhood abuse—including physical, psychological, or sexual abuse—and/or significant neglect. They had engaged in repeated self-harm (three or more instances) at

some point in their lives and were past or present attendees of a dialectical behaviour therapy (DBT) group, indicating prior treatment for self-harm and a capacity to reflect on their experiences. Participants were only included if they had capacity to give informed consent and could demonstrate an understanding of the research.

Exclusion criteria included individuals with active psychosis or a diagnosed learning disability, as these conditions may impact their capacity to provide informed consent. Participants were also excluded if their responsible clinician (RC) deemed them incapable of participation due to mental health concerns or risk factors. Additionally, service users receiving individual therapy from the researcher at the time of the study were excluded to prevent conflicts of interest.

Six white British women aged between 22 and 30 participated in the study. The age range was not an inclusion criterion but reflected those who responded and met the eligibility criteria during recruitment. All participants were given pseudonyms to protect their anonymity. Each had engaged in deliberate self-harm (DSH) on multiple occasions prior to and during their current hospital admission. Methods of self-harm included cutting, ligaturing, head banging, self-poisoning, and burning. All participants had experienced past sexual trauma, and half had also experienced other forms of childhood abuse, such as neglect and/or physical abuse. Further socio-demographic data—such as education level and length of hospitalisation—were not collected, as doing so could have compromised anonymity given the small, tightly defined forensic hospital setting. We acknowledge that this limits the contextual richness of the sample description and the ability to fully assess sample homogeneity.

2.3. Procedure

Stage 1: Recruitment and Screening of Participants

Participants were inpatients at a women's psychiatric hospital in Yorkshire, UK, which includes low secure and rehabilitation wards. Low secure wards treat individuals detained under the Mental Health Act (MHA, 1983/2007) with complex needs, posing a risk to others, where alternative placements are unsuitable (NHS England, 2021). The hospital provides mental health treatment and offence-related programs to stabilise patients and reduce reoffending.

To recruit participants, the researcher attended the hospital's DBT group, reading aloud the participant information sheet and answering questions. Potential participants were encouraged to take the information sheet and express interest either directly at a routine morning meeting or via DBT facilitators. A separate session for past DBT attendees followed the same process.

Interested individuals underwent screening, with clinical files reviewed for childhood abuse history and engagement in DSH. If deemed suitable, the participant and their clinician were informed, and the clinician assessed capacity to consent. If approved by the clinical team, the researcher arranged an interview. All interested individuals met the inclusion criteria.

Stage 2: Data collection

Semi-structured interviews were used to explore participants' experiences in depth. This flexible approach allowed questions to be adapted based on responses, fostering a conversational atmosphere (Smith et al., 2009). The interview schedule was developed through a literature review, discussions with research supervisors, and best practices for IPA in healthcare (Peat et al., 2019). A service user who met all but one inclusion criterion participated in a mock interview and found the questions clear and appropriate, so no changes were made.

The schedule consisted of open-ended questions encouraging participants to freely discuss their understanding of self-harm, reasons for engaging in it, factors influencing continued self-harm, and protective factors that helped reduce it. They were also invited to share advice for others struggling with self-harm, offering an alternative perspective on their experiences. The schedule served as a guide rather than a strict script, allowing participants to shape the conversation.

Interviews were conducted face-to-face in a private room within the hospital to ensure confidentiality. Each session lasted 40 to 60 min and was audio-recorded using an encrypted Dictaphone. Data were securely transferred to the institution's research data store (RDS) and deleted from the recorder. All audio files were permanently deleted from the RDS two weeks after transcription.

To protect anonymity, participants were assigned pseudonyms. At the end of the interview, they received a debrief sheet outlining the withdrawal process, which allowed them two weeks to request data removal, though no one did so.

Given the vulnerability of the participant group, safeguards ensured their well-being. On the interview day, participants identified key staff members available for support if needed. They could pause, reschedule, or end the interview at any time without penalty, but all completed their interviews in a single session.

After the interview, participants were asked if they needed immediate support before returning to the ward. As all had 24/7 nursing care access, none requested assistance. The debrief sheet also provided details on additional support options.

Stage 3: Data Analysis

All data analysis was conducted within the university's secure, encrypted portal to ensure data protection. The analysis followed [Smith et al.'s \(2022\)](#) guidelines for interpretative phenomenological analysis (IPA).

The first step involved repeatedly reading each transcript to fully immerse in the data. Next, exploratory noting was conducted, where descriptive and interpretative observations were made regarding key aspects of participants' language and experiences.

In the third step, experiential statements were constructed from the exploratory notes, summarising the meaning of participants' experiences. These statements were then examined for patterns and connections, leading to the formation of clusters that reflected broader themes. The clusters were refined into personal experiential themes (PETs), each given a unique title to reflect its core meaning.

This process was repeated for each interview before comparing themes across participants to identify group experiential themes (GETs) ([Smith et al., 2022](#)). The GETs underwent multiple revisions and refinements to ensure they accurately represented the data. The final themes, along with supporting participant quotes, are presented in the Results section.

To enhance transparency, a brief example of the theme development process is included here. One participant said, "I cut because it gives me something I can control when everything else feels out of my hands." This was initially coded as "need for control," and "self-harm as coping." Through iterative analysis and clustering of similar codes across transcripts, this contributed to the development of sub-theme 2.3: *To feel in control*, within the group experiential theme *Reasons why I self-harm*. This example illustrates how raw data were interpreted and organised to reflect shared experiential meaning.

2.4. Validity of Research

Given the interpretative nature of interpretative phenomenological analysis (IPA), researcher subjectivity is an integral part of the analytical process ([Smith et al., 2009](#)). The primary researcher, a British female with no personal history of adverse childhood experiences (ACEs) or self-harm, inevitably brought their own perspectives to the interpretation

of participants' accounts. However, in line with IPA's commitment to reflexivity, steps were taken to critically engage with and acknowledge this subjectivity.

To enhance rigor and reflexivity, the researcher kept a reflective diary throughout the research process, documenting thoughts, assumptions, and emotional responses to the data. This allowed for ongoing critical reflection on how their perspectives may have shaped interpretations. Academic supervision played a pivotal role in discussing emergent themes, exploring alternative interpretations, and distinguishing the researcher's clinical role from their role as an analyst. This was particularly important as the researcher worked within the hospital's psychology department, necessitating careful role differentiation.

To further ensure credibility, the secondary supervisor, an experienced IPA researcher, independently reviewed one transcript and its thematic analysis to assess coherence and consistency in the interpretative process. Additionally, a reflexivity statement was prepared to transparently acknowledge the researcher's position and potential influences on the findings.

2.5. Reflexivity Statement

As a forensic psychologist in training at a university in the UK, I was mindful of the challenge of maintaining neutrality in this research. At the time, I was a part-time doctoral student with ten years of experience in hospital and community settings, including six years in a low-secure forensic unit. My work involved supporting individuals with complex mental health conditions, shaping my therapeutic approach around rapport-building and trust, which contrasted with the brief researcher-participant interactions in this study.

My interest in this topic stemmed from working in women's secure units, where many had trauma histories and engaged in self-harm. This exposure, alongside literature and training, inevitably shaped my perspective. I was conscious of how prior clinical knowledge might influence my interpretations, particularly regarding self-harm triggers and coping mechanisms. To remain open to participants' lived experiences, I avoided clinical interpretations during interviews and maintained a reflective diary.

Conducting research in my workplace raised concerns about potential power dynamics and participant openness. Although I did not work directly with the women I interviewed, they were detained under the Mental Health Act, and I was aware that my professional identity might influence their willingness to speak freely. While participants appeared candid—perhaps due to familiarity with the shared environment—I recognised that therapeutic proximity could lead to perceived coercion or pressure to participate.

To mitigate these concerns, several safeguards were put in place. Participants were explicitly informed—both verbally and in writing—that participation was entirely voluntary, unrelated to their care, and could be withdrawn at any time without consequence. These points were reiterated prior to each interview. Recruitment was conducted via a third-party clinician not involved in the research to reduce any risk of perceived obligation. During interviews, I emphasised participants' control over what they chose to disclose and kept the tone informal. I also continued reflexive journaling throughout the research and discussed emerging dilemmas in supervision. These steps were taken to promote participant agency and reduce the impact of power imbalances as far as possible.

As a female researcher interviewing female participants, I also considered whether this contributed to their comfort, particularly as all had experienced sexual trauma by men. I reflected on whether shared aspects of identity—such as my age and working-class Yorkshire background—might have helped build rapport. While our life paths differed, I was struck by their resilience and humour despite their challenges.

2.6. Ethical Approval

The research project received ethical approval by the regional NHS Research Ethics Committee on 11.02.2021 (REC Reference: 21/YH/002) and met the standards of The British Psychological Society Code of Research Ethics ([British Psychological Society \[BPS\], 2018](#)).

3. Results

As part of data analysis, three group experiential themes were identified: *Journey of self-harm*, *Reasons why I self-harm*, and *Relationships and self-harm*. Within each group experiential theme, lay several sub-themes (See Table 1) with convergence and divergence across participants' narratives being discussed throughout the results section. All participants contributed to the group experiential themes.

Table 1. Group experiential themes and sub-themes.

Group Experiential Themes	Sub-Themes
1. Journey of self-harm	1.1 Self-harm just got worse. 1.2 Comparisons to substance addiction. 1.3 "You learn to live with it."
2. Reasons why I self-harm	2.1 When emotions get too much. 2.2 To punish myself. 2.3 To feel in control. 2.4 To feel something.
3. Relationships and self-harm	3.1 Negative relational experiences. 3.2 The importance of relationships in stopping self-harm.

Theme 1: Journey of Self-harm

The first group experiential theme reflected the journey of self-harm, which each participant had experienced throughout their lives. The theme revealed the longer-term struggles in which the participants learnt to live with DSH behaviours, with them detailing the initial escalation in the severity of DSH, as well as difficulties experienced when trying to stop self-harming. Three sub-themes were identified as follows: *Self-harm just got worse*; *Comparisons to substance addiction*; and *"You learn to live with it."*

1.1 Self-harm Just Got Worse

The first sub-theme reflects the participants' experiences of self-harm getting "worse and worse" (Sarah, p. 4). Three participants contributed towards this sub-theme with the participants' narratives focusing on the onset of self-harm and how this escalated with time. Participants spoke about the worsening of self-harm, with some participants giving specific accounts of the first time they remembered self-harming. Sarah, Jade and Laura spoke about how, when they first engaged in DSH, they "didn't do anything like really, really bad" (Jade, p. 3), however, this changed overtime.

For instance, Jade spoke about the first time she self-harmed, and how she did not consider it to be anything concerning at first:

I remember it being a really stressful day at school and I just remember ermmm, I didn't do anything like really really bad, the more I self-harmed the worse it got, so the first time I self-harmed it wasn't like bad but I remember using nail scissors and I used to cut my legs because ermmm, I was a dancer so like my arms, I had to wear like a leotard and stuff so obviously I didn't want people to see it. So I thought if I like cut all up my legs [pointed to top of legs] then I thought that obviously no-one would see it and I always used to listen to a certain like CD as

well and I don't know why it was just like certain songs I used to listen to whilst doing certain things. (Jade, p. 3)

Jade recalled having a stressful day at school, which she must have viewed as relevant to her in terms of the onset of self-harm. Jade viewed her first incident of DSH as not "like bad," which insinuated that she perceived the incident of DSH as minor. However, she went on to explain that her self-harm became more of a problem as "the more I self-harmed, the worse it got." She also described the event as being almost ritualistic in nature, with her listening to certain songs and CDs at the time of DSH, emphasising the intimate and personal nature of her engaging in DSH.

Jade then went on to compare the escalation in DSH as to that of building up a tolerance to adrenaline:

Like people who are like adrenaline junkies, to start with like a rollercoaster and then they like, go to like, I don't know, bungee jumping, do you know what I mean?... So like I think that like the more I self-harmed, the more I had to do to make me feel the way I did. (Jade, p. 3)

Here, Jade spoke about how the more she self-harmed, the more she needed to engage in DSH to get the initial feeling she felt. She compared this to someone building up their tolerance to adrenaline, with her using the analogy of someone initially starting with activities such as a rollercoaster but then progressing to activities such as bungee jumping. For Jade, this was the reason why her self-harming became more severe; she had built up a tolerance to the effects of self-harm and, therefore, needed to engage in more significant self-harm to achieve the same feeling as she did initially. Later in the interview, Jade went on to describe self-harm as a "slippery slope" (p. 8) and stated, "If I would have got help when I very, very, very first started self-harming, I probably wouldn't have got to the situation that I'm in now" (p. 8). Therefore, Jade believed that if she had received some form of intervention in the early stages of her DSH journey, then it may not have spiralled to the point of her needing to be hospitalised to receive treatment.

Similarly, Sarah also described her DSH behaviours worsening with time:

I was in my bedroom... I'd had a really bad day and I'd done like a little cut on my arm. It wasn't like serious. But that was the first time I'd done it, but it wasn't like bad or anything. It was just a little bit but then it started getting worse. (Sarah, p. 2)

Like Jade, Sarah described the first time she self-harmed in response to having experienced a difficult day, as well perceiving her initial incident of self-harm as minor in relation to subsequent episodes of self-harm, with her doing "a little cut." During this narrative, Sarah repeatedly stressed her view of the minimal nature of her DSH, stating that the self-harm injury was "little" and "it wasn't like serious" but then her self-harming subsequently worsened in comparison to this.

Later on, Sarah again emphasised how her trajectory of self-harm worsened with time: "Like when I first did it, like, I wasn't in a safe environment. Like I was just sat in my room, and it was getting worse and worse" (p. 4). In terms of giving a rationale for the escalation in DSH, Laura took this a step further by linking an increase in her self-harming to experiencing further trauma in her life:

As I got older and I had more, well trauma basically happened, the worse it got... And then it came to like, I was doing it every day, twice a day, three times a day like. Even when I was at school I'd just go to the toilets and do it. (Laura, p. 2)

Laura made a direct link between the severity of her self-harm and the trauma she experienced as she aged. Laura spoke candidly about the way her self-harming behaviour escalated from daily to multiple times a day. Laura reported engaging in self-harm at

school, with this behaviour emphasising her need to engage in DSH irrespective of the environment she was in at the time.

1.2 Comparisons to Substance Addiction

This sub-theme reflects the addictive nature in which two of the participants viewed their self-harming behaviours, with both individuals viewing their journey of living with problems related to DSH as being like those of learning to live with an addiction to substances.

Amy reported resorting to self-harm to survive a difficult period of her life:

I used to have a thing where you used to go like, write down how long, so I'd go like 20 days, a month, two months, three months and then when you start again it's like ohhh I might as well just carry on now. But it's harder not to self-harm, than it is to self-harm because it's so much easier to pick something up and self-harm. People don't realise, it's an easier thing to do . . . You've gotta [got to] fight that urge and you're trying to find something else to do to make you feel better. . . It's like drugs. It's like alcohol. (Amy, p. 6)

Amy described self-harm as a survival mechanism and compared this to some people using drugs and alcohol to survive, which, in her view, was another way to survive difficult life experiences. Amy spoke about trying to gradually increase the time periods in which she desisted from self-harming as a way of trying to stop, going from "20 days to three months" without self-harm. This emphasised the phased approach Amy used in trying to stop self-harm and highlighted the difficulty in just stopping completely.

Later on, Amy compared her trying to stop self-harming with an individual who drinks alcohol, trying not to drink:

You have to ride the urge out. So it's like a drink, if you feel like you need a drink, you have to do something to stop yourself from having a drink. To stop yourself from having a drink, you do something else. (Amy, p. 10)

Here, Amy described not acting on self-harm urges as "[riding] the urge out," suggesting that self-harming urges can be experienced as continuous for a specific time. She highlighted the importance of someone engaging in another activity to stop them from acting on urges to drink, just like someone must do something else to distract themselves from acting on self-harming urges. Amy went on to draw an equivalence between someone keeping something in the house that they could use to self-harm and an alcoholic keeping alcohol in the house:

Say I've got something here to hurt myself, even if I don't feel like hurting myself, that makes me feel like at least I've got something and I don't have to find it. . . Yeah a safety net. It's like having alcohol in the house. You're not going to drink it because you're an alcoholic but just in case you want it. It's there. (Amy, p. 13)

Given that, throughout her narrative, Amy highlighted several comparisons between self-harm and alcoholism, it was deemed reasonable to assume that Amy viewed DSH and her experiences in the context of an addictive behaviour.

Similarly, Lucy made a comparison between her stopping DSH to an alcoholic saying they would never drink again:

It's not like I'm gonna say I'm never gonna stop self-harming because that's like saying to an alcoholic "oh you're never gonna drink again" but well I suppose, eugh I don't really know to be honest. . . I know that sounds bad but in some ways I think it can be addictive. (Lucy, p. 3)

Like Amy, Lucy made a direct comparison between her experiences of stopping self-harm and an alcoholic abstaining from alcohol. Lucy clearly stated that she thought

self-harm could be addictive, although she sounded somewhat shameful about the fact that she viewed her experiences of self-harm within the framework of an addictive behaviour.

1.3 “You Learn to Live With it”

Four participants contributed to this sub-theme, which focused on the participants’ long-term struggles in continuing to experience DSH urges and trying not to act on them. This sub-theme highlighted how participants viewed self-harm as a long-term chronic problem around which they try to navigate their recovery. For instance, Amy talked about how self-harm would be a lifelong problem for her, but how she had learnt to better manage the DSH urges:

You learn to live with it. I might go years without self-harming but I’ll probably never be free from self-harm but I can try and live a normal life as much as I can without doing it. But I can’t say that I’ll never hurt myself ever again. But I’m gonna say I’ll try not to because there’s no point anymore, I don’t get the same thing out of it that I used to. (Amy, p. 6)

When giving this narrative, Amy sounded resigned to the fact that she would likely never be free from self-harm. She appeared hopeful that she could go for a prolonged amount of time without self-harming and seemed content with that. Towards the end of the interview, Amy described continuing to experience self-harm thoughts everyday but that she had developed ways to manage them:

I get thoughts everyday right, but it’s just the way you deal with them like. It’s the same as voices but they’re thoughts. Right but when you’re in a better place, you just try and ignore them, try and put the TV on and do things that, you do things that make you happy . . . but yeah there has been times and I’ve sat there and so badly wanted to hurt myself. (Amy, p. 12)

Amy divulged that she continued to experience daily self-harm thoughts, with them becoming overwhelming sometimes as she “so badly wanted to hurt myself.” However, she stressed the importance of being able to deal with them effectively. Amy attributed one’s mood and mental state to being more resilient to self-harm urges, stating “when you’re in a better place, you just try and ignore them.” When recalling incidents whereby she resisted the temptation to act on urges to DSH, she reported removing herself from the situation, distracting herself, and asking staff members to help her.

When being asked by the researcher to offer some advice to those wanting to stop self-harm, Lucy referred to the fact that DSH would be a lifelong problem:

I know it’s going to be hard to stop but try, try your best but in the end, you’re never gonna stop but try breathing skills or try find something that you’ll enjoy doing and if you enjoy it, stick to it. Just dunno just take each hour as it comes or take, each day by day, hour by hour don’t. . . and if you do end up doing it, don’t beat yourself up about it. (p. 5)

Lucy appeared comfortable with the notion that self-harm would continue to be a problem throughout one’s life and emphasised self-compassion when trying to stop self-harming but being unable to. She gave the advice of finding something enjoyable to do when trying to cease self-harm, as well as viewing the recovery process in a graded fashion, similarly to Amy.

Laura spoke about her experiences of self-harm and that she has experienced it as addictive:

I would say that when I was a young teenager at about 13, I was like addicted to it then. But then when I stopped when I was like 16 ermmm. I don’t even know why I stopped for a few months, it just happened. . . and every time I resorted back to it. (Laura, p. 3)

Laura highlighted the fact that she was able to stop self-harming for several months at the age of sixteen, but voiced that she always comes back to resorting to self-harm. Despite being a frequent self-harmer at the time of being interviewed, Laura spoke about being addicted to self-harm in the past tense, suggesting that she no longer experienced self-harm as an addictive behaviour. In using the term 'addictive' in this narrative, Laura was not making explicit reference to comparisons to substance abuse (see the sub-theme regarding *Comparisons to substance addiction*), however, Laura was perhaps using this term to describe the strength of the urges she had.

Sarah spoke about continuing to experience self-harm urges, although they were not as often or as strong as they used to be:

I used to like bang my head quite a lot and I'd like burn my hands with cigarettes. I used to also punch myself in the face but at the minute with my new medication, I'm feeling a bit more stable. I have less self-harm urges. I still get them but just not as often and as strong as I used to. (Sarah, p. 1)

Here, Sarah reflects on the varying methods she previously used as a form of self-harm; however, she reports feeling more stable due to the medication she was prescribed. Despite reportedly feeling more stable, she reports that she continues to experience self-harm urges, although reduced in terms of frequency and intensity. Again, this reflects the long-term nature of dealing with self-harm urges.

Theme 2: Reasons why I self-harm

This theme encompassed the intrinsic and intrapersonal functions of DSH described by all participants. Four sub-themes emerged within this: *When emotions get too much*; *To punish myself*; *To feel in control*; and *To feel something*.

2.1 When Emotions get too much

This sub-theme captured the role that self-harm played in the alleviation of overwhelming, intense, and unwanted emotions for three of the participants. When asked about reasons why Amy thought she engaged in DSH, she explained that it was a response to unwanted emotions:

That's how I used to deal with my emotions, or anger. I never got into trouble, I never got into, I'd never had a fight, I never got into a disagreement, I just hurt myself. I disliked myself a lot so. . . I'd felt like I'd been abandoned and I'd lived a different life from my sisters and that so I felt very. . . I felt rejected. (Amy, p. 4)

Amy explained how she never became involved in fights or disagreements with others due to being unable to appropriately deal with her emotions. Instead, she suggested that she would redirect the emotional turmoil she was experiencing towards herself, which led to self-inflicted injury. She linked this to disliking herself "a lot" and understood this in the context of feeling abandoned and rejected, due to her being placed in care whilst her sisters were able to live with their father.

Amy went on to give another example of self-harming in response to unpleasant emotions:

I did it because I think I got scared. All my emotions were coming back. . . I did a bit of my psychology and it was getting too real. . . I'd had some information about my past and I was just learning how to read it, I was just going over it and over it. (Amy, p. 5)

Amy described self-harming in response to fear, because of engaging in in-depth psychotherapy related to her past. The way Amy referred to the piece of psychology work being "really bad" might have reflected the intense and negative emotions which Amy experienced in response to the therapy. The way she stated she had "just had

enough” portrayed the distress she was experiencing in response to feeling emotionally overwhelmed, with this triggering periods of self-harm behaviour.

Laura spoke about self-harming in response to feeling anger: “When I’m angry, yeah it’s helpful, because it can bring me back down to normality just from self-harming, cutting mainly” (Laura, p. 9). Here, Laura speaks about self-harm as a beneficial coping strategy, stating that she found it helpful as it could ground her quickly.

When speaking about her experiences of DSH, Lucy spoke of it giving a sense of release from unwanted emotions:

It made me feel better when I self-harmed. . . Just relieving pressure and anxiety and stress and upset. . . I didn’t know anything different at the time. So that was my only, ermmmm like, sort of like release at the time. (Lucy, p. 1)

I feel a release. I feel like everything just off my shoulders. . . I know this sounds bad but when I see blood it feels, it makes me feel a lot better. . . It makes me relieved and that everything feels better. (Lucy, p. 5)

When describing her self-harm experiences, Lucy described experiencing a sense of relief and release, using both past and present tenses when speaking. This suggests that not only was the release of emotions a historical function of self-harm, but that it continues to perpetuate her use of DSH currently. She referred to not knowing anything different at the time of the onset of self-harm, and DSH being her only way of releasing the emotions she felt, suggesting that she was engaging in self-harm due to an absence of other coping strategies.

2.2 To Punish Myself

This second sub-theme captures the five participants’ need to punish themselves in response to different factors. This sub-theme portrays the relationship between the abuse and stressors the participants experienced in childhood, and how this led to participants believing they had “done something wrong” (e.g., Laura, p. 4), and therefore needed to punish themselves.

Laura reported that the function of self-harm has “been more for like self-punishment, than the actual pain of it” (Laura, p. 3). She went on to give more context to this realisation:

I had a lot of trauma through childhood, teenage years and like when I first turned 18. Errmmm staying at people’s houses on a weekend until like, party all weekend coz if not I’d literally be home, otherwise I’d have nowhere to stay. Like I still went to work, still went to college, I still did everything like that like. . . Yeah I managed to keep all that up and I was basically just self-medicating with drugs and alcohol and sex. And then I was in like an abusive situation. . . It was my drug dealer, so it just went tits up [i.e., things deteriorated quickly] from there, he got me like around quite a lot of bad people and things happened and I just didn’t see it until recently, but I just always thought it was like my fault, like I’d done something wrong. So, like I was just punishing myself. (Laura, p. 4)

Laura’s narrative reflects the chaotic and abusive lifestyle she endured during her peak self-harm period. She reported trauma throughout her development and described being in an abusive situation at 18 with a “friend with benefits,” which compounded her distress. Until recently, she believed the abuse was her fault, leading her to self-punish through self-harm. Her use of the past tense suggests she no longer self-harms for this reason.

Similarly, Sophia spoke about how she engaged in self-harm in response to feeling the need to be punished:

So, before I self-harm, everything is going really, really, fast and I have a lot of internal pain and then during self-harm, I feel like everything has stopped and the pain has stopped, the punishment has stopped when I've done it and I don't need to be punished anymore. (Sophia, p. 6)

Here, Sophia speaks of the self-harm as a punishment, and that once she had self-harmed, she "[didn't] need to be punished anymore." For Sophia, this narrative also linked to the sub-theme *When emotions get too much*, as she spoke about self-harming in response to "a lot of internal pain." It appears that Sophia's negative self-talk linked to her belief that she needed to be punished, and that therefore she needed to carry that action out herself. Sophia's account highlights the erratic nature of her mental state prior to DSH and how this was in stark contrast to how she felt following the self-harm, and once she believed the "punishment has stopped" and things seemed to have become somewhat calmer. Earlier on in the interview, Sophia directly linked her need to punish herself to the trauma she had endured, as she stated it was "obviously the childhood abuse, making me feel like I needed to be punished and that's what I deserved" (Sophia, p. 2). In this context, Sophia portrayed her self-harm as like a compulsion to re-enact the abuse she suffered and to re-victimise herself, as this was what she inherently believed she deserved at the time.

Sarah explained how she self-harmed as "... sometimes I thought I was a bad person and I deserved to do it but other than that I don't really know why I did it" (Sarah, p. 2). Like Sophia, Sarah believed she deserved to be hurt due to her negative self-perceptions, even if she had to inflict it herself. She expressed confusion about the function of her self-harm but, in hindsight, identified self-punishment as the only explanation for her behaviour.

Jade went one step further in her narrative, detailing specific situations which increased her need to engage in DSH as a form of self-punishment:

I don't know why I, yeah, I just did it but errmmm also I used it [DSH] as like a punishment, like if I'd thought I'd eating too much, or if I didn't like myself I'd kind of punish myself, so I used it as kind of like a punishment. (Jade, p. 1)

Here, Jade speaks about the complex relationship between her disordered eating and self-harm, both of which seemed to be in response to her negative self-image and stress from school. She reported self-harming as a punishment for eating what she perceived to be too much or if she did not like herself in any way. It appears that, at this point in her life, Jade was highly self-critical and had low self-esteem, with these characteristics likely having maintained her problem with DSH.

Amy also highlighted the link between negative self-image and the need to harm herself by saying "If I'd got upset, I'd hurt myself ... I would take it out on me. If you were horrible to me, I'd go back to wherever I was and hurt myself" (Amy, p. 3). Here, Amy reflects on the process whereby when others were unkind to her, she reinforced this further by hurting herself and punishing herself for other people's behaviour.

2.3 To Feel in Control

This sub-theme captures the role self-harm played in the participants' attempts to feel some form of power/control at a point in their lives where they felt they had little power/control elsewhere. Two participants contributed to this sub-theme. Sophia described the following:

I think with self-harm that was supposed to be secret but it was where I was both the perpetrator and the victim. So it gave me control to know that no-one else has to hurt me, I can hurt me and I don't have to let anyone else hurt me. (Sophia, p. 3)

This illustrates the role of secrecy which is pertinent to both the trauma she survived and her engagement in self-harm. She reflected on self-harm as a way of her inflicting the

abuse on herself, so that no-one else would have the power to hurt her, as she was already doing it to herself. The way in which she referred to herself as both “the perpetrator and the victim” suggests that she viewed self-harm as abuse in itself. She further reinforced this idea by explaining the function of self-harm as “power probably... knowing I can do something to my body that’s harmful but it’s me that’s doing it” (Sophia p. 2). Again, this emphasises the fact that Sophia engaged in DSH as a way of taking power away from the abuser, choosing to harm her body in a way that she had control over.

Jade voiced a similar perspective on the relationship between control, abuse and self-harm:

Sometimes I used it as like, a way of like, control like, if that was the only control I had in my life if you know what I mean and like hurting myself, and, and it made me feel like I had power so like even if like other people hurt me, I know that I can always hurt myself more. Do you know what I mean [i.e., can you relate or understand what I’m saying?] so like I had the power... Whereas like when other people hurt you, you’re not, you don’t have power over that. (p. 1)

Jade stated that no matter how much other people hurt her, it made her feel powerful to think that she could always hurt herself more. There appeared to be an element of finding the uncertainty of others hurting her daunting and therefore, she would take control of this by hurting herself anyway, so that, if others were to hurt her, it would have less of an impact. She reiterated this point later in the interview by stating “I know that if I’m like self-harming I’ve got the power. Do you know what I mean? I know that sounds a bit weird... Yeah so like, I’ve got more power than anyone, because I can hurt myself as much as I want” (Jade, p. 6). Here the researcher understood this statement as if anyone was to hurt Jade, physically or emotionally, she ultimately took some form of solace in the fact that she had the power to always hurt herself more.

2.4 To Feel Something

This sub-theme portrays the way in which not feeling anything and experiencing a certain “numbness” (e.g., Amy, p. 11) can also trigger episodes of self-harm. Three participants contributed towards this sub-theme.

Laura reflected on how she began self-harming as a desperate bid to start feeling something:

I first started self-harming when I was like 10 and I think it was because I was like, I was quite numb. And I didn’t feel anything and I can remember like whacking my arm on the door and like scratching all across my arm. I had this urge to actually feel something so after this I just like started cutting myself. (Laura, p. 1)

Laura reported feeling numb from a very young age and having an urge to actually feel something. It appears that, in response to not feeling anything emotionally, she would try to change this by inflicting physical pain on herself. Laura went on to explain that she still felt numb, even when self-harming, and that this could lead to her inflicting injuries, which she could not feel:

I can do like head banging for instance to get something out of my head. And I’ll just keep getting worse and worse coz like I can’t feel the pain. So you just do it harder and it like gradually, you just don’t feel the pain... Always I just feel numb. I can just like cut my arm open and like stare at it pouring with blood and I’m not even feeling it. (Laura, p. 6)

This description also linked to the sub-theme *Self-harm just got worse*, which lies within the GET: *Journey of self-harm*. Laura described how, because of the lack of pain she felt during self-harm, and the desire to feel something, her self-harm escalated. She reported being able to observe the damage she was doing to her body whilst being physically

disconnected from the pain and injury, illustrating the detachment Laura felt between her mind and body at the time.

Amy spoke about how the onset of depression led her to feel devoid of any emotion and an inability to feel the self-harm she engaged in:

When I was so bad in depression, I went and had my first breakdown, and I couldn't feel anything. I used to hurt myself and not even feel anything. I was I, I, I'd cut myself and I'd not even know that I was bleeding or whatever. I'd just do things and not have, depends how far you are in your depression. . . The beginning of your depression, I'd say, when you're really, really bad, you don't feel anything. You don't even know what sort of, what is going on. It's like adrenaline, that you have and you hurt yourself and you don't know you've done it really. I wouldn't even know there's a wound there. (Amy, p. 12)

Amy highlighted how depression stopped her from feeling anything, and like Laura, she would injure herself without being aware of this. Amy's account seemed somewhat more extreme than Laura's in the sense that she would not know she had self-harmed or inflicted a wound, rather than just seeing it visually but not feeling it physically. Amy elaborated on this point further by saying:

Sometimes, it's hard to describe but sometimes I'd feel numb and I used to feel like I was dead inside. . . And sometimes I used to hurt myself just to feel something and if I could feel it then I know I'm still alive basically . . . Like I used to stab myself and stuff just to feel something. I never felt something. (Amy, p. 11)

Amy went on to describe the complete disconnect she felt between herself and her experiences at the time, with her feeling as if she "was just floating through life." Interestingly, she described her numbness to the extent of feeling "dead inside," and that she would hurt herself to see if she could feel it to confirm that she was alive.

Jade described a slightly different relationship between feeling numb and self-harm:

I'm totally full so full I feel like I could burst so that's why I want to self-harm to get it out or I'm completely numb, I can't feel anything and I want to feel something, want to feel something physically coz I can't. (Jade, p. 7)

Here, Jade spoke about the 'all or nothing' experiences she encountered when it came to emotions. She reflected on the fact that she engaged in DSH when she felt too overwhelmed, on the one hand, to alleviate the emotions, or on the other hand, to feel something physically, when she felt completely numb.

Theme 3: Relationships and Self-Harm

All participants contributed to this theme, highlighting how negative relational experiences and lack of support influenced their self-harm journey, while positive support played a crucial role in their recovery. This theme comprised two sub-themes: *Negative relational experiences*; and *The importance of relationships in stopping self-harm*.

3.1 Negative Relational Experiences

This sub-theme captures the impact which negative relational experiences had on the participants' engagement in self-harm, particularly the onset of it. Amy spoke about how being regularly moved around placements led to her engaging in DSH as a way of coping:

I was in care and I was just moving from place to place. . . I'd moved in a year to about 12 different places, from a week, to a couple of days, to about 6 months. . . And I just couldn't hack it and that was like my way of just like releasing something and I'd wonder, I used to get upset and wonder why people couldn't cope with me. (Amy, p. 2)

Amy attributed the frequent change in care givers to internalising a belief that others could not cope with her, and that she must have been the root of the problem. This negative view of herself likely maintained her difficulties with self-harm. When asked about anything which may have helped her with her self-harm struggles at the time, she explained:

Maybe I could have tried to speak to the staff but we had different staff like here, and I was in a kid's home. So often there were such different ones that you didn't know the person. . . You might like that person, which I might talk to, but they might not be here the next day. (Amy, p. 5)

For Amy, it appeared she only felt comfortable talking to people she liked and reported that the staff members changed too frequently for her to build a rapport with them. Similarly, Sarah spoke about her experiences of being placed into foster care as a significant event which led to her engaging in self-harm:

Because when I was younger I got moved into foster care. . . I think it really started when I was about 13, because I was getting bullied at school and then I was just feeling really rubbish. I knew it wasn't normal but I just didn't like tell anyone. (Sarah, p. 1)

Sarah talked about the impact that being placed into foster care, coupled with being bullied at school, led to her feeling "rubbish" and engaging in self-harm. Likewise, Jade reflected on how being bullied at school had, along with a perceived lack of support at home, contributed to the onset of self-harm:

My aunty died from cancer and my mum was quite like, I wouldn't say she was depressed but obviously that was her sister so like she was. . . Grieving so I never felt like I, and I didn't have a good relationship with my mum at the time. . . And I think like I got picked on a lot at school and then I went, got put under a lot of pressure for my GCSEs [General Certificate of Secondary Education] and stuff and school work. I know that sounds a bit silly. (Jade, p. 2)

Jade attributed her self-harm to being bullied at school and feeling pressured during her GCSEs. She described a distant relationship with her mother, feeling unable to confide in her for fear of being a burden. She also minimised her experiences, expressing embarrassment about the factors leading to her self-harm, saying, "I know that sounds a bit silly".

Lucy also spoke about how the way she was treated by other people from a young age contributed to her engaging in DSH: ". . . because something happened to me when I was younger as well, bullying and then just not like being accepted in society, ermm being gay and things like that. People would just like take the piss" (Lucy, p. 4). Lucy reported how she viewed being bullied, not feeling accepted by others, and her sexuality, as contributing factors to problems with DSH. Although she was vague when stating "something happened to me when I was younger," it was presumed by the researcher that she was referring to her experiences of childhood sexual abuse, which were documented in her clinical notes. This highlighted the multifaceted nature of Lucy's self-harm.

Laura spoke about how being exposed to domestic violence and feeling invalidated were two factors which contributed to the start of self-harm: "I witnessed a lot of domestic abuse in the family and aggression. . . and obviously not very [pause] people didn't like validate my feelings as such. I'd say" (Laura, p. 1). Similarly, Sophia explained in her interview that a healthy childhood may have prevented her from engaging in DSH:

I had a healthy childhood, I know no-ones is perfect but I feel if I had a childhood where it was validating, reassuring, I could open up, there were no judgements, they wanted me to be healthy rather than perfect. (Sophia, p. 4)

By Sophia referring to a childhood which may have prevented her from engaging in self-harm, it was presumed that she was raised in an environment opposite to this. She highlighted the importance of being able to open up, feel validated, reassured and not feeling judged as key principles of a healthy childhood.

3.2 *The importance of relationships in stopping self-harm*

The second sub-theme captures the way in which positive relationships were viewed as being pivotal in trying to stop engaging in DSH, with four participants contributing to this sub-theme. Relationships mentioned included those with peers, professionals, family, and romantic relationships.

Amy talked about the importance of peer relationships in the hospital, and she viewed them as having a positive impact on her stopping self-harm:

I've made it this far because of the patients in this ward as well. People, we've helped each other, me and [name of service user], we've helped each other so much together, there's other people, me and [name of another service user], we went through it together, we've come through it together, because the staff yeah, are there to help us but what sometimes people think that it's bad, it is bad sometimes that patients help each other, but what they don't realise is, we've been through that same thing, right so I can probably help somebody, as long as I'm not encouraging them to hurt themselves, I can help that person better than a member of staff can. . . I know what they're going through. (Amy, p. 7)

Amy described how she and a peer supported each other during her hospital admission, believing they both benefited from the relationship. She found this peer connection more helpful than staff relationships in preventing self-harm, as they shared a mutual understanding of their experiences. She went on to describe a romantic relationship she developed with a peer in the same hospital:

I've found proper love in a hospital, where you wouldn't think so. But I, I have, all it is, in our minds our relationship is the same as anybody else's, right, so that's helped me love myself. . . Yeah and like acceptance of myself. (Amy, p. 8)

Here, Amy reflects on the significance that feeling accepted within a relationship has had in terms of improving her view of herself. Amy's emphasis that her relationship 'is the same as anybody else's' suggested she felt others might question its validity, possibly due to stigma around relationships between mental health patients. She may have perceived her relationship as being viewed as less legitimate.

Sarah discussed the positive impact that building relationships with hospital staff and peers has had on trying to stop self-harm:

Since I've been in hospital I've learnt like little skills and built relationships with like peers and the staff. And like I didn't really have many friends when I was younger so it's a lot more easy and things here." (Sarah, p. 4)

Here, Sarah reflects on the contrast between forming relationships with staff and peers in hospital, and the lack of friends she had when she was younger. It is likely that having the experience of developing positive relationships with others made her feel more accepted by others and reduced the need to self-harm in response to feeling bullied or lonely.

When asked about factors that reduced her self-harm, Sophia emphasised the importance of being around family and friends, stating, "The people I'm with. I'd probably say that's the main thing" (Sophia, p. 11). She reflected on the trauma her self-harm had caused both herself and her family, suggesting that the fear of inflicting further psychological harm on them acted as a deterrent. Her strong relationships with family enabled her to consider the wider impact of her actions.

Similarly, Laura described being around family and friends as a factor that reduced her self-harm, saying, “Probably being around my nephews and my family . . . being around friends. Going out and like, I dunno, grabbing food with a friend or going shopping” (Laura, p. 10). She appeared to view social interactions and activities as helpful distractions.

The overarching narrative of participants in this sub-theme was the importance of relationships. Specifically, this was having someone with similar experiences who participant’s felt understood by, having support from people whom they had a strong attachment with, or having relationships with people who they did not want to have a negative impact on.

4. Discussion

The GETs and sub-themes outline a trajectory of self-harm, covering its onset, factors influencing engagement, and experiences of recovery in hospital. Given this structure, addressing the research questions individually was considered more appropriate.

How do hospitalised women with a history of childhood abuse make sense of their experiences of self-harm?

In *The journey of self-harm* GET, participants discussed their personal self-harm journeys, highlighting long-term struggles, increasing severity, and challenges in stopping. While they did not explicitly reference biological factors, their experiences align with the biopsychosocial model (Paris, 2020), as they described significant psychological and social difficulties. Additionally, all had diagnoses of personality or trauma-related disorders, suggesting a biological element to their experiences.

The first sub-theme, *Self-harm just got worse*, highlights the escalating nature of three participants’ engagement in self-harm. They described initially engaging in what they perceived as minor self-harm, but, over time, their behaviours worsened in frequency and severity, becoming increasingly uncontrollable. Jade attributed this escalation to building a tolerance—needing to self-harm more to achieve the same initial relief. Laura linked the severity of her self-harm directly to the trauma she experienced as she aged. These findings are similar to those of Rouski et al. (2021), who found that adolescents in residential care did not anticipate how self-harm would escalate, later feeling unable to stop using it as a coping mechanism.

The second sub-theme, *Comparisons to substance addiction*, builds on this idea, highlighting how some participants framed their self-harm as an addiction. Two participants directly compared self-harm to substance misuse. Amy described resisting self-harm urges as similar to an alcoholic avoiding alcohol, stating, “you have to ride the urge out.” This reflects urge surfing, a distress tolerance technique used in substance misuse treatment (Dharmadhikari & Sinha, 2015; Shonin & Van Gordon, 2016). Lucy made a similar comparison, likening her saying that she would never self-harm again to an alcoholic pledging to never drink again.

These comparisons align with neurochemical evidence suggesting a biological basis for self-harm. Injury triggers the release of endorphins and endogenous opioids, which act as natural painkillers and enhance well-being (Stanley, 2010). Research shows that individuals with a history of repeated self-harm tend to have naturally lower levels of endogenous opioids (Sher & Stanley, 2008, 2009), which may be linked to childhood trauma and genetic predisposition (Stanley, 2010). This could explain why individuals engage in self-harm during stress—to increase opioid levels and self-soothe—contributing to its cyclic and seemingly addictive nature. While this framing resonates with some participants’ lived experiences and is supported by neurobiological findings, it is important to consider the broader theoretical and clinical debates around conceptualising self-harm as an addiction.

Theoretical literature often conceptualises self-harm as a behavioural addiction, but empirical research remains limited (Victor et al., 2012). Victor et al. (2012) found that, unlike

substance misuse, which is maintained by both positive and negative reinforcement, self-harm appears to be driven primarily by negative reinforcement. Some studies suggest that the emotional state and physical urges before self-harm resemble withdrawal symptoms in substance addiction (Faye, 1995; Washburn et al., 2010). Nixon et al. (2002) developed a self-harm dependence scale based on DSM-IV substance dependence criteria (American Psychiatric Association [APA], 1994), finding that approximately 80% of participants met five or more criteria. A literature review by Blasco-Fontecilla et al. (2016) concluded that self-harm is best understood as an addictive behaviour, recommending that treatment approaches account for this similarity.

While several participants described their self-harm as feeling “addictive,” it is important to critically engage with the broader debate surrounding this framing. Blasco-Fontecilla et al. (2016) propose that non-suicidal self-injury (NSSI) can, in some cases, be conceptualised as a behavioural addiction, citing similarities in compulsivity, neurobiological mechanisms, and cycles of relapse. This view supports the idea that addiction-informed interventions—such as craving management or urge surfing—may be helpful for certain individuals. However, other researchers, such as Victor et al. (2012), caution against applying addiction models too broadly. Their empirical findings suggest that, unlike substance use, NSSI is predominantly driven by negative reinforcement (i.e., alleviating distress) and not characterised by the same patterns of craving or compulsive pursuit seen in addiction. From a clinical perspective, framing self-harm as an addiction may resonate with individuals who experience it in this way, but it must be employed carefully to avoid pathologising adaptive coping mechanisms or overlooking trauma-related emotional regulation needs. Furthermore, adopting an addiction framework risks over-medicalising self-harm and framing it in deterministic terms, potentially obscuring the agency and contextual meaning behind individuals’ actions. It is important that such models are not used in a reductive way that sidelines social, relational, and developmental contributors to distress. A flexible, individualised approach is therefore recommended, with theoretical framing guided by the person’s own narrative.

These findings also lend themselves to interpretation through broader developmental and psychodynamic frameworks. Fonagy and Target’s (1997) mentalization theory suggests that early trauma can impair an individual’s ability to understand and regulate their internal states, leading to difficulties in processing emotions and relationships. This perspective may help explain why participants described self-harm as a way of making emotions tangible or regaining control.

Similarly, Linehan’s (1993) biosocial model of borderline personality disorder, which underpins dialectical behaviour therapy (DBT), offers a useful lens. It conceptualises self-harm as an emotionally dysregulated response shaped by biological sensitivity and invalidating early environments. Several participants’ narratives align with this view, especially those who cited interpersonal invalidation and emotional overwhelm as key triggers. Integrating such frameworks into clinical practice supports the development of interventions that validate emotional experience while fostering alternative regulation strategies.

What factors affect their engagement in self-harming behaviours, particularly what has caused them to self-harm on some occasions but not others?

The GET, *Reason why I self-harm*, captures the factors participants identified as increasing their likelihood of self-harming. This theme includes four sub-themes: *When emotions get too much*; *To punish myself*; *To feel in control*; and *To feel something*.

The sub-theme, *When emotions get too much*, reflects how three participants used self-harm to manage overwhelming emotions. Given that four participants had a diagnosis of EUPD, where emotion dysregulation is a key feature (American Psychiatric Association

[APA], 2013), this finding is unsurprising. A meta-analysis of 49 studies found a significant association between emotion dysregulation and DSH (Wolff et al., 2019). Similarly, Selenius and Strand (2017) found that women in forensic psychiatric care self-harmed in response to intense emotions such as sadness, hopelessness, anger, and anxiety.

The second sub-theme, *To punish myself*, illustrates how five participants linked self-harm to past abuse and self-punishment. Laura and Sophia felt they deserved punishment due to their experiences of abuse. Sarah attributed self-harm to negative self-perceptions, believing she was "a bad person," while Jade engaged in self-harm due to self-hatred. Amy self-harmed in response to cruelty from others. These findings align with Stănicke (2021), whose qualitative study with adolescent girls in Norway identified a theme, the punished self—I deserve it, where participants described using self-harm as a means of self-directed punishment.

Two participants contributed to the third sub-theme, *To feel in control*, describing self-harm as a way of reclaiming control when they felt powerless. Sophia and Jade viewed self-harm as inflicting harm on themselves before anyone else could. Baker et al. (2013) similarly found that women in a medium-secure unit described self-harm as a means of regaining control, particularly when feeling controlled by others.

The final sub-theme, *To feel something*, was reported by three participants, who self-harmed in response to chronic feelings of "emptiness" and "numbness." Given all participants had experienced childhood sexual trauma, it is likely they also experienced dissociation. This is supported by a meta-analysis by Vonderlin et al. (2018), which found higher levels of dissociation in individuals with a history of childhood abuse, with the highest levels associated with CSA. This could explain why participants described self-harming to "try and feel something."

In terms of factors that helped reduce self-harm, the GET regarding relationships and self-harm and the sub-theme regarding the importance of relationships in stopping self-harm highlight the role of social support. Four participants described how relationships helped them resist self-harm urges. Amy reported that forming relationships with peers in hospital, including a romantic relationship, improved her self-acceptance and reduced self-harm. This aligns with research showing that increased self-esteem improves mental well-being (Gilbert & Irons, 2005), and social support enhances self-esteem (Harris & Orth, 2020). Additionally, self-esteem and social support have been found to protect against adolescent mental health problems (Liu et al., 2021). Sarah, Sophia, and Laura similarly identified relationships with family and friends as protective factors. These findings mirror those of Caulfield (2014), who found that individuals receiving mental health support viewed personal relationships as key protective factors against self-harm.

4.1. Methodological Strengths and Limitations

As with all qualitative research, the findings of this study are not intended to be generalisable. This is further limited by the small sample size and the focus on a highly specific group—hospitalised women with a history of childhood abuse. While this reduces broader applicability, the data provided rich, personal insights relevant to clinical work with this population (Caulfield, 2014). IPA aims to explore the experiences of a small, homogenous group rather than produce widely generalisable findings. In line with IPA principles, efforts were made to recruit a homogenous sample (Smith et al., 2009), with all participants being young, white British adults with a history of childhood sexual trauma. However, individual differences in life experiences and upbringing inevitably existed.

It is of note that all six participants were young, white British women, however, it is important to acknowledge that while homogeneity was sought in terms of clinical and experiential factors (e.g., history of self-harm, inpatient status, and childhood abuse), the

resulting demographic profile was not an intentional inclusion criterion with respect to ethnicity. No participants were excluded based on racial or ethnic background; rather, the sample composition reflected the demographic profile of those who volunteered and met the inclusion criteria within the specific recruitment setting. This lack of diversity does, however, limit the inclusivity and generalisability of the findings. It is possible that individuals from different racial, cultural, or gender identities may experience and interpret self-harm differently, particularly given the intersection of trauma with social and systemic factors such as discrimination or marginalisation. Future research should seek to purposefully include a more diverse sample to examine how these intersecting factors may influence self-harm experiences and recovery trajectories. A more nuanced understanding across different demographic groups would strengthen the applicability of findings to a broader range of clinical contexts.

Researcher interpretation is a fundamental aspect of IPA, meaning that findings may be subject to interpretive bias (Smith et al., 2009). The lead researcher, a British female with no history of adverse childhood experiences or self-harm, may have influenced data interpretation. However, steps were taken to minimise bias, including academic supervision, maintaining a reflective diary, and writing a reflexivity statement.

It is of note that, while IPA was well-suited to exploring the nuanced lived experiences of a small, homogenous sample, it does have inherent limitations. Its idiographic and interpretative focus prioritises depth over breadth and therefore does not aim for generalisability. This limits the extent to which findings can speak to broader systemic issues or capture the full complexity of structural influences, such as institutional power dynamics in forensic settings.

Lastly, the study did not incorporate triangulation or participant validation. Given the sensitive nature of the topic and participants' detained status, we made a deliberate decision not to return transcripts for verification to avoid placing additional emotional or cognitive burden on participants. While this limits opportunities for co-construction and confirmation of meaning, credibility was supported through reflexive journaling, supervision, and detailed interpretative engagement with the data. We acknowledge that incorporating participant or stakeholder validation in future work could strengthen data robustness and support a more collaborative approach.

4.2. Implications for Clinical Practice and Suggestions for Further Research

A better understanding of self-harm in hospitalised women, as provided by the current study, can inform risk assessment and management, leading to more person-centred hospital interventions and policies, as well as improved community-based programmes. The findings also highlight the importance of trauma-informed care (TIC), as participants frequently linked their self-harm to childhood trauma. Two core principles of TIC are empowerment and collaboration in service users' care pathways (Office for Health Improvement & Disparities, 2022). Women with trauma histories often lack control over their lives, so actively involving them in treatment decisions is essential (Wilson et al., 2015). This could include offering various trauma-informed interventions, allowing individuals to make informed choices about their care. In forensic inpatient settings, trauma-informed approaches have been applied through modifications to both clinical practice and the care environment. For example, some UK services have introduced trauma-informed formulation meetings, where staff and service users collaboratively explore how past trauma may relate to current behaviours, including self-harm (Nikopaschos et al., 2023). Group-based interventions adapted for secure settings—such as the Self-Regulation Programme or versions of the Trauma Recovery and Empowerment Model—have also been used to support emotional regulation and enhance safety (Fallot & Harris, 2002). These interven-

tions emphasise collaboration, empowerment, and an understanding of trauma's impact within the constraints of secure care, helping to reduce the risk of re-traumatisation and promote recovery.

Evidence-based treatments that reduce PTSD and related symptoms include mindfulness (Kelly & Garland, 2016), the Trauma Recovery and Empowerment Model (Masin-Moyer et al., 2020), cognitive behaviour therapy (Wieferink et al., 2017), cognitive processing therapy (Asmundson et al., 2019), and eye-movement desensitisation and reprocessing (Wilson et al., 2015).

Findings also suggest that conceptualising self-harm within an addiction framework may be beneficial. This approach could validate the intense and compulsive urges associated with chronic self-harm, making it more relatable to those who engage in it. Recognising self-harm as an addictive behaviour may also inform more effective treatment approaches, particularly for individuals with a history of childhood abuse.

Understanding the factors influencing self-harm in vulnerable populations, such as hospitalised women with ACEs, is crucial. This group is at risk of severe, repeated self-harm, with a strong link between DSH, accidental death, and suicide. While research on risk factors for self-harm has grown, there remains a significant gap in understanding protective factors. Future studies should explore what prevents individuals with ACEs from engaging in self-harm and what supports them in stopping.

Finally, this study focused exclusively on white British women. Future research should explore self-harm in men and individuals of other genders, as well as in individuals from different cultural and ethnic backgrounds. Experiences of self-harm may differ across demographic groups, and greater diversity in research is needed to ensure that findings are inclusive and applicable to a broader population.

5. Conclusions

The findings highlight the role of emotion dysregulation, a need for control, self-punishment, and chronic numbness in maintaining self-harm among hospitalised women with a history of childhood abuse. These results align with previous research linking self-harm to emotion dysregulation (Wolff et al., 2019), self-punishment (Stänicke, 2021), and dissociative experiences (Vonderlin et al., 2018). The study also underscores the impact of negative relational experiences on the onset of self-harm and the protective role of social support. While research on protective factors is limited, these findings are consistent with studies highlighting the role of personal and social support in self-harm desistance (Rotolone & Martin, 2012).

Additionally, the results reveal the long-term, escalating nature of self-harm and how individuals may perceive it as an addictive behaviour. This has important implications for intervention strategies, particularly for women with ACEs, as clinicians may need to conceptualise self-harm within an addiction framework (Blasco-Fontecilla et al., 2016). Hospitalised women with childhood abuse histories may have distinct clinical and treatment needs compared with those without such experiences. Given the high-risk nature of this population and the prevalence of DSH and childhood trauma in women's inpatient services, understanding their lived experiences remains crucial.

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