Harming Oneself and Harming Others: Young People's Experiences Coping with Difficult Emotions

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Abstract

It is well established that a key function of self-injury is managing difficult or uncomfortable emotions. Interestingly, emotion regulation is also a key function of aggression. Despite this and other apparent similarities in risk and protective factors, these behaviours have never been compared at length. The current research aimed to fill this gap by exploring to what extent self-injury and outward-directed-injury were ways of dealing with the same issues, especially managing negative emotions. Twelve semi-structured interviews were conducted with participants aged between 18 and 35 years old. Reflexive thematic analysis was used to analyse the data and develop seven themes. Although this research initially set out to explore injury specifically, many of the experiences described by participants did not involve physical injury but were still harmful to themself or others. Accordingly, the findings of this study focus more broadly on harm. The themes outline the self-harm and outward-directed-harm engaged in by the participants, as well as shared risk and protective factors. Factors that influenced participants' engagement in self-harm and outward-directed-harm included adverse life challenges such as mental illness, trauma, low self-worth or nonconformity to social norms; their friends and family; a difficulty in differentiating emotions; an indifference for personal safety; and a lack of support services and mental health education in New Zealand. This exploratory study gives insight into twelve young people's experiences using self-harm and outward-directed-harm to cope with their difficult emotions. These insights contribute to an area of research that is lacking whilst also highlighting the need for further research comparing these distinct but related behaviours.

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Chapter One: Introduction

In recent decades, self-injury has become an issue of growing concern among clinicians and researchers as the prevalence seems to have increased both in New Zealand and globally. Self-injury, also known as self-harm, refers to any behaviour in which an individual chooses to deliberately injure or harm themselves (International Society for the Study of Self-Injury, n.d.). Recent research (e.g., Fitzgerald & Curtis, 2017; Kimbrel et al., 2018; Mann et al., 2022) suggests that self-injury can take different forms, with some directly harming themselves via methods such as cutting and scratching, and some indirectly harming themselves via more outward directed methods such as punching a wall or instigating a fight. Although outward-directed-injury involves behaviour in which an individual chooses to deliberately injure or harm someone or something else; it seems that counterintuitively, this behaviour may also be a form of self-injury.

Despite this apparent similarity, most of the existing research conceptualises self-injury and outward-directed-injury very differently, presenting them as distinct. Self-injury has become synonymous with psychological disorders, such as depression and anxiety, as well as suicidality (Bentley et al. 2015; Briere & Gil, 1998; Gratz et al., 2015; Griep & MacKinnon, 2020; Klonsky et al., 2014; Nock & Favazza 2009; St. Germain & Hooley, 2012). As a result, those who engage in self-injury are viewed generally as being unwell or upset. Alternatively, outward-directed-injury is often associated with antisocial behaviour and criminality (Garofalo & Velotti, 2017; Shafti et al., 2022; Slade et al., 2022). Consequently, those who engage in outward-directed-injury are viewed as being unlawful, unruly or immoral. This distinction made between self-injury and outward-directed-injury impacts not only their conceptualisation by researchers, but also the way in which they are treated by service providers.

Although they are conceptualised very differently, review of these two distinct literatures indicates that the risk and protective factors for engagement in self-injury and outward-directed-injury are very similar. It is well established that self-injury is used as a means of managing difficult or uncomfortable emotions (e.g., Curtis, 2017; Curtis, 2018; Gratz et al., 2015; Klonsky et al., 2014; Lurigio et al., 2023). However, recent research has found that emotion regulation also plays a key functional role in aggression (e.g., Donahue et al., 2014; Garofalo & Velotti, 2017; Velotti et al., 2016).

Presently, these apparent similarities between self- and outward-directed-injury have not been compared at length. Therefore, the main aim of this research is to gain a greater understanding of these two distinct, but related behaviours. Accordingly, this thesis aims to explore people's experiences engaging in self-injury and outward-directed-injury with the main research question being: to what extent are self-injury and outward-directed-injury ways of dealing with the same issues, especially managing negative emotions?

Although this thesis initially set out to explore injury specifically, many of the experiences described by participants did not involve physical injury but were still harmful to themself or others. Accordingly, this thesis is focused more broadly on harm and will explore young people's experiences with self-harm and outward-directed-harm.

First, the relevant literature pertaining to both self-injury and outward-directed-injury will be reviewed and discussed, whilst describing the aims of the current study and highlighting the significance of this research. The qualitative methods that were used will be outlined and justified. The procedure for recruitment, facilitation, transcription and analysis of the interviews will be described. The seven main themes that were developed during reflexive thematic analysis will be discussed in relation to the previous literature to demonstrate both the nuance and similarity among participant's experiences with self- and outward-directed-harm. Lastly, concluding observations and final comments will be made,

strengths and limitations of the study will be outlined, and future directions for the research will be considered.

Chapter Two: Literature Review

In this chapter, a theoretically informed, located rationale for this research will be provided by outlining how this research will meaningfully contribute to the existing understandings of self-injury and outward-directed-injury. To do so, research on the topics of self-injury and outward-directed-injury will be overviewed. This will begin with a general description of the difference between non-suicidal self-injury (NSSI) and suicidal behaviour. Next, the methods, functions and prevalence of NSSI will be overviewed. This will be followed by a review of the literature relevant to ODI, including the antisocial behaviour and aggressive behaviour literatures, respectively. The concept of dual harm will then be discussed and theory relevant to NSSI and ODI will be outlined. Next, some key commonalities and differences between NSSI and ODI will be compared. Following this, cultural considerations pertaining to the current study will be described. Finally, the purpose, aims and significance of the current study in relation to both research and practice will be explained.

Differentiating Suicidal Behaviour and Non-Suicidal Self-Injury

Although self-injury is often implicitly associated with suicidality, many individuals who engage in self-injury do not actually have any intention of ending their own life (Hamza et al., 2012; Klonsky et al., 2014). For this reason, it is necessary to make a distinction between two different types of self-injury. The first is suicidal behaviour, in which an individual purposefully engages in self-inflicted physical harm with the intention of ending one's own life (Curtis, 2016b). The second is non-suicidal self-injury (NSSI), which refers to intentional engagement in self-inflicted physical injury without intending to end one's own life (Nock & Favazza, 2009). However, behaviours that cause physical harm but are socially or culturally sanctioned (i.e., tattoos, body piercings, religious self-flagellation) are not considered NSSI (International Society for the Study of Self-Injury, n.d.).

Beyond making the necessary distinction between the two behaviours, it is also important to highlight the complex relationship between NSSI and suicidal behaviour. Though the behaviours are distinct, they are not mutually exclusive and frequently co-occur in individuals (Hamza et al., 2012). Studies have shown that determining the intent behind self-injury (i.e., suicidal or non-suicidal) can be difficult for both observers and those engaged in the behaviour (Hawton & James, 2005; Kapur et al., 2013). Further to this, engagement in NSSI has been found to be a reliable predictor for future engagement in suicidal behaviour (Griep & MacKinnon, 2020; Kiekens et al., 2018; Ribeiro et al., 2016).

Despite being distinct behaviours, NSSI and suicidal behaviour are inextricably linked, and this fact must be considered when doing any research around self-injury. However, for the purposes of this study, we are primarily interested in engagement in NSSI.

Non-Suicidal Self-Injury

Before embarking on this review of the current literature, it is important to note the different terminology used within the self-injury literature. “NSSI” and “self-injury” are often used synonymously within the literature. “Self-harm” is another term commonly found in the literature. Generally, when researchers, clinicians and lay people use the term “self-harm”, they are usually referring to behaviours that would fall under the classification of self-injury. However, this term is also used more broadly to encapsulate all self-directed harm, direct or indirect, regardless of the intention behind it (International Society for the Study of Self-Injury, n.d.).

Methods of NSSI

There are differing methods or ways in which individuals engage in NSSI. The most common form of NSSI is cutting oneself with a sharp object, typically on the legs, arms, or stomach (Nock, 2010). Other common forms of NSSI include scratching, burning, hitting, biting, skin picking, head banging, hair pulling and interfering with the healing of a wound

(Klonsky, 2011; Lurigio et al., 2023). It is also important to note that most individuals who engage in NSSI have reported using multiple methods (Klonsky et al., 2014).

Although there are numerous ways in which to engage in NSSI, the scope of behaviours considered NSSI under the current definition is relatively narrow. The current definition only considers acts that deliberately and directly damage one's own body tissue, such as cutting your skin. This definition does not include acts that deliberately but indirectly result in harm or injury to self, such as drinking excessively, or overdosing on medication (Nock & Favazza, 2009). However, several studies have re-examined the existing distinctions between direct and indirect self-harm.

St. Germain and Hooley's (2012) study compared individuals who engaged in NSSI, indirect self-injury (such as reckless behaviour, substance abuse, disordered eating) and a control group who did not engage in any form of self-injury. The study supported the continued distinction between NSSI and indirect self-injury due to the finding that those who engage in NSSI had a higher suicide risk than those who engaged in indirect self-injury. However, the study also found that there were numerous measures in which there were no significant differences between NSSI and indirect self-injury.

Compared to the control group that did not self-injure, those who engaged in NSSI or indirect self-injury had lower self-esteem, were more aggressive, struggled more with negative emotions, reported more symptoms of borderline personality disorder, were more impulsive, struggled more with disinhibition, and reported more dissociative experiences. Although the authors advocated for NSSI and indirect self-injury to continue being conceptualised and treated as distinct, the study found a significant number of commonalities between NSSI and indirect self-injury.

Another study in which distinctions between direct and indirect self-injury are re-evaluated is Fox et al.'s (2019) study, in which the self-harmful intentions behind

engagement in NSSI and disordered eating are compared. Typically, NSSI is considered direct self-harm as the harm or injury is inflicted with the intention of causing injury or harm and occurs directly after engagement in the behaviour. Whereas disordered eating is typically considered indirect self-harm as the behaviour is thought to be motivated by factors other than self-harm, and the harm does not occur immediately after engagement in the behaviour, but rather sometime later. Contrary to this general belief, Fox et al. found that participants reported engaging in NSSI and disordered eating for the same reason, to intentionally physically harm or injure themselves.

More generally, new ideas have been emerging recently in the literature as to what behaviours should be classified as NSSI. One such study by Mellin et al. (2024) investigates sexual activity as a form of self-injury. Undertaking a scoping review of the existing literature, Mellin and colleagues confirmed that sexual activity is used by individuals as a method of NSSI. The sexual activities identified as being used for self-injury include selling sex, injury to the genitals, exposure to HIV/AIDS and other sexually transmitted infections, sadomasochistic behaviours engaged in for punishment instead of pleasure, and sexual encounters with undesired partners and/or consisting of undesired acts. Although some of the sexual activities identified in this study (e.g., selling sex) would not result in physical injury as such; the behaviours were considered by the authors to be indirectly self-harmful and still relevant due to the resulting psychological harm.

Another study by Mann et al. (2022) proposes the idea of NSSI by proxy whereby an individual is intentionally injured via the actions of another being. Under this definition Mann et al. also consider sexual activity with a partner to be a form of NSSI by proxy as well as five other behaviours including: tattooing and body piercing, initiating injury from an animal, initiating a physical fight with another person, engaging in elective medical or cosmetic procedures, and initiating injury through engagement in sports. As mentioned previously,

behaviours that cause physical harm but are socially or culturally sanctioned, such as tattoos, body piercings, and elective cosmetic or medical procedures are not considered NSSI under the current definition (International Society for the Study of Self-Injury, n.d.). However, Mann et al. (2022) argue that although these behaviours are socially sanctioned, they should still be considered NSSI by proxy if the individual is engaging in the behaviour for the purpose of physically injuring themselves; rather than for the socially sanctioned purpose (i.e., improving aesthetics or artistic expression).

Functions of NSSI

There are several reasons why people choose to engage in self-injury, almost all of which are a result of psychological distress. In terms of NSSI, research has shown that there are several different functions. Most commonly, people report using NSSI as an emotion regulation strategy, a way to help them cope with difficult emotions. (Nock, 2009; Klonsky, 2011; Curtis, 2016b; Tanner et al., 2016). Several studies have also found that people engage in NSSI to punish themselves (Hawton & James, 2005; Klonsky, 2011), and as a means of invoking sensation or feeling after a period of feeling numb (Kingi et al. 2017; Klonsky, 2011; Tanner et al., 2016). Some individuals also reported engaging in NSSI to gain a sense of control over one's own body (Chandler, 2012; Harris, 2000; Hill & Dallos, 2011).

Some research has also suggested that NSSI serves as a protective factor against suicide. Participants in a study by Curtis (2017) described NSSI as being counter-suicidal, for a few differing reasons. Some participants reported NSSI as means of distracting themselves from their feelings of suicidal ideation. Others described using NSSI as a means of coping with their suicidal ideation, that is they would hurt themselves rather than killing themselves.

Although most individuals engage in NSSI primarily as a means of dealing with their psychological stress, this is not the case for everyone. For some people, their engagement in this behaviour is socially motivated. Heilbron and Prinstein (2008) cited peer influence as

being a key motivating factor for adolescent engagement in NSSI. Multiple participants in Curtis' (2017) study explained that conformity rather than distress was a motivator for engaging in NSSI. They outlined how other people in their school year group cutting themselves is what prompted their engagement in the behaviour. Klonsky's (2011) study also cited social factors as motivators for engagement in NSSI. Some of these factors include communicating with someone else, getting attention, getting out of doing something, or getting away from someone.

There is a common assumption that NSSI is used as a tool to manipulate and seek attention. Although this may be the case for some individuals and in certain situations, there is also a significant amount of research in the literature which indicates that for many people, NSSI serves little or no social function (Claes et al., 2010; Curtis, 2016b; Klonsky et al., 2014). This is evidenced in the fact that most self-injurers do not seek support, and that the majority of NSSI episodes were carried out in private (Nock, 2008).

Prevalence

Self-injury is a prevalent issue among young people in New Zealand, particularly among our young women. According to the Ministry of Health, the female rate of hospitalisation for intentional self-injury was over twice the rate of male hospitalisations; in the 2013, 246.9 per 100,000 females were hospitalised for intentional self-injury versus 107.1 per 100,00 males (Ministry of Health, 2016). These statistics do not take into account all people engaging in self-injury, only those who had to be hospitalised as a result of their injuries. Another local study by Nada-Raja et al. (2004) of 26-year-old New Zealanders, found that 16% of the women, and 11% of the men had engaged in a form of self-injury in their lifetime. However, these statistics do include suicide attempts. A more recent study suggests that NSSI prevalence is increasing. In a New Zealand birth cohort of 709 adults, Coppersmith et al. (2017) found a lifetime prevalence rate of 34% for NSSI.

It should be noted that establishing an accurate estimate for the prevalence of NSSI is a challenge for a few reasons. First, most official statistics recording self-injury do not record or differentiate between suicidal and non-suicidal self-injury (Curtis, 2017). Second, the majority of those engaging in NSSI do not seek medical attention for their injuries (Hawton & James, 2005). For some, this may be due in part to the inherent stigma associated with NSSI, leading many individuals to be secretive about their engagement in the behaviour and consequently, to avoid getting medical treatment for their injuries (Chandler, 2012). Others may not seek medical attention as the injuries they have sustained through NSSI are not severe enough to require medical treatment (Nock & Favazza, 2009).

Outward-Directed-Injury (ODI)

Whilst there are well established definitions and classifications for self-injury and NSSI, there are some intentionally harmful and injurious behaviours that do not meet these definitions. Some people choose to direct their harmful or injurious behaviour externally, towards other people or objects. For some, the sole purpose of their behaviour may be to cause physical harm externally. For others, their purpose may be to harm themselves whilst also harming other people and objects around them. In either case, the behaviour is not congruent with behaviour that is defined as NSSI.

As part of this research, we propose a new term to encompass this behaviour and fill an apparent gap in the self-injury literature: outward-directed-injury. Outward-directed-injury, or ODI, refers to behaviour in which an individual chooses to deliberately harm other people or objects in their external environment, by 'lashing out' in response to emotional or psychological distress. In much the same way that NSSI falls under the larger umbrella definition of self-injury, we propose that ODI falls under the larger umbrella definition of aggressive behaviour. The current study proposes that in some instances, ODI may still be a form of self-injury (Kimbrel et al., 2018); in other instances, as per Mann et al.'s (2022)

definition for NSSI by proxy, ODI may also be an intentional form of self-injury. This could be due to the physical harm resulting from harming other people or objects, or the more emotional harm that comes with damaging those people and objects close to you.

As ODI is a new term, there is no existing literature directly about it. However, the existing definitions for aggressive and antisocial behaviour, do encompass much of the behaviours that we are interested in defining here. Therefore, the literatures on antisocial and aggressive behaviours may provide some relevant insights. However, these definitions fail to conceptualise the behaviour in relation to the distress and dysfunction that has led to them. Rather, the emphasis in their conceptualisations is on the criminality and the deviance of the behaviour. Through this research, we aim to establish a definition for behaviour directed outwards, that is the result of psychological distress rather than criminal intent.

Antisocial Behaviour

Antisocial behaviour in and of itself is difficult to define due to the implicit social construction of the concept. However, it is important to outline here whilst reviewing the literature relevant to ODI as much of the behaviour that we are proposing would be classed as ODI, would also be classed as antisocial behaviour. Klahr et al. (2012) define antisocial behaviour as "a cluster of problematic and disruptive aggressive and rule-breaking behaviours, the core of which involves persistent violations of societal norms and the rights of others (e.g., bullying, stealing)." (p. 699). Antisocial behaviours can range largely in scale from behaviour that is a minor inconvenience to a few people, through to behaviour that causes major harm to many people (Curtis, 2016a). Antisocial behaviour is also often associated with criminality; although criminality is not inherent in the behaviour, the nature and context in which the behaviour occurs determines the criminality.

The current study proposes that ODI diverges from antisocial behaviour in a few key ways. First, antisocial behaviour encompasses a broad variety of behaviours, from those that

negatively affect individuals on a one-to-one basis (i.e., bullying or stealing), to behaviours that negatively affect people at a community and society level (i.e., terrorism and hate crimes) (Curtis, 2016a). Alternatively, ODI primarily involves behaviours that negatively impact individuals on a one-to-one basis (i.e., getting into a physical fight with someone, punching a wall, verbally lashing out). Second, the intention behind the behaviour also differentiates antisocial behaviour and ODI. Individuals engaging in antisocial behaviour tend to do so with the intention of being disruptive or problematic. Whereas for those engaging in ODI, causing problems or disruption was not the intention, but may be an inadvertent consequence.

Aggressive Behaviour

Generally, aggressive behaviour is defined as any behaviour carried out with the intent to cause harm or injury to another individual who is motivated to avoid such behaviour (Bushman & Anderson, 2001; Geen & Donnerstein, 1998). However, aggression is a multidimensional construct that exists in many distinct forms and serves various functions (Little et al., 2003). There are overt forms in which the aggression is direct and obvious such as physical and verbal aggression (i.e., hitting, kicking, punching, insulting people, threatening people) (Little et al. 2003). There are also more covert forms that are indirect and less obviously aggressive such as relational or social aggression in which the perpetrator manipulates social relationships to intentionally harm another (i.e., spreading rumours, withdrawing friendship, ignoring people) (Little et al., 2003; Parrott & Giancola, 2007).

In terms of the functions of aggression, there are two main types consistently cited within the literature. The first is hostile aggression, also known as reactive aggression. The second is instrumental aggression also known as proactive aggression (Little et al., 2003). Hostile or reactive aggression tends to be more angry, impulsive and volatile. The behaviour is motivated in response to a perceived threat or provocation and intends to harm another

person. Alternatively, instrumental or proactive aggression tends to be more calculated and deliberate; the behaviour being motivated by achieving a self-serving goal rather than inflicting harm (Bushman & Anderson, 2001; Dodge, 1991; Little et al., 2003; Parrott & Giancola, 2007).

Methods and Functions of ODI

As stated previously, ODI falls under the larger umbrella definition of aggressive behaviour; all ODI is aggressive behaviour, but not all aggressive behaviour is ODI. The current study proposes that ODI would encapsulate aggressive behaviours that occur primarily as a result of emotional distress and dysregulation. Accordingly, ODI would entail mainly overt forms of aggression, such as physical and verbal; this aggression being more hostile or reactive in nature due to the emotionality and dysregulation involved.

Focusing on the connection between aggressive behaviour and emotional distress is not a novel idea. Many studies in the literature have explored this relationship whilst investigating the causes for engagement in this behaviour. Velotti et al. (2016) examined the role of three antecedent factors on aggressive behaviour; impulsivity, emotion dysregulation and alexithymia, a condition in which it is difficult to recognise and describe one's own emotions (Preece & Gross, 2023). The relationship between the three antecedent factors and aggression was examined in both a psychiatric sample, and a community sample. The clinical sample reported higher levels of aggressive behaviour than the community sample, as well as higher levels of all three potential antecedents. Emotion regulation and impulsivity were found to mediate the relationship between alexithymia and aggression in the community sample, however in the clinical sample, only emotion regulation mediated the alexithymia-aggression relationship.

A propensity to experience negative affect has also been closely associated with aggressive behaviour; negative affect being a general feeling of emotional distress, including

a wide variety of aversive mood states such as anger, sadness, guilt, fear, disgust, contempt and nervousness (Watson et al., 1988). A study by Garofalo and Velotti (2017) found that emotion dysregulation moderated the relationship between negative emotionality and physical aggression. Similarly, Donahue et al.'s (2014) study identified emotion dysregulation as a mechanism underlying the association between negative affect and aggressive behaviour. Further to this, Donahue et al. found preliminary evidence that certain aspects of emotion dysregulation may explain the association; specifically, difficulty in inhibiting impulsive behaviour in both males and females and limited emotional awareness in males only.

Prevalence

As ODI is a new concept that we aim to define through this research, it is not possible to know the true prevalence. However, we can look at other concepts/behaviours that are similar and/or encompassed within the definition that this study proposes for ODI. In 2023, 17,830 "acts intended to cause injury" were recorded by the New Zealand Police (n.d.). In terms of antisocial behaviour, Curtis et al. (2002) cited that between 4% to 15% of youth in the US, UK and New Zealand engaged in this behaviour.

Also of relevance to ODI is the prevalence of violent crime. Several studies have examined the prevalence of community violence perpetration and victimisation among mentally ill adults. A study by Desmarais et al. (2014) found that over a six-month period, almost one quarter (23.9%) of participants in a mentally ill population reported perpetrating an act of community violence. Of the participants who perpetrated violence, roughly one third (36.7%) reported perpetrating more than one act of community violence in the previous six-month period. Another study by Choe et al. (2008) reported similar results. They found that between 12% to 22% mentally ill inpatients and outpatients reported perpetrating an act of violence in the past 6 to 18 months. Interestingly, both studies found that rates of violence

victimisation among their participants was the same or higher than the rates of violence perpetration. However, it should be noted that these studies are limited in their applicability to the current study, as this research is not just focused on those with a diagnosed mental illness.

Rates of violence victimisation in the general population are also quite high. The New Zealand Crime and Victims Survey (NZCVS) reported that 185,000 New Zealanders were the victim of a violent crime in 2023; violent crime including physical assault, sexual assaults and robberies (Ministry of Justice, 2024). Although this statistic gives an indication of ODI prevalence due to the inclusion of physical assault, it is also limited in its applicability to the current study as sexual assault and robbery are not within the scope of ODI.

Dual Harm

There is also an emerging discourse in the literature around dual harm. Dual harm is classified as the engagement of an individual in both self-injury and aggression towards others (Shafti et al., 2022; Slade et al., 2022; Spaan et al., 2022; Tanner et al., 2016). The emerging dual harm literature is important to note here as the current study will be exploring the same behaviours that are encompassed within the construct of dual harm. However, the current study diverges from the existing dual harm literature in its the focus on both NSSI and ODI as distinct but potentially related constructs. Although the primary aim of the current study is to establish if engagement in NSSI and ODI are driven by similar motivations and serve similar functions; the behaviours will still be considered separately. The current study is also likely to diverge from the dual harm literature in the severity of the behaviour, as the dual harm literature tends to be drawn from forensic populations and includes serious violence and murder, whereas the current study will utilise a community sample. Even though the current study is not focused on “dual harm” as such, there are aspects of this literature that are potentially relevant to the current study.

Much of the dual harm literature has found that engagement in one behaviour (either NSSI or ODI) significantly increases the risk of engagement in the other behaviour. Spaan et al. (2022) found that the risk of self-harm for those that engaged in other-directed harm was 1.9 times higher than for those that did not harm others. Richmond-Rakerd et al.'s (2019) study found similar results when comparing dual harm prevalence among twins. For a twin that engaged in self-harm their risk of engaging in a violent crime (ODI) was three times higher than for their co-twin who had not engaged in self-harm; this result indicating that self-harm is a predictor for ODI independent of genetic and environmental factors.

Many studies have found that those who engage in dual harm are more likely to have experienced adverse life events in early life, such as family violence, parental neglect, bullying, poverty, substance misuse (Boxer, 2010; Carr et al., 2020; Richmond-Rakerd et al., 2019; Tanner et al., 2016). Not only are people who engage in dual harm more likely to have experienced adverse life events, studies in this area have also indicated worse outcomes for those engaged in dual harm, as opposed to only NSSI or ODI. Slade (2019) cited that prisoners with a history of dual harm engagement spend 40% longer in prison than those who engage in aggressive behaviour only. Richmond-Rakerd et al. (2019) also found that those who dual harmed had higher rates of concurrent psychotic symptoms and higher rates of substance dependence than those who only self-harmed. Spaan et al.'s (2022) findings were similar, with dual harming participants reporting more emotional and behavioural issues, and more substance use than those participants who only engaged in self-harm.

Relevant Theory

Opponent-Process Theory

Solomon (1980) theorised that when an unconditioned stimulus causes a deviation in an individual's state of equilibrium (known as the primary response), a secondary response may occur when the unconditioned stimulus is terminated, which brings the individual back

to a state of homeostasis. According to Solomon, this secondary response acts as an opponent process, which gives the opposite effect to the primary stimulus.

Opponent-process theory was initially developed to account for how motives were acquired in many different areas including food cravings, social attachments, love, drug dependency and the need for achievement (Solomon, 1980). More than three decades later, researchers in the field began to suggest that opponent-process theory may also provide an explanation for why people engaged in NSSI and other injurious behaviours (De Oliveira, 2023; Franklin et al., 2010; Franklin et al., 2013; Gordon et al., 2010; Hamza & Willoughby, 2015; and Joiner, 2005).

In terms of NSSI, an act of self-injury, such as cutting, would be the unconditioned stimulus. The primary response to this unconditioned stimulus is pain, and the secondary response or opponent process following the termination of the cutting is relief. Opponent-process theory could similarly be applied to an act of outward-directed-injury. For example, punching a wall would be an unconditioned stimulus, to which the primary response is pain. Once the individual has stopped punching the wall, the secondary response or opponent process is relief.

Researchers have suggested that the relief felt following the opponent process transcends the physical pain, also relieving feelings of emotional pain that the individual may be experiencing (Franklin et al., 2013). Therefore, the removal of physical pain results in both decreased physical pain and decreased emotional pain (Eisenberger, 2012; Hamza & Willoughby, 2015).

Emotional Cascade Theory (Distraction)

In her work on borderline personality disorder, Linehan (1993) theorised that individuals would engage in problematic coping behaviour (i.e., binge-drinking, substance abuse, binge-eating) as a means of distracting them from their overwhelming negative

emotions. This theory provided a compelling explanation for engagement in problematic coping behaviours; however, it failed to explain why individuals would engage in more extreme distractions, such as NSSI, as opposed to less extreme distractions (i.e., a cold shower, a long run etc.).

Selby and Joiner (2009) later elaborated on this theory, proposing a reason as to why individuals would choose to use NSSI as a distraction rather than something less harmful. Their theory outlined that individuals with high levels of emotional dysregulation tend to focus and ruminate on these negative emotions. This in turn would lead to more negative emotions, creating a negative feedback loop resulting in an extremely negative mood. Selby and Joiner called this process an "emotional cascade". In order to effectively distract from this extremely negative mood, the distraction needs to be equally extreme.

Although Selby and Joiner's (2009) paper outlines emotional cascade theory within the specific context of NSSI in individuals with borderline personality disorder; this theory is more broadly applicable to all NSSI and other injurious behaviours. For example, Anestis et al.'s (2009) study found that aggressive behaviour, including both verbal and physical aggression, was linked with rumination. The study found that rumination on feelings of anger was a significant predictor of engagement in verbal and physical aggression. The findings of this study indicate that aggressive behaviour, and evidently ODI, could also be explained in part by Selby and Joiner's emotional cascade theory.

Social Learning Theory

Prior to social learning theory, the consensus in personality theory was that behaviour was driven by forces within oneself (as cited by Bandura, 2019). However, Bandura (1977) theorised that people learned new behaviours by observing, imitating and modelling the behaviour of others. Bandura famously exemplified this theory in practice through his Bobo doll experiment in which children learned to be aggressive towards an inflatable doll known

as “Bobo” by observing a social situation in which an adult was physically aggressive with the doll. Those children who observed aggression towards Bobo, adopted this aggressive behaviour when put in a room with Bobo; whereas those children in the control group who did not see the aggression modelled were rarely aggressive towards Bobo (Bandura, 2013).

Social learning theory can be applied broadly to explain a wide variety of behaviours including NSSI and ODI. Evidently, social learning theory can be applied to ODI as seen exemplified in the Bobo doll experiment and other publications by Bandura (e.g. Bandura, 2019).

Social learning theory has also been applied to the behavioural acquisition of NSSI. For example, Muehlenkamp et al.’s (2008) study examined whether exposure to NSSI and/or suicide would increase an individual’s likelihood of engaging in NSSI. Participants that reported knowing someone who engaged in NSSI were much more likely to also have engaged in NSSI than those who were not exposed to either NSSI or suicide. Interestingly, being exposed to suicidal behaviours only, not NSSI, was not associated with increased rates of NSSI. These findings are consistent with social learning theory as they indicate that exposure to NSSI specifically was associated with increased risk of NSSI engagement.

Commonalities and Differences between NSSI and ODI

Self-Destruction and Negative Consequences

A key commonality between NSSI and ODI is the self-destructive nature of both behaviours. The impact of engagement in NSSI and ODI is largely negative, for both the person engaged in the behaviour, and those around them. However, most individuals choosing to engage in these behaviours are aware of these consequences and choose to engage regardless. Although there are negative consequences of engagement in both behaviours, the consequences are where the behaviours can vary.

The most obvious consequence of NSSI is the pain that results from injuries inflicted (Briere & Gil, 1998; Griep & MacKinnon, 2020; Nock & Prinstein, 2005). Another consequence due to the associated stigma, is the lack of sympathy, empathy or understanding from others (i.e., family, friends, health professionals). Also as a result of the stigma, there is likely to be some discomfort when an individual is asked by those around them about the nature of their injuries, or when they feel they need to hide their injuries or scars from others (Briere & Gil, 1998; Curtis, 2017; Garisch & Wilson, 2015; Hamza et al., 2015; Harris, 2000; Kingi et al., 2017; Lurigio et al., 2023).

Although these negative consequences have been associated with NSSI in the literature, they are also applicable in many cases to ODI. For example, if a person is upset and subsequently starts a physical fight with another person, the likely result is injury to themself and the other person. This is likely to garner little empathy or sympathy from others. It is also likely to be uncomfortable to address the nature of their injuries with others.

Risk Factors

There are several overlapping risk factors for NSSI, and behaviours potentially related to ODI. Carr et al.'s (2020) study found that adverse childhood events are risk factors for engagement in both NSSI and violence. Some of these adverse events included the death of a sibling or parent; hospitalisation due to an assault, serious accident or self-harm; residential transience; parental unemployment; child-parent separation; or a mental illness diagnosis. Similarly, Ejlskov et al.'s (2023) study also found that growing up in a low socioeconomic neighbourhood increases an individual's risk of engaging in NSSI and violent criminality.

A history of sexual abuse is a known risk factor for engagement in NSSI (Briere & Gil, 1998; Curtis, 2016b; Curtis, 2017; Hawton & James, 2005). Similarly, studies have shown that previous sexual abuse associated with aggression and criminality later in life (Estévez et al., 2016; Norton-Baker et al., 2019; Swanton et al., 2003).

Additionally, studies have shown that engagement in one behaviour (either NSSI or aggression towards others) is a significant risk factor for engagement in the other behaviour (Richmond-Rakerd et al., 2019; Spaan et al., 2022). Therefore, if an individual engages in NSSI, it is likely that they have a much higher risk of also in engaging in aggression towards others, and vice versa.

Impulsivity and Emotion Regulation

A factor that has been linked to engagement in both NSSI and aggression is impulsivity and difficulty with emotion regulation. As outlined previously in this chapter Donahue et al. (2014) identified emotion dysregulation as a mechanism underlying the association between negative affect and aggressive behaviour. Further to this, they found that certain aspects of emotion dysregulation, specifically, difficulty in inhibiting impulsive behaviour, partially mediated the relationship between negative affect and aggression. Also previously outlined in this chapter, the clinical sample in Velotti et al.'s (2016) study reported higher levels of aggressive behaviour, alexithymia, impulsivity and emotion dysregulation than the community sample. They also found that emotion regulation mediated the alexithymia-aggression relationship in the clinical sample.

In terms of NSSI, Hamza et al. (2015) conducted a meta-analysis of the literature examining the relationship between NSSI and impulsivity. They found that individuals who engaged in NSSI reported higher impulsivity than those individuals that did not engage in NSSI. St. Germain & Hooley (2012) also found that individuals who self-injure, both directly and indirectly, were more impulsive than those who did not self-injure.

Mental Illness

Although mental illness is not a prerequisite for engaging in NSSI or ODI, most mentally ill individuals are more likely to engage in such behaviours (Briere & Gil, 1998). NSSI is commonly associated with several different mental disorders. Some of these include

depressive disorders, anxiety disorders, eating disorders, obsessive compulsive disorder, substance use disorders, bipolar disorder, schizophrenia, post-traumatic stress disorder, and borderline personality disorder (Bentley et al. 2015; Claes et al., 2010; Gratz et al., 2015; Nock & Favazza 2009; St. Germain & Hooley, 2012).

ODI related behaviours, including antisocial behaviour and aggression, are also associated with several mental disorders including depressive disorders, anxiety disorders, antisocial personality disorder, post-traumatic stress disorder, oppositional defiant disorder, conduct disorder, and substance use disorders (Curtis, 2016a; Little et al., 2003). Although NSSI and several ODI related behaviours are associated with some of the same mental disorders (i.e., depressive disorders, post-traumatic stress disorder, substance use disorders); there are some that are primarily associated with aggression or antisocial behaviour (i.e., oppositional defiant disorder, conduct disorder, antisocial personality disorder), and some that are primarily associated with NSSI (i.e., obsessive compulsive disorders, eating disorders).

Gender

Existing research into aggressive and antisocial behaviour, both of which may have similar properties to ODI, has shown that these behaviours are predominantly engaged in by men (Bettencourt & Miller, 1996; Curtis, 2016a). Research also indicates that men and women tend to express aggression in differing ways; men being more physically aggressive, and women being more indirectly/socially aggressive (Björkqvist, 2018; Klahr et al., 2012). However, Björkqvist's (2018) study found that men and women engaged in verbally aggressive behaviour at a similar level.

There are several theories that attempt to explain the apparent gender difference in physical aggression. Eagly and Wood (2016) posit that men tend to be more physically aggressive as masculine gender roles endorse aggression, whereas feminine gender roles

discourage aggressive behaviour. Studies such as Wagels et al's (2018) study also suggest that biological differences between males and females (i.e., higher levels of testosterone) may account for the higher levels of aggression.

The relationship between gender and NSSI has also been well documented in the literature. The majority of the research has found that women are much more likely to engage in NSSI than their male counterparts (Bresin & Schoenleber, 2015; Curtis, 2018). In Aotearoa, women are hospitalised at more than double the rate of men for intentional self-harm related injuries (Ministry of Health, 2016).

However, although a large proportion of the literature suggests that women are more likely than men to engage in NSSI, there have been several more recent studies that have found evidence contrary to this, suggesting that women and men engage in NSSI at similar rates (see Fitzgerald & Curtis, 2017; Kimbrel et al., 2017; Kimbrel et al., 2018). These studies also found that women and men tend to engage in different types of NSSI, a possible explanation for the gendered discrepancy in reporting of NSSI engagement. For example, women are more likely to engage in more discreet forms of self-injury that can be easily hidden, such as cutting, biting, burning or scratching their thighs or wrists (i.e., places where the injuries can be easily hidden). Alternatively, men are more likely to engage in more obvious forms of self-injury, such as punching, banging, or kicking themselves or others (see Fitzgerald & Curtis, 2017).

Further than that, research indicates that men and women tend to express psychopathology in different ways (Bresin & Schoenleber, 2015). For instance, in terms of emotion regulation strategies, women tend to ruminate more than their male counterparts, which may partially explain the higher levels of depression and anxiety in women (Nolen-Hoeksema, 2012). Alternatively, men are more likely to utilise other emotion regulation

strategies, such as aggression and alcohol consumption (Bettencourt & Miller, 1996; Nolen-Hoeksema, 2012).

Perception

Both NSSI and ODI related behaviours are perceived very differently within society. Individuals who engage in NSSI are usually perceived as being in significant distress; as being anxious, stressed and extremely sad. In contrast, individuals who engage in aggressive or antisocial behaviour are typically viewed as being confrontational, dangerous, and threatening. NSSI is treated as a symptom of illness and distress, whereas aggressive and antisocial behaviours are treated as a symptom of criminality (Slade, 2019). As a result, those who engage in NSSI are often treated with a lot more empathy than those who engage in ODI related behaviours. They may also have access to more support systems and intervention measures as they are referred to engage with health care providers rather than the correctional system.

Cultural Considerations

A Western Perspective

Currently the literature on NSSI and behaviours potentially related to ODI is heavily dominated by research conducted in western countries such as the United Kingdom, the United States, Canada, Australia, and New Zealand. Consequently, the majority of the theories and information emerging from this research are biased to a western perspective. As discussed previously in this chapter, NSSI and ODI are perceived and are subsequently treated as two very distinct issues in Aotearoa New Zealand. Although the western view of intentional injury, particularly NSSI, is very negative, this sentiment is not shared universally. There are many cultures throughout the world in which intentional injury, in various forms, is not only socially accepted but also encouraged in some situations (Black & Kisely, 2018; Favazza, 2009; Gholamrezaei et al., 2015; Kingi, 2018; Kingi et al., 2017).

Kiri Hahae and Māori Perspectives on Self-Injury

In Te Reo Māori, kiri hahae means to slit, lacerate, tear, cut, or slash the skin of yourself (Te Aka Māori Dictionary, n.d.-a, n.d.-b). This is the term used traditionally by Māori for self-injury. Te Awekotuku (2009) describes the practice of kiri hahae as "...a more primal form of modifying the body, including the face, in response to grief and death. Unlike tā moko, which was an erudite art form applied by an expert tohunga with chisels and pigment, hahae was a spontaneous expression of intense grief. Inflicted with tuhua, or obsidian flakes, sharp mata or whaiapu stone, or razor shells; you did this to yourself. It was not seen as mutilation, as self-harm; it was a visceral compulsion, still occurring today, but usually misread and misunderstood in modern times. Many waiata tangi, or songs of lamentation, allude to this practice as a vivid demonstration of loss." (Te Awekotuku, 2009, p. 5).

Although kiri hahae involves deliberate self-inflicted physical injury without the intention of ending one's own life; it does not fit within the definition of NSSI and is not viewed as being a form of self-injury as the practice is culturally sanctioned. In addition, Kingi et al (2017) also notes that for many rangatahi Māori (Māori youth), their definitions of self-injury reflect a much broader and holistic worldview. Some of the behaviours described by the rangatahi and whānau who took part in their study did fit within the western definition of NSSI. However, there were other behaviours identified by rangatahi and whānau, such as excessive drinking and non-cultural tattoos, that served the same purpose but did not fit the western definition of NSSI.

The Purpose, Significance and Aims of this Research

The main aim of this research is to explore to what extent self-injury (NSSI) and outward-directed-injury (ODI) are ways of dealing with the same issues, especially managing

negative emotions. Accordingly, it is hypothesised that there will be significant overlaps in risk factors, immediate triggers and functions for NSSI and ODI.

The prevalence of self-injury among youth in New Zealand is high (Garisch & Wilson, 2015). Although the true prevalence for ODI is not known, statistics pertaining to related behaviours such as aggression, antisocial behaviour and acts intended to cause injury indicate that ODI is also a significant issue (Choe et al., 2008; Curtis et al., 2002; Desmarais et al., 2014; New Zealand Police, n.d.). For these reasons, it is imperative that we look to implement new and improve current prevention and intervention strategies. If NSSI and ODI are found to have similar risk factors and serve a similar function, then prevention and intervention strategies developed for NSSI may be applicable to ODI, and vice versa.

NSSI and ODI are not symptoms or behaviours unique to any one specific psychological disorder. As stated previously, NSSI and ODI are associated with numerous different psychological disorders (Bentley et al. 2015; Claes et al., 2010; Curtis, 2016a; Gratz et al., 2015; Little et al., 2003; Nock & Favazza 2009; St. Germain & Hooley, 2012). Accordingly, if this research does find that there is significant overlap in the functions and risk factors of NSSI and ODI, the benefit will be far-reaching.

This research is significant for several different stakeholders. First, for researchers as it will provide in-depth insight into two risky coping behaviours that are leading causes of both physical and psychological health problems in young people. This research will also be of significance for clinicians who encounter individuals engaging in NSSI and ODI on a day-to-day basis. The findings of this research can be used to review current prevention and intervention strategies which in turn will improve the level of care they are able to provide.

And most importantly, this research is significant for those engaging in NSSI and/or ODI as those individuals are enduring negative physical and mental health outcomes from engaging in this behaviour.

Summary

There is a wide range of research in the literature on NSSI, and on behaviours potentially related to ODI. The review of this literature began with an overview of the nuanced differences between suicidal behaviour and NSSI. This was followed by a discussion around methods of NSSI, including what behaviours are currently considered NSSI under the current definition, and emerging ideas around what other behaviours could be included in this definition. Next, different functions of NSSI and the prevalence of NSSI were outlined.

Overall, the review of the literature pertaining to NSSI demonstrated both the severity and the breadth of this issue for young people in New Zealand and globally. Whilst emphasising emotion regulation as a key function of NSSI, this review also highlighted several other functions including gaining control over one's own body, punishing oneself, invoking sensation after a period of numbness, and conformity. The emerging ideas in the literature around what behaviours should be classified as NSSI also highlighted other self-harming behaviours that may not have necessarily been considered as self-harm prior to the review being undertaken.

The following section focused on ODI. Although there are well established definitions for NSSI in the literature, ODI is not an established concept within the literature. As part of this research a definition for ODI is proposed: behaviour in which an individual chooses to deliberately harm other people or objects in their external environment in response to emotional or psychological distress. The existing definitions for aggressive and antisocial behaviour encompass much of the behaviours included within the current study's proposed definition. Accordingly, the literatures on antisocial behaviour and aggressive behaviour were reviewed to get an idea of the methods, function, and prevalence of ODI. Crucially, the review of the literature did identify emotion regulation as a function of aggression. The review also identified an association between negative affect and aggression. Review of the

literatures on antisocial behaviour and aggression demonstrated that in most instances, outward directed injury or harm is conceptualised and viewed through a very different lens than self-harm and NSSI, being viewed as more deviant or criminal rather than a sign of emotional distress as self-harm is viewed. This is despite the association between negative affect, emotion regulation and aggression that is evident in the literature.

There is an absence in the literature of research that directly compares NSSI and ODI. Dual harm, an emerging concept in the literature in which an individual engages in self-injury and aggression towards others, does focus on both behaviours. However, the dual harm literature conceptualises self-injury and aggression as one behaviour rather than two separate behaviours and accordingly, does not compare them. The dual harm literature also differs in that the aggressive behaviour included in this literature tends to be more severe (i.e., aggravated robbery, murder) as the research has been conducted in forensic populations, whereas the current study will utilise a community sample. Although some comparisons from the existing NSSI and ODI literatures could be drawn through this review; research such as the current study, that sets out to directly compare these behaviours will provide clinicians and researchers with more insight into these two behaviours. Further, this knowledge could be used to inform current and develop new prevention and intervention measures.

Chapter Three: Method

This chapter describes the methods used for this study. The qualitative approach that was used is outlined and justified. The role of the qualitative researcher is explained, and the researcher reflects on her own contextual positioning in relation to the study. Participant demographic information and the recruitment process are described. The procedure for facilitating and transcribing the interviews is overviewed, and the data analysis process is discussed. Lastly, the ethical considerations made throughout the study are detailed.

Research Design

A qualitative approach was chosen for this study to gather in-depth information on individuals' experiences dealing with difficult emotions using NSSI and ODI, and how these experiences may be similar or different. Using a flexible qualitative method allowed participants to share all the complexities and nuances of their experience and introduce new ideas that the researcher may not have previously considered or been aware of (Rubin & Rubin, 2012). The process of discussing the topic also encouraged participants to reflect on and share aspects of their experiences that they may also not have considered prior (Curtis & Curtis, 2011). A semi-structured interview schedule was developed to guide the discussion. This interview schedule (see Appendix A) utilised primarily open-ended questions, which facilitated the discussion about participants' experiences and perspectives on NSSI and ODI, without the constraints of rudimentary classifications and categories that may hinder the introduction of new meanings and ideas (Magnusson & Marecek, 2015).

This study takes a critical realist ontological stance. Critical realism postulates that a singular external reality exists but acknowledges that different perspectives, interpretations and representations of this reality exist (Braun & Clarke, 2021). In terms of epistemology, this study takes a contextualist stance in which knowledge and meaning are viewed as being socially produced (Braun & Clarke, 2006). This means that the knowledge an individual has

cannot be meaningfully studied without also acknowledging the context in which they live and how this shapes the knowledge they produce (Braun & Clarke, 2021). However, this also means that quality research cannot be conducted without acknowledging the role that the researcher plays in the creation of knowledge in the research process.

The Role of the Qualitative Researcher

As knowledge from the interview is constructed during the discourse between the researcher and the participant, the qualitative researcher cannot be considered a neutral party in the research process (Curtis & Curtis, 2011). In fact, the qualitative researcher is often considered to be 'the research instrument' (Dodgson, 2019). As a result, qualitative research is inherently subjective. However, when the researcher engages in reflexivity, this subjectivity is not only a strength of the research, but a key aspect of the research process (Braun & Clarke, 2021).

Reflexivity is the process of reflecting on your own situatedness (e.g., socio-economic status, age, culture, ethnicity, beliefs, assumptions, actions) within the research, whilst simultaneously acknowledging how your positionings may impact the research process (Braun & Clarke, 2021). Engaging in reflexivity by describing how the contexts of the researcher and participants intersect not only enhances the reader's understanding of the research, but also increases the overall integrity of the findings (Dodgson, 2019). Below I will discuss my own contextual positioning as the researcher in relation to the participants in the study, and how that impacted the way in which I conducted, interpreted and analysed the interviews.

I am a twenty-four-year-old cis-gendered female. I have lived in Aotearoa New Zealand for my whole life, and I identify as both Pākehā (NZ European) and Māori. I also identify as a member of the LGBTQ+ community. My identity, particularly as a queer woman, plays a big role in how I view the world and relate to others. This may influence the

way I interpret conversations about structural, political, and social issues that may impact a participant's emotions or mental health.

As a teenager and young adult, I have suffered from anxiety and depression periodically. I have never intentionally injured myself or others however, I can relate to the feelings of intense emotional distress that many of the participants describe. And although I do not have personal experience with NSSI or ODI, I have friends and family members that do. I was also previously employed as a support worker at a high and complex needs mental health residence in which I worked closely with individuals who engaged in both NSSI and ODI.

After suffering from depression and anxiety as a teenager, I made the decision that I wanted to pursue a career as a clinical psychologist, as I want to help young people in times of intense emotional distress as I had been helped. My personal experience and my career aspiration have influenced my interest in this area of research, specifically how we can improve prevention and intervention strategies for young people in emotional distress.

Participants

Twelve participants were interviewed for this study. The initial age criteria of 16-25 was chosen as NSSI and ODI behaviours are more prevalent among young people, as they tend to have more difficulty with emotion regulation (see Nashiro et al., 2011; Sanchis-Sanchis et al., 2020; Zimmermann & Iwanski, 2014). However, of the twelve participants, five did not meet the advertised age criteria of 16-25 years old. These participants were still included in the study for several reasons.

After conducting the first five interviews, all with participants being in the advertised age criteria, I found that almost all of them were speaking about their experiences engaging in NSSI or ODI after several years had passed. Given that the behaviours are more prevalent within this age group, there was an assumption that participants would be speaking about

their current or very recent experiences with the behaviours. However, as participants within the target demographic were speaking about their experiences after several years had passed, I felt that those outside of the target demographic should not be prohibited from doing the same. Another factor considered was the number of people who expressed their interest in taking part in the study who were outside of the advertised age criteria. Many of those who expressed interest in participating in the study and sharing their experiences were just outside of the advertised age criteria (i.e., late 20s and early 30s).

After further consultation with my supervisor, it was decided that extending the age range would be advantageous as participants aged over 25 may have had more time to reflect on their experiences and in turn, have greater insight to share. However, we were also cognisant that as more time may have passed between engagement in NSSI or ODI and participation in the interview, there was a risk that participants aged over 25 may have less accurate memories than those of younger participants who had more recently engaged in the behaviour. Ultimately, the age range of participants included in this study was 18-35 years old ($M = 25.67$, $Mdn = 24$, $SD = 4.70$).

The participants in this study are diverse. The participants self-identified as NZ European ($n = 10$), Māori ($n = 6$), South African ($n = 1$), Latin American ($n = 1$), Filipino ($n = 1$), and European ($n = 1$). Eight participants identified with multiple ethnicities. The gender of participants was predominantly female ($n = 8$), but did include male ($n = 3$) and non-binary ($n = 1$) participants. A breakdown of the participant demographics is presented below in Table 1. All participant names included in Table 1 are pseudonyms.

Table 1

Participant Demographic Information

Participant	Age	Gender	Ethnicity
Alex	18	Non-binary	Māori, NZ European
Brooklyn	24	Female	NZ European
Charlotte	24	Female	European, South African
Damian	22	Male	Māori, NZ European
Eleanor	22	Female	Latin American, NZ European
Finn	35	Male	NZ European
Gemma	27	Female	Māori, NZ European
Hailey	27	Female	Māori, NZ European
Imogen	32	Female	Māori, NZ European
Jessica	23	Female	Māori, NZ European
Kendall	23	Female	Filipino
Liam	31	Male	NZ European

Recruitment

Recruitment for this study began in August 2023 and concluded in early May 2024. Participants for this study were recruited as part of the Self Harm and Injury Exploration (SHInE) Project, a large-scale research project led by my supervisor, Dr. Cate Curtis, Senior Lecturer for the Division of Arts, Law, Psychology and Social Sciences at the University of Waikato. Like this study, the SHInE project aims to investigate the relationship between NSSI and ODI by conducting research with young people, and professionals who work with young people. Data was collected for another study undertaken as part of the SHInE Project via an online survey. At the end of this survey, participants were asked if they would be

interested in taking part in further research as part of the project. If they responded yes, they were contacted by me to ask if they were interested in being interviewed. Further to this, a recruitment poster (see Appendix B) was posted on social media platforms and around the University of Waikato campus.

Potential participants either contacted me directly after seeing an advertisement for the study or by responding to my email following their completion of the survey. All potential participants were sent the Participant Information Sheet (see Appendix C). They were asked to read through this information and let me know if they were still interested in participating. If so, an interview was scheduled.

Procedure

Before each interview, we would begin with whakawhanaungatanga (process of establishing relationship). This activity was more informal and was not recorded as part of the interview. However, this time spent on introductions and rapport-building prior to the interview itself was integral as it facilitates a respectful relationship with the interviewee, allows them to feel more comfortable, and leads to a fuller discussion of topics during the interview (Curtis & Curtis, 2011).

If the interview was conducted in person, food and drink were offered to participants. Following this, I would check that the participant had read the Participant Information Sheet (see Appendix C) and ask if they had any questions before we began. Once all queries had been answered, we went through the process of signing the consent form (see Appendix D). During this process, I would also go over what would happen with their information and who would have access to it. I would then invite participants to open the interview with a karakia (prayer) if they wished to do so.

Following this, I would confirm that the participants were comfortable with me taking an audio recording of the interview. All participants gave permission for their interview to be

audio recorded. Once this permission was obtained, I would start the recording and begin the interview. Throughout the interview I would take notes by hand. Once all questions in the interview schedule had been asked, the notes would be reviewed with the participant. This review ensured that all the key information was captured, and that no information had been misinterpreted or unintentionally omitted.

Interviews were conducted in person (n = 9) and over audio visual link (AVL) (n = 3). Length of the interviews ranged between 32 minutes and 1 hour and 39 minutes (M = 53.25 minutes, SD = 18.42). At the end of the interview, participants were given a $40 Warehouse voucher as a koha (gift) to thank them for their time. Once the audio recording was stopped, time was spent debriefing with participants. This varied based on the individual needs of each participant, but usually involved discussions about their current work or study, general interests, and their plans for the rest of the day. I also made sure to ask all participants whilst debriefing if they had any questions or comments about participation and ensured they understood the next steps (i.e., being sent a copy of the transcript for review, withdrawing from the study up to four weeks following the interview). After sufficient time was spent debriefing and the participant seemed comfortable, the interview concluded. The opportunity was also provided for me to debrief any potential concerns I had following the interviews in my supervision meetings. My supervisor was also aware of the date and time of the interviews to ensure researcher safety.

The audio recording of each interview was transcribed using the audio transcription tool in Microsoft Word. To ensure the accuracy of each transcription, they were carefully read through while listening to the corresponding audio recording. Amendments were made where necessary. Any identifying information was redacted (e.g. [friend's name]) or replaced with a pseudonym. The name of each participant was also replaced with a pseudonym. Participants were all sent a copy of their transcripts to provide them the opportunity to make

any amendments if necessary or withdraw from the study completely. They had up to four weeks following the interview to do so. No participants requested any amendments, and no participants withdrew from the study.

Data Analysis

The transcripts were analysed using Braun and Clarke's (2006, 2021) Reflexive Thematic Analysis (RTA). RTA involves six phases: data familiarisation, generating initial codes, generating initial themes, reviewing themes, defining and naming themes, and producing the report. These phases are not necessarily distinct from one another or linear in direction but do tend to be generally progressive in nature. Each phase of RTA is detailed below.

Data Familiarisation

To conduct effective RTA, the researcher needs to be intimately familiar with the content of the dataset. To do this, the researcher must immerse themselves in the data (Braun & Clarke, 2021). This involves re-listening to the interviews, reading the interview transcripts repeatedly, as well as taking notes of any recurrent ideas or concepts. Familiarising myself with the dataset for the current study began during transcription of the interviews. Although I utilised the transcription tool in Microsoft Word to transcribe the interviews, I listened to each interview recording whilst reading the respective transcript to both ensure accuracy and the begin the familiarisation process. Once all the interviews had been transcribed, I re-read each transcript multiple times, taking note of any key ideas or concepts, as well as any patterns that I noticed across the data. My notes at this phase took the form of both bullet-pointed lists and flow charts. This process enabled me to develop a general understanding of the data as a whole and what each participant was trying to convey in their interview.

Generating Initial Codes

Once I felt sufficiently familiar with the content of the dataset, I moved onto the next phase, generating codes, also known as "coding" the data. This phase involves organising the data into meaningful groups (Tuckett, 2005). These groups, known as codes, identify specific ideas or meanings present in the dataset that are relevant to the research question (Braun & Clarke, 2006). Codes are the smallest unit used in RTA and form the building blocks for the rest of the analysis (Braun and Clarke, 2021). In RTA, there are two types of coding – semantic and latent. Semantic coding focuses on surface level information in the data, information that is explicitly stated or described by the participants themselves; whereas latent coding focuses on meanings and ideas that are implicit in the data (Braun and Clarke, 2021). For the current study, a combination of semantic and latent coding was used.

This dataset was coded manually using Microsoft Word and Microsoft Excel. A copy of each transcript was pasted into separate documents, each containing a table. The table in each document had three columns. As suggested by Curtis and Curtis (2011), the column on the left was for the transcript, the column in the middle was for any general comments or notes, and the column on the right was for the codes. The code was recorded in the right column adjacent to the relevant section of the transcript in the left column. This relevant coded section in the left column was also highlighted. Each code was also recorded in an Excel spreadsheet. Participants were recorded on the vertical axis and codes were recorded on the horizontal axis. If a code appeared in a participant's interview, a "Y" was recorded in the overlapping cell. By recording the codes in this manner, I was able to get a general overview of their prevalence across the dataset as well as any patterns among the data.

Generating Initial Themes

Once initial codes had been generated, I began looking for codes that had similar or shared meaning. In this process I was able to further refine the codes. If I found that a code expressed ideas that were too like another, these codes were combined. The clusters of codes

that appeared have shared ideas or meanings were then organised into groups known as candidate themes (Braun & Clarke, 2021). At this phase, codes were re-shuffled into numerous different clusters as these candidate themes were only potential themes and required further exploration and consideration in relation to the research question before they could be considered fully formed themes. Once I was happy that the candidate themes shared the same core idea and conveyed something meaningful in relation to the research question, I began to organise them using a flow chart into themes and sub-themes.

Reviewing Themes

In this phase, the candidate themes were thoroughly scrutinised in relation to the entire dataset. This was to ensure that the themes were an accurate representation of the dataset and effectively captured shared meaning across the dataset (Braun & Clarke, 2006). The quotes under each candidate theme were reviewed to see if they expressed what the participant was trying to convey and were portrayed accurately by the candidate theme it came under. As with the initial codes, if candidate themes were found to be too like another, they were combined. Alternatively, candidate themes were also split into separate, more specific themes if the scope of the candidate theme was too broad.

Some candidate themes were also completely discarded once codes and their corresponding quotes were presented under each candidate theme, as this process highlighted whether the candidate theme had sufficient support to stand on its own. For example, the initial sub-theme of "*toxic masculinity*" was discarded. This sub-theme fell under the theme focused on ODI engagement, "*hurt people, hurt (other) people*". Although the relationship of toxic masculinity to ODI is distinct and interesting; the relevant quotes from participants were all brief and did not elaborate enough.

Candidate themes were also discarded if they did not have relevance to the research question. For example, "*negative reactions stopped engagement*", was an initial candidate

sub-theme centred around participant's experiences discontinuing engagement in NSSI due to the negative reactions they received from those close to them. The candidate sub-theme was discarded as although it had distinct and interesting meaning it did not offer insight into the research question: *"to what extent are self-injury and outward-directed-injury ways of dealing with the same issues, especially managing negative emotions?"*

Defining and Naming Themes

This phase involved further refining themes, naming them, and providing a definition for each of them (Braun & Clarke, 2021). Defining each theme requires the researcher to be able to describe the scope and content of each theme in a few sentences. If this was not possible, I would revise the theme until it met these criteria. The name of each theme needed to be both informative and interesting; an informative name would accurately convey the pattern of meaning addressed by the theme, and an interesting name would effectively engage in the reader in the story being told in the analysis. Significant time was spent brainstorming and editing theme names until they met this standard.

Producing the Report

The last phase of RTA is writing the analysis, which is presented in chapter four of this thesis. Writing the analysis was a key component of the RTA process as this is where the story that the data is telling takes shape (Braun & Clarke, 2006). This story must emphasise both the merit and validity of the analysis. To achieve this, it was important to have a strong analytical narrative. Accordingly, the themes and sub-themes were reshuffled until they told a coherent story that flowed well.

Ethical Considerations

Ethical approval for this study was granted by the University of Waikato Human Research Ethics Committee [HREC(Health)2023#16] (see Appendix E). This research was conducted under the supervision of Dr. Cate Curtis, who has extensive experience conducting

research in the fields of self-injury, anti-social behaviour and suicide. In addition, to ensure that this research was conducted ethically, several ethical issues were taken into consideration throughout the process. These are detailed below.

Confidentiality

Given the sensitive nature of the information we discussed in the interviews, confidentiality is a requirement to protect our participants. Participants were informed about what would happen with their information and assured that they would remain anonymous. This involved removing or altering any identifying information and providing each participant with a pseudonym. Access to the interview transcripts was restricted to my supervisor and myself.

Cultural Considerations

To create an environment in which participants felt safe to be interviewed, cultural safety was a vital consideration. Due to the diverse backgrounds of participants in this study, I made sure to ask and not assume the cultural preferences of each participant. In preparation for the interviews, the participants were contacted and asked about both their cultural and dietary needs. However, no participants had any cultural or dietary specific requests. At the beginning of the interview, we shared kai and spent significant time building rapport so that the participants felt both safe and comfortable. Cultural advisors for the SHInE Project Dr. Gloria Fraser (Kāi Tahu, Kāti Māmoe) and Dr Suzanne Phibbs (Kāi Tahu, Kāti Māmoe) were also available for consultation throughout the data collection and analysis processes.

Informed Consent

Informed consent involves informing potential participants about the purpose and design of the study, as well as any potential benefits or risks involved in participation (Brinkmann & Kvale, 2017). Informed consent also requires voluntary agreement from an

individual (or from a legal guardian if the individual is underage) to take part in the research (Brinkmann & Kvale, 2017; Lloyd-Richardson et al., 2015).

To ensure participants were giving informed consent, potential participants were only contacted by the researcher if they had already indicated interest in participating through either responding to my email following their completion of the SHInE project survey or contacting me directly after seeing an advertisement for the study. Those that did indicate interest were sent a copy of the Participant Information Sheet (Appendix C). They were then asked to take some time, read through the information, and contact me again if they were happy to proceed. This step helped to ensure informed consent in two ways. The first was alleviating any pressure to participate by asking them to take some time and contact me if they wished to proceed. The second was providing them with key information about the study, including what participation in the study would entail.

If they proceeded with an interview, the Participant Information Sheet and Consent Form (Appendix D) were both reviewed before beginning and participants were invited to ask questions. They were reminded at the beginning of the interview that they did not have to answer any questions that they did not want to. Following the interview, they were also reminded that they may withdraw their participation up to four weeks following the interview.

Minimising Potential Harm or Distress

Most of the participants were not currently engaging in these behaviours but speaking retrospectively about their experiences. However, due to the sensitive nature of both NSSI and ODI, it was still important to be cautious of the potential harm or distress talking about these sensitive matters might cause. A list of support services was provided on the Participant Information Sheet (Appendix C). It was also outlined on the Participant Information Sheet that talking about your problems and difficult emotions can be very upsetting, and to consider

whether taking part was the right choice. However, for those that felt it would be upsetting but were still keen to participate, suggestions were made on the sheet to help mitigate this such as planning a fun activity to do after the interview or bringing a support person to the interview. Although this option was available, no participants chose to bring a support person to the interview. During the interview, I remained vigilant, monitoring the participants for signs of distress so that they could be offered a break or to stop the interview to minimise potential harm.

Summary

This study utilised a qualitative research approach, to gain a more in depth understanding of two very nuanced behaviours, NSSI and ODI. A semi-structured interview schedule which utilised primarily open-ended questions was used to conduct the interviews. The role of the qualitative researcher was explained, and the researcher acknowledged her own contextual positioning in relation to the study. There were 12 participants in this study with diverse backgrounds. Participants were recruited as part of the SHInE Project, a large-scale research project led by my supervisor, Dr. Cate Curtis, and through advertisements posted on social media platforms and around the University of Waikato campus. The transcripts of each interview were analysed using Braun and Clarke's (2006, 2021) Reflexive Thematic Analysis (RTA). Ethical issues including confidentiality, cultural considerations, informed consent and minimising potential harm or distress were considered throughout the research process to protect the participants in this study.

Chapter Four: Findings

The aim of this study was to explore to what extent self-injury (NSSI) and outward-directed-injury (ODI) are ways of dealing with the same issues, especially in terms of dealing with negative emotions. The following chapter will describe the seven themes that were developed during analysis of the interview transcripts. These themes are: *hurt people, hurt (other) people; self-harm comes in many different forms; adverse life challenges; people are a product of their environment; difficulty differentiating emotion; understanding the risk, doing it anyway; and ambulance at the bottom of the cliff.* These seven themes and their corresponding sub-themes are illustrated below in Table 2.

Table 2

Summary of Themes and Sub-themes

Themes	Sub-themes
1. Hurt people, hurt (other) people	1.1. Physically lashing out 1.2. Verbally lashing out 1.3. Motivations for lashing out
2. Self-harm comes in many different forms	2.1. Cutting and other forms of NSSI 2.2. Restrictive eating 2.3. Sexual activity as self-harm 2.4. Substance use/abuse 2.5. Other self-harmful behaviours
3. Adverse life challenges	3.1. Nonconformity to social norms 3.2. Traumatic events(s) 3.3. Strained relationship with close family member(s) 3.4. Low self-worth 3.5. Depression, anxiety and suicidality
4. People are a product of their environment	4.1. Learned and encouraged behaviour 4.2. Importance of healthy relationships
5. Difficulty differentiating emotion	
6. Understanding the risk, doing it anyway	6.1. Indifference to safety 6.2. Risk is worth the reward
7. Ambulance at the bottom of the cliff	7.1. Not struggling enough 7.2. It was all I knew

Theme one will outline the other-directed injury and harm that participants described engaging in; whilst theme two will outline the self-injury and harm that participants described

engaging in. Themes three through seven will each outline a different common element between self-injury and harm and other-directed injury and harm that emerged during analysis of the data. The themes and sub-themes will be described in the sections to follow, utilising illustrative quotes from the participants' interviews. Themes will also be discussed considering the previous literature. All names have been replaced with pseudonyms, and all identifying information has been withheld to maintain participants' confidentiality.

Theme One: Hurt People, Hurt (Other) People

This theme explores participant's experiences with outward-directed-harm. Although this study was primarily interested in people's experiences with outward-directed-injury (ODI), there were many experiences described by the participants that were outwardly harmful but did not involve physical injury. Behaviours ranged from physical injury to other people, to physical damage to objects, to emotional or psychological harm to other people. These experiences are still important to discuss but are more accurately described collectively as outward-directed-harm (ODH).

As mentioned in earlier chapters, those who engage in NSSI and self-harm more broadly are generally viewed as being unwell or upset. In contrast those who engage in ODH are viewed as being unlawful, unruly or immoral due to the association of the behaviour with criminality. Contrarily, the experiences of our participants indicates that the former perception, of being unwell or upset, was also the driving force behind engagement in ODH. These behaviours fell into two broad categories, physical aggression and verbal aggression. Three sub-themes will explore these behaviours: *physically lashing out, verbally lashing out,* and *motivations for lashing out*.

1.1 Physically Lashing Out

This sub-theme describes the different ways in which some participants would physically lash out when feeling difficult emotions. The nature and extent of this behaviour

varied largely between participants. When asked if she had ever lashed out at others, Gemma detailed getting physically aggressive both at home and at school:

> *"Oh, yeah. Fuck yeah. I assaulted my mum once. I used to beat my younger sister, like out of anger. I used to start fights. Well, I didn't used to start fights, I'd always like finish fights. Like after school, people would have fights with me, and I'd finish them. In like what are they called? Like parks and stuff like the typical high school girl fights and shit like that."* – Gemma.

Finn also described physically lashing out by getting into physical fights with other people while out drinking on the weekends:

> *"Yeah, heaps. When I was younger, I used to, you know, wasn't happy in life, so as soon as I got the weekend, get drunk and just go out, look for fights. Just love it. That's all I used to do. Yeah, so I used to lash out quite a bit. Quite ashamed of how I used to carry on now that I'm older, but yeah, at the time I was very angry and you know…So, yeah, I did that for years and years. Yeah, hurting people violently lashing out."* – Finn.

Hailey, who also discussed physically lashing out at other people whilst out drinking, describes engaging in this behaviour only after being provoked, rather than seeking out a situation in which to lash out:

> *"…but I guess like if I was in a situation like I have been before when I've been like bit angry, and I've been out in a bar setting and someone's like shoved me and said something, like just done something to wind me up, I do lash out and I have physically assaulted someone."* – Hailey.

Although Liam details physically lashing out, the context of his experience is quite different. For Liam, this behaviour occurred primarily within the confines of his romantic relationship with his ex-partner:

"But that [verbal abuse] would be instigated by my ex more so, but then it would lead to physical [abuse]. And generally, that would be started by him, but sometimes it would just be me." – Liam.

For other participants, lashing out would not involve harming another person. These participants would instead tend to lash out at their surrounding environment:

"Yeah, I went through this phase where I would like punch doors."– Alex.

"I indirectly self-harm at times when I would like, punch the shower wall and that until my knuckles were red." – Damian.

Kendall also described physically lashing out at things in her external environment. However, she tried to channel her physical aggression in a more socially sanctioned setting, boxing classes. Although this was not always successful as she explains:

"But as for other things, do I punch things? Yeah, absolutely. That's why I started going to like boxing classes, HIIT boxing classes back in the day. Because I would just, yeah. And last time I was really upset I like threw things across the room and stuff." – Kendall.

1.2 Verbally Lashing Out

In addition to physically lashing out, many participants also discussed their propensity to verbally lash out at those around them when trying to manage difficult emotions. This sub-theme focuses on participants' experiences with this behaviour. Kendall describes how a small inconvenience will prompt her to pick a verbal fight with somebody, despite her best efforts not to:

"Picking fights like I can fucking do that every day. When I'm upset if there's a small inconvenience, I will lash out [verbally] at someone. I'm trying my hardest not to, you know. I have gone to therapy so many times for my anger." – Kendall.

Hailey explains that if somebody does something minor that upsets her, she will intentionally verbally attack that person, even though they are undeserving of it:

> *"So, I guess if I'm angry and like I know someone does something little that's not necessarily like the worst thing in the world, I would just make it worse and then I'll make it out like it's worse than what it is. And then I will say like, I don't know, like awful personal attacks towards that person when they've not really done a lot to deserve it."* – Hailey.

Finn detailed how he would verbally lash out in his relationships when he was feeling upset:

> *"I had some volatile relationships. So, they were quite toxic, like verbally. You know, very, very toxic verbal fights. Yeah, which no one's a winner out of. It's just, you know, bad."* – Finn.

Similarly, Liam would also verbally lash out, however, he refers specifically to one romantic relationship, rather than his relationships more generally:

> *"I guess like in my previous relationship that I mentioned earlier. That became a very unhealthy relationship. Yeah, like reasonably early on. Like just lots of like infidelity, drugs and then that led to kind of being like verbally abusive."* – Liam.

Evidently, the ODH discussed by participants consisted of verbally and physically aggressive behaviours. However, the nature of this aggression seemed to vary. Most of the aggression described tended to be hostile/reactive as it was more impulsive in nature and was engaged in with the intention of harming another (Little et al., 2003). Surprisingly, some participants also described instrumental motives for their aggression, tending to be more deliberate and motivated by achieving a self-serving goal (Bushman & Anderson, 2001; Dodge, 1991; Little et al., 2003; Parrott & Giancola, 2007). For example, Hailey describes verbally lashing out at others. Her intention is both to harm another and make herself feel

better; as she is aware that making someone else feel bad, will make her feel better. This makes the behaviour more instrumentally motivated as it has a deliberate, conscious purpose rather than being impulsive.

As mentioned previously in this thesis, ODH in some instances may still be an inadvertent form of self-harm due to either the physical harm resulting from harming other people or objects (e.g., Fitzgerald & Curtis, 2017; Kimbrel et al., 2018), or the more emotional harm that comes with harming those people and objects close to you. An example of this from the current study's findings is Damian punching a wall to hurt his hand.

In other instances, as per Mann et al.'s (2022) definition for NSSI by proxy, ODH may also be an intentional form of self-injury. The findings indicate as such. For example, Finn seeking out and initiating fights with another person is consistent with Mann et al.'s (2022) definition of NSSI by proxy whereby an individual is intentionally injured via the actions of another being; that is, Finn was injured by another person, but only as a result of Finn's own instigation.

1.3 Motivations for Lashing Out

This sub-theme explores participant's various motivations for lashing out externally. Participants detailed different reasons for their verbal and physical aggression. In terms of what motivated her physical aggression towards others, Gemma said she used it to diffuse the anger she was feeling about other things:

> *"I had so much anger in me that I wanted to, like, take it out on anybody who was like willing to let me. And so, if people wanted to fight like, come on then, like, let's go. Like I'm angry about other stuff, I don't mind doing it."* - Gemma.

Gemma also explained that getting into physical fights with people at school gave her a sense of control over her life that she felt she otherwise did not have:

"And like people wouldn't fuck with me. Or like people would try to fuck with me and then realize that I, like, wasn't playing around and sort of like backed down. And I kind of felt like I had no control over anything else in my life because I was so angry. I had control over, like, people being scared of me. So, I just used that." – Gemma.

For Finn, the feeling he got from fighting people was also a motivating factor. However, this "feeling" was not described with the same positive connotation, but rather indicates that the "feeling" from fighting was a means of circumventing or distracting himself from emotional numbness:

"It depended like, I grew up in a small town, but like I'd go out and get drunk and just like, look for fights like physical fights, like altercations, just to feel something." – Finn.

Finn also explains that lashing out physically and verbally, at both people and the environment around him, was his main method of coping with the negative emotions he experienced:

"That's how I emotionally coped with things. Yeah, was to lash out…Whether it's slam a door, or fucking yell abuse or punch a wall, or yeah." – Finn.

This sentiment was shared by Liam, who also described lashing out to be how he coped with the toxic relationship with his ex-partner:

"…kicking and punching abuse, shouting at people…It was just to try and like cope with the situation." – Liam.

Kendall explains that for her, "being mean" is a key indicator that she is not doing well. When she is not doing well, she describes deliberately lashing out at those around her by starting arguments. These arguments were a means of venting all her negative emotions:

"But I do like, I also lash out at the people obviously, and I think like, I know I am struggling the most when I'm mean…And when I like purposefully say mean things to

people or start an argument, because if I start an argument with someone and they argue back, I can let out all my upsetness and anger." – Kendall.

Hailey details how for her, verbally lashing out at others made her feel better by bringing others down, so she was not the only one feeling bad:

"And then I think the lashing out [verbally]… is just about maybe kind of making someone else feel bad, so I feel better that I'm not the only one feeling that way." – Hailey.

Whereas for Finn, verbally lashing out was a result of negative emotion being pent up and not expressed:

"If I'm angry, it'll be like a build-up, and then it'll explode because just the severity of how it comes out… Like little things tick me off and then I'll just like verbally explode. You know, like fuck off, or just you know." – Finn.

All participants discussed engaging in ODH as a means of trying to regulate their difficult emotions. This is consistent with the existing literature in which there is an established relationship between aggression, negative affect and emotion dysregulation (Donahue et al., 2014; Garofalo & Velotti, 2017; Velotti et al., 2016).

As can be seen from these results, ODH is a nuanced behaviour that participants engaged in to differing extents and for different reasons. This theme highlights ODH as an emotion regulation strategy, as for all participants, at least an element of their motivation for lashing out was to regulate their emotions.

Theme Two: Self-Harm Comes in Many Different Forms

This theme explores participant's experiences with self-harm. Although this study was primarily interested in people's experiences with NSSI, there were many experiences described by the participants that did not fit the definition of NSSI. These experiences tended

to fit the more general definition of self-harm. Accordingly, participant's experiences with self-harm are explored in five sub-themes: *cutting and other forms of NSSI, restrictive eating, sexual activity as self-harm, substance use/abuse,* and *other self-harmful behaviours.*

2.1 Cutting and Other Forms of NSSI

Cutting was the most common form of NSSI and self-injury among participants, with 8 out of 12 having engaged in cutting to varying degrees of severity. Charlotte detailed her experience with cutting, explaining that she mainly cut in an area that she felt was less visible to other people:

> *"So, I would cut like my forearm. Predominantly the arm, which is why I've got most of the scars on it. I think I once like did it on my leg. I stopped doing that because in PE, you can see your legs. And then, I once did it on my chest as well. But it was predominantly my left forearm."* – Charlotte.

Both Gemma and Hailey also described their experiences with cutting and similarly, describe hiding the behaviour from others:

> *"Yeah, and like I used to, I grew up self-harming. Yeah, like from maybe like 13 to like maybe 16. I was self-harming as in cutting and stuff like that and hiding it."* – Gemma.

> *"So, when I was younger, when I was really sad, I used to self-harm. So, I would obviously cut myself…On my legs. The inside of my thighs, tops of my thighs. Like kind of anywhere that was covered, by clothes, yeah."* – Hailey.

Brooklyn discussed her extensive engagement in different forms of NSSI, and touched on how this behaviour was quite upsetting for those around her:

> *"So, I did used to cut myself. And I would pull my hair out in clumps cause it felt like velcro in my head, it felt like velcro so I enjoyed pulling my hair out. I would skin pick. When I was 12 it was only via cutting but obviously once I came out of high*

school, I really just stopped caring. So, I did skin pick quite badly. I would, I mean this might be one of those not direct ways, but I would try and break my arm to get out of work or punch walls… I would bang my head, or smash things against my head. Which was really traumatising for those around me cause I would just have no regard for them. I think I was always just pissed off. I would smash cups against my head, or plates or vases." -Brooklyn.

Jessica describes how she used to interfere with the healing of a wound:

"Yeah, and I also think in terms of like physical self-harm, like I've never really done any physical self-harm, but when I was very, very, very sick, I used to just absent mindedly scratch at this one little spot. And I was scratching at the same spot, it's got this little scar there. And it's just, it used to be like quite a deep cut, and I'd always be playing with it, and it would not be great. But so absent minded…And then when I wasn't sick anymore, I was like, oh, shoot. Like, that is painful. It's just when I was in that state, I just physically couldn't feel it. It wasn't painful. So it was weird." – Jessica.

For Eleanor, her engagement in NSSI included both cutting and skin-picking:

"I used many types of self-harm. I used to, my form that I used to do was cutting." – Eleanor.

"One of the things I did do, that I forgot to add is I would skin pick…And then like I'd end up with sores on my head. And like, it was quite dangerous cause I obviously can get infections. And so like, I had open wounds on my head and it was really bad. It was not fun." – Eleanor.

Damian discussed cutting himself with a blade, stabbing his hand with a pin, and mentioned encouraging the cat to scratch up his hand:

"I started stabbing the top of my hand with a pin a bunch… I'll get the cat to, like, scratch up my hand and that as almost as a way of indirectly self-harming, I think… But I have cut my arms and thighs in the past." – Damian.

Alex described hurting themself by pinching themself when feeling upset, elaborating that their response depended on the intensity of the emotions they were feeling:

"Sometimes like I'll hurt myself, like I'll pinch myself or something. Yeah, it kind of like depends on like I guess why I'm in that headspace and how intense that headspace is." – Alex.

When asked what they did last time they were feeling an intense negative emotion, Alex said:

"I think cut myself." – Alex.

Kendall used to engage in NSSI by cutting herself. However, she explained that although she no longer intentionally cut herself, she felt like she may be engaging in other self-harmful behaviours unconsciously:

"I did used to self-harm…– Kendall.

"And I think I must, like there's so many other different ways you could hurt yourself. So, like, I'm sure I am subconsciously doing that anyway. But no, I'm not like cutting myself anymore in the current state." – Kendall.

The majority of the NSSI engaged in by participants is consistent with the common forms of NSSI documented within the existing literature (Klonsky, 2011; Klonsky et al., 2014; Lurigio et al., 2023; Nock, 2010; Nock & Favazza, 2009). Not so commonly mentioned in the existing literature is the injury engaged in by Damian, in which he encouraged his cat to scratch his hand. However, this form of injury does draw parallels with more recent research by Mann et al. (2022) on NSSI by proxy, in which an individual is intentionally injured via the actions of another being. Under this definition Mann et al.

considers initiating injury from an animal to be a form of NSSI by proxy as well as five other behaviours.

In line with previous literature, many participants in this study reported using multiple methods of NSSI (Klonsky et al., 2014). Although there were numerous ways in which the participants in the current study engaged in NSSI, the scope of behaviours considered NSSI under the current definition is relatively narrow, only considering acts that deliberately and directly damage one's own body tissue, without suicidal intent. However, alongside using multiple methods of NSSI, participants also reported engaging in many different behaviours intended to harm themselves that did not fit the definition of NSSI. Accordingly, the following sub-themes will explore participant's experiences with self-harm that do not meet the definition for NSSI.

2.2 Restrictive Eating

This sub-theme will explore participants experiences with restrictive eating. Gemma identified her bulimia as a form of self-harm. She described struggling with bulimia for a period of time as she was unhappy with her weight:

> *"Oh, is bulimia another one? Like another thing of self-harm? ...Because I was like that too, for a couple of years. Yeah, because there was that as well. And I feel like that was self-harm as well for me. Yeah, because I was trying to, like, make myself better. But like, not doing it the right way."* – Gemma.

Gemma later elaborated on how she engaged in this behaviour, and explained that she only made the decision to stop as she was not losing weight as she intended to:

> *"And I just had an absolute gutsful of like hearing the comments [from her father about her weight] and I was like, if I make myself skinny like I won't have to hear them again. And so, I would eat dinner upstairs with my family and then go downstairs, and I'd either turn the shower on or flush the toilet because the water*

level is lower than the toilet, so it's gotta, like pump up. So, it takes ages and it's really loud at my parents' house. And so, while the toilet was doing that, I was with a toothbrush over the toilet, like doing what I had to do. And it wasn't working. And I was like, what is going on? And it was probably the fact that I would binge-eat. And then do it. And then I also had PCOS, but I didn't realize because I had always been like big, and we couldn't understand why. And I didn't realize it was like an actual disorder. Like, I've got something wrong with me. So, I stopped because it wasn't getting me like, where I wanted it to get me. So, I stopped that and then I tried all these weight loss, fat burner stuff and all that instead." – Gemma.

Brooklyn, who is 24 years old, described an extensive history with restricting her eating, recounting that she has struggled with an eating disorder since she was 12 years old:

"So, they took me to the hospital and they said well you're a healthy weight, therefore you don't have an eating disorder. I was at [mental health inpatient unit] for 30 days. I ate one of those days and on my discharge notes it said, "she ate once on Wednesday therefore, she doesn't have an eating disorder"; when I've had this eating disorder since I was 12." – Brooklyn.

Brooklyn discussed in her interview how behaviours associated with her restrictive eating, such as consuming eating disorder content online, would make her feel worse:

"Like I had an eating disorder in the past so I would consume myself in that kind of part of the internet and just really make it worse. Not because I, no I don't think I enjoyed it, I think I just knew what to expect when I felt like shit." – Brooklyn.

Eleanor also described restrictive eating behaviour as self-harm, explaining that she had been hospitalised numerous times because of this behaviour:

"I used many types of self-harm… And restricting eating was another one." – Eleanor.

> *"So yeah, in the past, the things I did were like, very risky. Yeah, like lack of food intake led to many hospitalizations and things. And that's not good for you."* – Eleanor.

The self-harmful intentions behind the restrictive eating varied among participants. Whilst Gemma and Eleanor both identified the behaviour as self-harm and acknowledged the intended harm, Brooklyn did not identify her eating disorder as a form of self-harm, rather something that upset her. Disordered eating is typically considered indirect self-harm as the behaviour is thought to be motivated by factors other than self-harm, and the harm does not occur immediately after engagement in the behaviour, but rather sometime later.

However, some of the participants in the current study seemed to identify their restrictive eating alongside their direct methods of self-harm (i.e., cutting and other forms of NSSI). In line with the findings by Fox et al. (2019), this suggests that these participants engaged in NSSI and disordered eating for the same reason, to intentionally physically harm or injure themselves.

2.3 Sexual Activity as Self-Harm

Some participants also described their experience using sex as self-harm. Liam discussed engaging in unprotected sex with men he did not know when he was feeling negative emotions, and how this often resulted in him contracting sexually transmitted infections:

> *"I mean like in the past, I guess, like when I was feeling down or low, well like not necessarily when I was feeling down, but there's definitely like a pattern that I've noticed. And then I'll do like risky things, like I'll go out and, like, have hookups with other men and that will be unprotected sex. And yeah, I mean, many times, that's like resulted in me getting sexually transmitted infections and stuff. But I've been lucky enough that everything's treatable."* – Liam.

Hailey describes a similar experience explaining that she would have sex with people she did not know in unsafe conditions when she was feeling negative emotions:

> *"… or even like five years ago I'd use sex as a form of self-harm. And it was just like a way to, like, make my emotional feelings more, I guess physical. So, I guess I would do that… But it would be risky behaviour because it would be with people that I didn't know. It would be with strange people. It wouldn't be in safe conditions."* – Hailey.

There were different motivations for these behaviours among participants. Liam describes enjoying the thrill of the encounter and confidence boost:

> *"I mean sex for example, I guess that's just kind of like that exhilarating feeling. And then I, you know, from meeting up with someone and then I guess, you know, gives this kind of weird thing of feeling a bit sexy."* – Liam.

For Hailey, the risky sexual activity was a means of distracting her from negative feelings, as well as channeling the emotional pain into a physical sensation:

> *"I think it was definitely like a distraction thing using the sex as a form of self-harm, and then making that emotional pain feel more physical as a way of dealing with it."* – Hailey.

Imogen also recalls engaging in risky sexual activity in the past. However, unlike Liam and Hailey, Imogen did not explicitly identify her risky sexual activity as being self-harm, but rather identified it as being risky coping behaviour. Nonetheless, the behaviour she describes is strikingly like the sexual activity that was described as self-harm by other participants:

> *"Like the last time I was single, which was back when I was like 22, you know, there was some more impulsive, risky sex stuff. Like just meeting up with people that I hadn't really gotten to know. Everything worked out OK, fortunately for me. But yeah, there's definitely been a history of some risky business, yeah."* – Imogen.

The experiences of these participants support the emerging literature around the use of sexual activity as a form of NSSI. As outlined by Mellin et al. (2024) participants reported exposing themselves to sexually transmitted infections and engaging in sexual encounters with undesired partners and/or consisting of undesired acts. Some participants indicated that they engaged in sexual activity with a partner to intentionally injure or harm themself, which would qualify as an act of NSSI by proxy as outlined by Mann et al. (2022).

However, contrary to this literature, in some instances participants indicated that they would engage in the sexual activity not necessarily with the intention of directly harming or injuring themselves but to make themselves feel better by distracting themselves, receiving validation from others, or experiencing an adrenaline rush. In some instances, it seems that the harm caused by the sexual activity, such as sexually transmitted infections and engaging in sexual encounters with undesired partners and/or consisting of undesired acts, were unintended consequences rather than the intended outcome. It could also be true that participants were dually motivated by both the desire to feel better, and the desire to cause harm or injury to themselves.

2.4 Substance Use/Abuse

Use, and in some cases abuse, of substances was a common experience among participants. Many identified this as a form of self-harm. For Hailey, recreational drug use was regular weekend activity during her teenage years:

> *"I mean, like I did abuse recreational drugs, but I think that, yeah, could, could probably be that [self-harm] too."* – Hailey.

Finn described how as he got older; binge drinking would accompany his physically aggressive behaviour:

> *"So, I'll just as a kid lash out physically and then as I got old enough to start drinking, I'd drink and lash out. Or black out."* – Finn.

Although Finn no longer physically lashes out at others, he described still using alcohol as a coping mechanism. Despite still using drinking as a coping mechanism, Finn also acknowledged that alcohol would make him feel worse:

"If I'm having a shit day, which I do sometimes, I'll get on the piss, just to block it out. Yeah, I use alcohol as a.... I self-medicate with that… like it's, it's one of my tools of coping. It doesn't make it better. But, you know, escape it for a couple of hours… The next day, it's worse. Probably next couple of days." – Finn.

Gemma explains how she developed an addiction to tramadol. Although the medication was prescribed to relieve her physical pain, she quickly found that it also relieved the emotional pain she was experiencing too:

"I get migraines really bad. And so, the tramadol was prescribed for migraines. And then, like, so I was originally taking it for that. But then I liked the way that it made me feel drowsy because I was kind of like, not there. So, like I that's what I would do, when I would feel like overwhelmed, I would just take like not the prescribed amount. I'd take more than the prescribed amount just to be like, OK, like I'm chill, I can't feel anything, it's good, type of thing." – Gemma.

Gemma also discussed abusing recreational drugs and alcohol. She described how this behaviour was a means of distracting herself from the negative emotions she was feeling, by numbing these emotions:

"…I would put myself in stupid situations to feel better about how I was feeling. So, like doing things with people that I shouldn't have been like doing, like drugs and drinking alcohol and lying to people about it." – Gemma.

"I think the like the drugs, the alcohol, like the Tramadol and all that stuff. I think it just, I was trying to find ways to numb myself. I don't think to be fair that like any of it really helped because it just got to a stage where I was just drunk all the time. I would

like go to school and drink alcohol at school and just be drunk so that I didn't have to feel anything." – Gemma.

Imogen also details her experience with addiction, explaining that previously alcohol was an emotional crutch for her, and that she is a recovering alcoholic:

"So, for context, I'm 32 now, I'm technically still a recovering alcoholic… I stopped drinking when I was 23. Yeah. So that was previously a big crutch and that was common in my family as well. That was, you know, like the feelings management tool." – Imogen.

Imogen goes on to explain that she currently smokes marijuana as a means of coping day-to-day with some difficult life events, including a recent break up:

"And I'll be honest, I've been smoking a bit of weed lately, yeah… after my breakup, we were smoking a fair bit of weed before that, but when that happened it was just really hard, and I was still trying to go to work and get on with it and ended up relying on it. Yeah, unfortunately, but that's where we're at." – Imogen.

Liam also described using marijuana as a coping mechanism, as it stopped him from ruminating on things. However, he also explains how his casual use developed over time into a dependence:

"So, I guess like the main one is marijuana or weed. I guess it's kind of like an escape. And I guess it just stops for me, like I feel like I overthink stuff. And sometimes it just kind of stops that from happening. But then that kind of becomes like an unhealthy sort of like coping like "oh I've had a bad day", or just like "I'm bored". And like you develop that kind of like dependence of like just wanting that kind of feeling." – Liam.

The participants were all aware of and acknowledged the self-harm caused by their substance use or abuse, even though the intention of the behaviour was not to self-harm but

rather, a means of coping with their difficult emotions. Although the self-harm was not deliberate, it was an unintended consequence, and therefore, a form of indirect self-harm. This resulting harm included both physical harm, such as the dependence that both Imogen and Liam developed, and psychological harm.

Engagement in indirect self-harm is still significant to discuss here as there are numerous commonalities between indirect self-harm and NSSI. Some of these commonalities include lower self-esteem, higher levels of aggression, depressive symptoms, negative temperament, symptoms of borderline personality disorder, greater impulsivity, higher levels of disinhibition, and more dissociative experiences (St. Germain and Hooley, 2012).

2.5 Other Self-Harmful Behaviours

There were some behaviours identified by participants as being self-harmful that did not fit within the parameters of the previous sub-themes. However, these behaviours and experiences are still relevant and important to mention. For Jessica, her people-pleasing tendencies were often to the extent of self-harm. She explained how this would lead her into risky situations that she would not know how to get out of:

> *"I think I would say that a lot of my people-pleasing tendencies were to the point of self-harm…and then, you know, like I'm in a situation I can't get out of. Like there's you know, I'm in a dark room under the bar, and everyone's doing cocaine and I'm like, oh, my God, this is actually a bit out of my comfort zone, but I don't know how to get out of here now."* – Jessica.

Jessica also discussed how she went through a long period in which she refused to take pain relief medication, instead choosing to remain in pain:

> *"…or there were times where I would kind of purposefully make myself feel worse… Like for the longest time I would just never take painkillers cause I was like, no, I don't need it. I don't need it. And I would tell myself like it was because I wanted to*

know how much pain I was in so I knew, like, where my limits were and stuff. But it just it wasn't. And then one day I woke up and I was like, why do I not like, you know, like period cramps for example, like they come. I know what they are. I know why they're there. Like why wouldn't I take pain relief to get rid of them. That's so bizarre of me. So, I started taking pain relief, but for the longest time I would just deny that, deny myself that." – Jessica.

Damian described driving dangerously when he was feeling negative emotions. Although there is no direct or immediate injury or harm from this behaviour, Damian intentionally put himself in a dangerous situation as a means of regulating his negative emotions:

"Depending on like if it's later at night, I'll go for a drive. And I'll drive with loud music, generally at the higher speeds because it's therapeutic. Go around the back roads, whatnot, just cruising it around 100 in the back roads. Listen to music, yeah. But I do probably drive a bit dangerously when it gets like that. Yeah, probably cause it's as I said, I find speeding therapeutic." – Damian.

Imogen also discussed her tendency to binge-eat when she was feeling sad or stressed:

"Like I had a fairly clear history of sad and stress eating. As opposed to like, if I'm hungry…" – Imogen.

"It's like you stop and think about it afterward and you're like, I've just dumped so many calories because I had a bad day. And then I'm going to feel bad about it for, you know, x amount of time." – Imogen.

Many of the behaviours outlined in this sub-theme are not considered to be self-harm in any part of the literature. However, participants identified these behaviour as either self-harm or self-harmful. One potential explanation for this finding is that these participants viewed self-harm more holistically. Of note, all three participants who described experiences

of self-harm in this sub-theme are Māori. This is significant as Kingi et al.'s (2017) study found that for many rangatahi Māori (Māori youth), definitions of self-injury reflected a much broader and holistic worldview. Like the current study, many of the behaviours described by the rangatahi and whānau who took part in Kingi et al.'s study served the same purpose but did not fit within the western definition of NSSI.

This theme and each successive sub-theme highlighted the significant variation in self-harm behaviours engaged in by participants. Although 8 out of 12 participants discussed their engagement with NSSI, specifically cutting, their self-harm behaviour was far more extensive than that. Some of these behaviours resulted in immediate harm or injury, whilst others were detrimental to participants over time, after continued engagement. These findings are consistent with the emerging literature that proposes the definition for NSSI should be expanded beyond only acts that deliberately and directly damage one's own body tissue (Fox et al., 2019; Mann et al., 2022; Mellin et al., 2024; St. Germain & Hooley, 2012). As evidenced in the previous literature and by these current findings, there are many different behaviours utilised to injure or harm oneself. Overall, these findings draw attention to the fact that participants tended to engagement in diverse coping behaviours.

Theme Three: Adverse Life Challenges

This theme explores personal life challenges that were commonly experienced among the participants. Each challenge was an antecedent factor, either predisposing, precipitating or perpetuating the participant's risky coping behaviour. These challenges were sources of distress for participants, which in turn contributed to their engagement in self-harm, ODH and other risky coping behaviours. These personal life challenges will be explored in five sub-themes: *nonconformity to social norms, traumatic event(s), strained relationship with close family member(s), low self-worth,* and *depression, anxiety and suicidality.*

3.1 Nonconformity to Social Norms

This sub-theme describes participant's experiences with being different, and the difficulties experienced when diverging from a prescribed social norm. For Alex, who is non-binary, their gender is something that can make them feel upset; largely due to the challenges that come with being transgender such as body image issues, hormone therapy, coming out, and being misgendered:

> *"And the way that like, because I'm trans, and being trans is hard, so like everything that comes with being trans like other people's views of it, my body, having to do hormone therapy all that, yeah."* – Alex.

For Charlotte, who has a vision impairment, there were many challenges in navigating not only the vision impairment itself, but also navigating the ways in which this impairment made her different from her peers:

> *"So, when I was in school… to help with my vision impairment I would have like a teacher aid. And I also received an iPad through BLENNZ to sort of take photos of the board, and like type up notes that kind of thing. And so those kinds of things made me sort of stick out. So, people would sort of pick on me in terms of like, oh, I only got good grades because I had a teacher aid. Or because people don't really have an understanding around vision impairments, and the range that it is, because there are certain things that I could do, people like some people joked that I was faking it or something along those lines."* – Charlotte.

Speaking more generally, these sentiments are shared by Imogen who described always feeling different from those around her:

> *"I think, like it's kind of always been the same thing from when I was younger. Just kind of feeling like a bit different to the world, if that makes sense."* – Imogen.

The existing literature shows that LGBTQ+ youth have a higher risk of engaging in NSSI than heterosexual, cisgender youth in both community and psychiatric samples (Peters et al., 2020; Speer et al., 2022). Disability is also a risk factor for engagement in NSSI and suicidality (Tseng & Ditchman, 2024). Although there are no studies that have investigated the relationship between vision impairment specifically and NSSI, Akram & Batool's (2020) study found that participants with a visual impairment were much more likely to engage in suicidal behaviour than youth without a sensory impairment. This finding is still relevant as NSSI and suicidality are known to frequently co-occur in individuals, the intent behind self-injury (i.e., suicidal or non-suicidal) is often unclear, and NSSI is a reliable predictor for future suicidal behaviour (Griep & MacKinnon, 2020; Hamza et al., 2012; Hawton & James, 2005; Kapur et al., 2013; Kiekens et al., 2018; Ribeiro et al., 2016).

Whilst the existing literature documents having a disability and being a member of the LGBTQ+ population as risk factors for engagement in NSSI, little research has been conducted investigating whether membership of these minority groups is a risk factor for engagement in ODH. Alex discussed briefly engaging in ODH as a coping tool when they were upset. Alex also explained that being transgender and the challenges that come with that was one of the main reasons they felt upset. Although Alex's experience indicates that there may be a relationship between being a gender minority and engaging in ODH; this is not generalisable as this sample was not intended to be representative, but rather to provide in-depth insight into these participant's experiences with self-harm and ODH. Therefore, it would be beneficial for future research to be undertaken with a larger, more representative size to investigate whether there is an association between engagement in ODH and having a disability or being LGBTQ+.

3.2 Traumatic Event(s)

This sub-theme highlights the role of trauma for those that engage in self-harm and ODH. Many participants discussed traumatic events or experiences that they had lived through, and how these events or experiences impacted them and their subsequent coping behaviours. To maintain the privacy of participants some of their accounts of their experiences are heavily redacted. Liam discussed being groomed and sexually abused by a man that he met online as a teenager:

> *"But when I was maybe like 14 or 15, I was like groomed by this guy online…You know, like it's weird. I struggle at times to deal with, it's such like a fucked up thing, yeah. But now like it influences you know, like my sexual preference [for anonymous risky sex], I guess you could say."* – Liam.

Eleanor discussed the passing of her father, and the impact of that sudden loss on herself and her family, who were her usual support system:

> *"Like my dad passed away suddenly and stuff and everything just kind of went downhill. So, I think I feel like, I just didn't have the skills to cope with it and like my family situation, the people I had always had really close to me were also grieving… it was kind of like the rug was pulled out from under me and like, unfortunately, I think the more and more I did it [cutting], the more and more it kind of became a cycle."* – Eleanor.

Gemma also struggled with grief due to the unexpected death of her older sister, and described feeling a lot of anger following this loss:

> *"Even though, like [older sister] was already dead… I was still angry. Like, there was a lot of anger. I was so angry about everything."* – Gemma.

In addition to the loss of her sister, Gemma also discussed being the victim of childhood sexual abuse and feeling like she did not receive sufficient support following the abuse:

> *"I was sexually abused from the ages of 6 to 10 by a family friend. And my parents were too busy going through shit to kind of, maybe see that something was not quite right. And then when things came out, they never got me the help. Like I didn't wanna press charges, and I understand that. But they should have got me help for that as well. Because I think that's a lot of the anger as well."* – Gemma.

Finn, who regularly lashed out at those around him verbally and physically, discussed how his anger was the product of unresolved abandonment issues. These issues were a result of his father leaving the family when he was a young child:

> *"...so when I was younger my dad left, and [it] all comes back to emotion. I was only a little boy and my dad left and [I felt like] we're not good enough, self-worth, all that stuff. And then so as I got older, I just lash out, lash out anger and that. And so, I understand that now and so and I'll process it now, so I'm not as angry as I used to be, but it was more just, you know, like that abandonment issues."* – Finn.

These findings align with the previous literature that has identified adverse childhood events as risk factors for engagement in both NSSI and aggression. Participants in the current study identified the death of a sibling or parent and child-parent separation as significant traumatic events that impacted the way in which they cope with difficult emotions. This is consistent with the findings of Carr et al.'s (2020) study which also identified the death of a sibling or parent and child-parent separation as risk factors for engagement in both self-harm and violence; as well as other adverse events including hospitalisation due to an assault, a serious accident, self-harm, residential transience, parental unemployment, or a mental illness diagnosis.

Two participants also discussed being victims of sexual abuse in childhood and explained how this abuse impacted their subsequent coping behaviour. This is significant as a history of sexual abuse is an established risk factor for engagement in NSSI, aggression and criminality (Briere & Gil, 1998; Curtis, 2016; Curtis, 2017; Estévez et al., 2016; Hawton & James, 2005; Norton-Baker et al., 2019; Swanston et al., 2003).

3.3 Strained Relationship With Close Family Member(s)

A consistent theme among participants was having a strained relationship with a close family member. The relationships described by participants varied in nature from differences in personality to dysfunctional, to abusive. However, each different dynamic provided participants with a source of significant stress and tension. Damian, who lived with his mother, described their relationship as being toxic:

> *"Home can be a bit.... Me and my mum don't have the greatest relationship. So, it can be a bit toxic at times, but she doesn't help. Yeah, I mean, nor do I. But yeah, that's just how I am with my mother."* – Damian.

Imogen also discussed the relationship with her mother, explaining that her mother's difficulty relating to and empathising with other people was a point of contention:

> *"I do struggle sometimes with the relationship that I have with my mum. For years I actually thought she had narcissistic personality disorder, but in the last few years I've figured out that I'm probably autistic, and she's highly likely to be autistic herself, so she has a really poor ability to relate to other people."* – Imogen.

Brooklyn described struggling to relate to her mother, and harbouring a lot of resentment towards her mother as she did not support Brooklyn while she was unwell in the way that she wanted her to:

> *"I had a lot of emotion towards my mum. And the mother who she is, so I really attacked her as a mother when I was unwell… But I know like when she was, when*

she had me and my brother, she had really bad post-natal depression. She suffered, so she's gone through some of the things I've gone through, but she's not the emotionally expressive person, and that's what I always wanted her to be. I wanted her just to show emotion. But my mum's not like that so [I] either had to accept it, or not accept it, and I, I mean I love my mother. And so she did at times make me very upset or just very angry and hateful." – Brooklyn.

Charlotte detailed growing up with an abusive father and the complicated feelings that come with that relationship due to the abuse she witnessed and experienced:

"So, I mean like my main sort of the main protagonist in our family is probably my dad… he was quite an aggressive person… he was like emotionally abusive to all of us. And physically abusive to my mum, which we had to witness quite a bit when we were growing up…So, we have very strong feelings towards him in terms of like he's our father and we love him, but we also have strong negative feelings towards him. How would I label those like? I'd want to say like anxious feelings towards him. Yes, he's quite, or he can be quite unpredictable in that regard." – Charlotte.

Gemma also described having a difficult relationship with her father due largely to the inappropriate comments he would make:

"My dad is just very different to how I am, and he doesn't think about what he says before he says it and it comes across as [bad]. It's very damaging some of the things he says." – Gemma.

Gemma went on to elaborate on her previous comment, explaining that her father would constantly make comments about her weight as a child:

"…my dad was making comments, he's always made comments about my weight. Like for as long as I can remember. And I was always like the fat kid. And he made, like,

special nicknames for me. Like just to point out that I was the fat kid of the family." – Gemma.

Hailey described having a difficult relationship with her mother, father and her brothers due to the differing ways in which her and her brothers were treated by their parents:

"I've had a strange relationship with my [parents] for quite a long time… And I've kinda always felt like I was the extra child or the child that was just there and unwanted. So, I felt like I've unfairly been treated by them on occasion. Not always. I wouldn't say it was always abusive the way they treated me, but I do think some of the aspects were quite awful. And I think my relationship with my brothers is a bit strained just because I noticed that they got treated better than me and didn't have as much responsibility or didn't get forced to do as many things as I had to. So, it's a bit of resentment." – Hailey.

The family relationship dynamics described by participants vary significantly, from resentment because of childhood abuse to clashes in personality. However, regardless of the reasoning, poor family functioning was reported as a significant stressor for participants who engaged in self-harm and/or ODH. This finding corresponds with the existing literature in which family dysfunction is associated with engagement in NSSI and aggression. Inversely, healthy family functioning is associated with NSSI recovery and reduced aggression (Andreas & Watson, 2009; Kelada et al., 2018; Pérez-Fuentes et al., 2019; Wang et al., 2022).

The existing literature along with the current study's findings indicate that interventions targeting self-harm and ODH should be targeted at both the familial and individual levels, as improving an individual's family dynamic should in turn reduce the individual's engagement in self-harm and/or ODH by removing a significant stressor.

3.4 Low Self-Worth

This sub-theme explores participant's feelings of low self-worth and the impact this had on their ability to cope with difficult emotions. Some participants had good self-awareness and were able to directly identify how their low self-worth influenced their risky coping behaviour. Hailey described engaging in risky coping behaviour because she felt that her feelings were not important or valid and therefore, did not deserve to be spoken of:

> *"I think it was just easier to do these [self-harm and ODH] rather than talking to people about my issues because I didn't feel like the way I was feeling was valid and I felt that my emotions were kind of not worth speaking about."* – Hailey.
>
> *"So, I think I just feel like, oh, like, who cares about having sex with this person because, you know, like it doesn't matter. They're not important, my feelings are irrelevant, type of thing. Just trying to, yeah, I guess it's just using that and like having low self-worth and being like oh well it's not worth anything, you know?"* – Hailey.

Finn explained that he had low self-worth as a result of his father leaving when he was a child. He identified that his low self-worth is what caused him to lash out at others as he got older:

> *"I was only a little boy and my dad left and [I felt like] we're not good enough, self-worth, all that stuff. And then so as I got older, I just lash out, lash out anger and that."* – Finn.

Other participants did not necessarily relate their low self-worth directly to their risky coping behaviour, but did discuss how this impacted them more generally. Damian described feeling that his worth was tied into how useful he could be to other people, insinuating that he had to continue to be "useful" so that people would still want him around:

"I don't know, at least with me, it's the constant kind of like low ringing in the back of your head; of what a worthless, useless piece of shit you are. The nagging in the side of your head that one day you're gonna become useless to everyone, and that you're going to become alone again, that everyone is going to not need you." – Damian.

Brooklyn described intensely disliking herself, and the impact that had on her ability to plan for or feel optimistic about her future:

"I mean I really did not like myself." – Brooklyn.

"…I mean I often got sad, or not even sad maybe just… very despairing about my future, what I'm capable of, I didn't have very high expectations, I didn't have any, what's the word? Like I didn't think I was ever gonna do anything, amount to anything, be anything, be capable of anything." – Brooklyn.

Eleanor explained that she had not always felt so negatively about herself, but how her self-hatred developed as she became more mentally unwell. She described feeling resent towards herself as she went from succeeding to struggling:

"I feel like I just felt, it sounds so bad, but I just felt like such a massive, intense hate for myself. Like I was very much an overachiever, and my life went from, like doing alright to like, literally not passing school. I was like almost really mad at myself. I just hated myself. I just couldn't." – Eleanor.

Jessica mentions how Christian ideology around sin played a role in her low self-worth and feelings of inadequacy:

"I think because, for a very long time, I just had this idea that if I wasn't perfect, then there was kind of no hope or like there was no, like if I wasn't perfect, then everyone would leave. Like was kind of like, you know, like very, very weirdly like that Christian ideal of like "oh you sin then you're a lost hope", you know." – Jessica.

Consistent with the previous literature, the current study found that those who engage in self-harm and ODH reported having low self-worth (Forrester et al., 2017; Garofalo et al., 2015). Those with low self-worth are predisposed to aversive mood states (Forrester et al., 2017) which in turn may instigate engagement in self-harm or ODH as a means of emotion regulation (Donahue et al., 2014; Garofalo & Velotti, 2017; Nock, 2009; Klonsky, 2011; Curtis, 2016b; Tanner et al., 2016; Velotti et al., 2016).

Whilst some participants were able to identify the antecedent role of their low self-worth on their risky coping behaviour, other participants could only acknowledge their low self-worth, but not the influence it had on their coping behaviour. As self-worth was not directly asked about, there may have been other participants in the current study who, similarly to some of the participant's reports above, could not see the connection of their self-worth to their engagement in self-harm and/or ODH and therefore felt that this factor was not relevant enough to mention.

3.5 Depression, Anxiety, and Suicidality

It is well known that depression, anxiety, and suicidality are associated with NSSI and self-harm more broadly. However, struggles with depression, anxiety, and suicidality were also very common among those struggling with ODH. This sub-theme describes participant's experiences with depression, anxiety and suicidality. Finn, who engaged primarily in ODH outlined his struggles with anxiety:

> *"So, like with the anxiety going back to work, I just, cause I've dealt with anxiety for probably the last 10 years, I just try and... what positive reinforcement. If I have, like an anxiety attack, I'll do like breathing techniques that I've learnt and that really helps sort of calm me down."* – Finn.

Finn also discussed suffering from depression in the past, and struggling with suicidal thoughts during this time:

"When I was young when I had suffered depression. Like yeah. A lot of times, thinking oh you know, the world will be better off without me, blah, blah, blah self-pity all that sort of thing." – Finn.

Brooklyn described previously struggling with suicidality when she felt she was not going to recover from an eating disorder:

"But I was very, I was struggling with an eating disorder at the time, and I didn't think I was ever gonna recover. Therefore, it was pointless living, cause I didn't wanna live with one, and I didn't see myself recovering, so what was the point of me being here?" – Brooklyn.

An ongoing stressor for Brooklyn is anxiety. However, she discusses knowing what triggers her and managing herself accordingly:

"Because I know the world is quite, not a trigger for me, but I am easily susceptible to getting anxious from the state of the world. If I notice that's coming up or more occurring in my head, I pretty much just go off my phone, go off social media. Like I did that a few weeks ago, I haven't been on social media much in the past three weeks just because I get anxious from what's on there." – Brooklyn.

Kendall also struggles with anxiety, explaining that she does not have any specific triggers:

"…well, being anxious is like the biggest thing for me. And it doesn't like actually have [to be] anything specific, it just happens." – Kendall.

Gemma touched on the fact that she had depression, and then discussed an instance where she tried to commit suicide:

"And even like now, I've got, like, I've been diagnosed with, like, depression and stuff like that." – Gemma.

"…like when I was feeling overwhelmed and stuff like that, I tried to commit suicide…I tried to overdose with Tramadol, but I didn't take enough and then I also tried to slit my wrists. I smashed a bottle and used the glass to slit my wrists." – Gemma.

Eleanor also mentioned that she had attempted to commit suicide multiple times:

"And then I had like, recurrent suicide attempts." – Eleanor.

Jessica has suffered from both depression and anxiety, and discussed how she often felt that people did not fully understand the extent of what she had been through when she told people she had depression and anxiety:

"And then when I would be like, oh, yeah, like, you know, going through depression, I had depression, I had a depressive episode, people would be like, "oh yeah." And I would just have this panic because I was like, no, but you don't know what I mean…And it's so hard to explain and same with anxiety. You know, it's just like it's so hard to explain. An anxiety attack to someone that hasn't had one before. It's just like it's, it's very freaky." – Jessica.

Hailey, who has had depression, described how antidepressant medication had alleviated some of her depressive symptoms by stabilising her moods and her responses:

"I definitely think antidepressant medication has changed the way I behave a bit, which is nice in creating a stable kind of reaction rather than being more volatile." – Hailey.

Depression, anxiety, and suicidality were common among both those who engaged in self-harm and ODH. As outlined in the previous literature, both self-harm and ODH are commonly associated with depressive and anxiety disorders (Bentley et al. 2015; Claes et al., 2010; Curtis, 2016a; Gratz et al., 2015; Little et al., 2003; Nock & Favazza 2009; St. Germain & Hooley, 2012). Though mental illness is not a prerequisite for engaging in self-harm or

ODH, those who are mentally ill are more likely to engage in such behaviours than the general population (Coppersmith et al., 2017; Desmarais et al., 2014; St. Germain & Hooley, 2012).

As discussed throughout this thesis, NSSI and suicidality are inextricably linked behaviours. Though they are distinct, they do frequently co-occur in individuals (Hamza et al., 2012). Further than this, some research has even proposed that NSSI may serve as a protective factor against suicide. In Curtis' (2017) study some participants described NSSI as means of distracting themselves from their suicidal feelings; whilst some described NSSI as a means of coping with their suicidal ideation (i.e., they would hurt themselves rather than killing themselves). No participant discussed suicidality directly in relation to ODH, however there were numerous participants who struggled with suicidality that engaged in ODH. Determining if ODH serves as a protective factor against suicide in a similar way to NSSI could be an interesting area for future study.

The interviews revealed several adverse life challenges for the participants. Each sub-theme covered a challenge that was recurrent among participants and was an antecedent factor for the participant's engagement in self-harm and ODH. Each challenge was experienced by both participants who engaged in self-harm, and participants who engaged in ODH. Overall, this theme highlights that the antecedent factors for engagement in self-harm and ODH among participants were similar.

Theme Four: People are a Product of Their Environment

This theme explores the impact of your environment and who you choose to surround yourself with, for better or for worse. This was a recurrent idea that was discussed by every participant. Some participants described having relationships that negatively influenced their behaviour, serving as precipitating and perpetuating factors for the behaviour. Other participants described having relationships that positively influenced their behaviour, serving

as protective factors for the behaviour. Some participants described a mixture of both. This phenomenon will be explored in two sub-themes: *learned and encouraged behaviour*, and *the importance of healthy relationships.*

4.1 Learned and Encouraged Behaviour

When asked *"do your friends engage in this type of behaviour?"*, every participant answered yes. For the most part, they either had current friends who engaged in that behaviour in the past, but who no longer did; or former friends who may still engage in that behaviour, but who they no longer associated with. Participants discussed how their risky coping behaviour, self-harm, ODH or otherwise, was learned behaviour from those close to them. For Kendall, lashing out at others was a behaviour that she learned from her parents:

> *"Lashing out? I don't know. I think that's to be honest just learned behaviour. From my parents, my dad."* – Kendall.

Imogen shares a similar experience, discussing how the alcohol abuse modelled to her by both of her parents influenced her own behaviour:

> *"As I say, I was raised by two alcoholics actually…So that was sort of the example that I had as well. If my mum was feeling bad, if she was having a problem, if she was feeling good, if she was having a good day, it was on the piss. It was the same with my dad as well. So, I guess to an extent there's learned behaviour there."* – Imogen.

For Charlotte, cutting was a behaviour that she learned from her friends who were also engaging in the behaviour. She states that had she not been introduced to the concept by them in the first place, she likely would have never engaged in the behaviour to begin with:

> *"And then also too, like the kind of people I was friends with definitely contributed to it [NSSI] as well. I don't think I would have ever thought about going down that path if it wasn't for my friends, like introducing that, even that concept [cutting]. Yeah. So,*

I had like probably my two best friends were the ones that introduced me to it [cutting].” – Charlotte.

Despite being environments that were supposed to support young people struggling with mental illness, Eleanor discussed how inpatient mental health support services such as the hospital and respite services provided an environment for unwell people to socialise and learn from other unwell people:

“Yes, I think another thing is the psych wards. I met quite a few people there. Especially respite centres, but I think yeah… [residential mental health service], the people I met there were helpful. I can't say the same about hospitals and respite. My mum used to hate me going because she's like, she's just going there to get ideas. You know, like in prison how like, it's not the same, but like how some people like go and then take the more criminal things that people do off them. Like even though, yeah, I feel like it was very similar. And in hospital, I feel like adolescent mental health became like a who's the sickest. Like, I hated that.” – Eleanor.

Not only were self-harm and ODH behaviours that participants often learned from their peers, but they were also behaviours that were strongly encouraged and reinforced by peers. For Finn, who regularly engaged in ODH, his friends would cheer him on and praise him following physical fights:

“Yeah. Well, some friends would be like, fuck yeah, you smashed them…Like you know, typical macho bullshit.” – Finn.

Finn also explained that due to the friends he had and the behaviour he was surrounded by, the ODH behaviours were both normalised and admired:

“You know, when I was younger, I thought it was cool. Like fuck it, who cares if I go to prison because one of my mates had been to prison…” – Finn.

For Gemma, who also engaged in ODH, the external validation that she received from her peers for being the "cool girl" who got into fights reinforced the behaviour:

"Like people kind of thought I was cool. Like I was kind of like the cool girl for it." – Gemma.

Gemma also described not only being encouraged by her friends at the time but enabled by her friends to get into fights and abuse drugs and alcohol:

"Back in high school, yeah. Like I was getting drunk with my friends, stoned with my friends. They were recording me fighting. Not the friends I have now, though. Absolutely not…back then I had friends that actually like, carried the habit. So, like with the alcohol, I had a friend who would make sure that we had alcohol at her house so that we could pour it into a fizzy drink bottle to drink. So, I had like, enablers, they enabled me." – Gemma.

Hailey also acknowledges the role a particular friend of hers played in risky behaviours including self-harm and ODH:

"Yes, I guess one of [my friends] does [engage in similar behaviour]. I don't really see a lot of her now, but when I did, I think these behaviours were worse." – Hailey.

Consistent with the previous literature, the findings of the current study demonstrate that young people engaging in self-harm and ODH are heavily influenced by their peers (Curtis, 2017; Heilbron & Prinstein, 2008; Klonsky, 2011). However, the extent of the social influence varies greatly among participants. For example, Hailey engages in risky coping behaviour regardless of whether her friends are but acknowledges that she engages in the behaviour less when she does not see a particular friend as frequently; whereas Charlotte states that she never would have started cutting had it not been for her friends introducing her to the concept.

Despite the varying extent of peer influence, the current findings along with the existing literature indicate that negative peer influence is a significant risk factor for engagement in self-harm and ODH. This information should be used to inform intervention and education measures, and accordingly, strategies should be implemented with the aim of reducing negative peer influence.

Although participants primarily discussed the influence of their peers, Kendall and Imogen discussed the influence of their parents' behaviour, explaining that their current coping behaviour was learned from their parents when they were children. The learning from their parents as outlined in participant's accounts seems to be applicable to Bandura's (1977) social learning theory. This suggests that intervention strategies should also target parents of young children who are engaging in self-harm and/or ODH to reduce the risk of these behaviours being observed and the subsequently imitated by young people.

4.2 The Importance of Healthy Relationships

This sub-theme explores how people's environment and close relationships can serve as a protective factor against engaging in self-harm and ODH. In addition, when asked *"what is important to you in terms of your emotional wellbeing?"*, the majority of participants referred to their family and/or friends:

> *"I try to be open with like friends and my partner."* – Alex.
>
> *"I do talk to my family now. If I'm feeling more down or more sad, mainly out of fear of feeling it. So if I can analyse it with them, then maybe it will go away. And kind of just sharing the load I mean, otherwise it does get too heavy to carry."* – Brooklyn.
>
> *"I would probably say like my partner keeps me pretty grounded. When I am in that heightened state, he's my sort of logic, I guess, yeah. And I do have another friend, a close friend who I can talk to as well."* – Charlotte.

"I guess the friends and family that are around me. Because those are like my biggest supports." – Damian.

"Yeah, I guess like spending time or like talking to friends. Like, yeah, my best friend, [name of best friend], like we generally ring each other every day after work and have a chat and a bit of a debrief about what happened in our day and just general kind of shit talking." – Liam.

"My dog. Yeah, my family. And my connections with people." – Eleanor.

"And just having good people around you, I don't think humans are meant to be by themselves, eh. Like I've spent a lot of time in my adult life by myself…So, like, you do need other people, whether it's just a normal conversation. I think humans are meant to be, you know, social." – Finn.

"But you know, sometimes talking about it helps. But at the same time, I just want friends to be friends, and I don't want to talk about my feelings all the time. Like watch a movie with me, you know? Hanging out with friends definitely helps." – Kendall.

Participants not only emphasised the importance of having healthy and supportive relationships, but also the importance of being selective about the relationships that you choose to have and maintain. For Brooklyn, she recognised that maintaining friendships with people that are still mentally ill was not beneficial for her own mental health and recovery:

"I mean I try to limit my close friendships with people who are still quite mentally unwell. Just cause I do still find it quite hard and that's still something I'm actively working on. But a few good friends of mine, they did self-harm in the past, they don't now… I don't have many friends, I keep my friend circle quite small…" – Brooklyn.

Charlotte shares this sentiment in a broader sense, mentioning the importance of surrounding yourself with people who share the same life goals and values:

> *"Right and I think the fact that I recognize that I probably need to surround myself with a bit more people that are, they don't necessarily need to be like doing everything right with their lives. But like other people with similar values that are like trying to work towards, like a goal."* – Charlotte.

The findings outlined in this sub-theme are supported by the existing literature, which suggest that having different sources of social support is a protective factor for engagement in both self-harm and ODH (Hamama & Ronen-Shenhav, 2013; Scarpa & Haden, 2006; Yuan et al., 2024; Zhou et al., 2024).

As discussed previously, the existing literature and current findings suggest that interventions for self-harm and ODH should be targeted more broadly than just the individual level. In addition to improving familial dynamics and reducing negative peer influences, interventions should also intend to equip the family and friends of an individual with the skills necessary to support their loved one in a time of need.

The participants demonstrated that the friends and family with whom they had close relationships played a pivotal role in how they coped with difficult emotions. This was especially evident in those participants who described having relationships with some people that negatively influenced their coping behaviour and relationships with other people that positively influenced their coping behaviours. Having both healthy and unhealthy relationships highlighted the dichotomy in their influence on coping behaviour.

Theme Five: Difficulty Differentiating Emotion

A particularly prevalent theme that emerged among participants was a difficulty in differentiating between negative emotions. Participants would use different terms to describe their negative feelings, such as anxious, sad, angry and upset. However, when asked if they did different things based on the emotion they were feeling, most participants were not able

to identify differences in behaviour based on emotion. Alex explained that it is not the emotion itself that dictates their response, but rather the intensity of that emotion:

> *"So like if, I don't know how to explain it. I don't see it as like, when I'm sad or when I'm angry I have like a spectrum I guess, of like intensity, and yeah intensity. Like super intense or not intense if that makes sense? So like if what I'm feeling, whether that is sad or angry, is on like the lower half, it's not as intense, I will try to just like breathe through it. Or I will try to like talk to my partner or something. If I'm in like, a more intense headspace, like thoughts of like self-harm and me probably self-harming would come up more."* – Alex.

The relationship between emotional intensity and coping behaviour was also acknowledged by both Charlotte and Damian, who also explained that the strength of the emotion is what influenced their actions:

> *"Depending on the strength of it [the emotion], definitely the same [reaction]."* – Charlotte.

> *"Most of them are always... I'll use the same kind of mechanisms and whatnot…Yeah, those all stay the same, whereas the context is what changes… Like if I'm really angry, I might act a bit more rashly. Because I mean, that's kind of how emotions work when you're overwhelmed and that."* – Damian.

Participants not only had difficulty identifying differences in behaviour based on emotion, but some also had difficulty differentiating emotions in general. For Gemma, who felt only negative emotions for a long time, it was difficult to distinguish between these different feelings:

> *"I don't know. I spent so much of my time angry and upset that I probably don't actually know the difference. Like I spent that much time, like seriously years being like the worst I could be that I don't know. I don't know."* – Gemma.

This sentiment was shared by Brooklyn, who experienced a long period in which she felt emotionally numb:

> *"Like I was chronically numb for years and I could never identify an emotion…So I don't really know with certain emotions because for such a long time I couldn't identify them as being present. I knew I felt like shit, but I didn't know what that shit was as an emotion."* – Brooklyn.

In contrast, some participants discussed feeling overwhelmed by emotion which clouded their ability to recognise emotions. Charlotte described feeling consumed by emotion and struggling to identify what the feelings were:

> *"But when I am consumed with emotion, I can't necessarily identify if it's anger or sadness or that kind of thing."* – Charlotte.

Kendall explained how any overwhelming emotion will make her feel anxious, even if that emotion was initially positive:

> *"It [the emotion] doesn't make a difference. Honestly, even I think any overwhelming emotion, I think it's my fucking anxiety arousal, you know? Like, arousal will always translate to anxiety. Even if I'm excited and extremely happy, I'll probably lash out."* – Kendall.

In addition, Kendall was able to identify that emotions are nuanced, and that for her, part of the issue with differentiating negative emotions was that they were usually felt simultaneously:

> *"Yeah. Oh yeah, I don't think upset is ever crying. It's always anger…Actually, I don't think I've been upset without anger."* – Kendall.

Finn also identified an association between anger and other negative emotions, explaining that anger can be a front for other difficult emotions a person may also be feeling:

> *"Once got told, you know, what's the core emotion, then just peel it off and like [there is] something, you know, under anger. Anger is just like the byproduct of another emotion. Like yeah, what's deep down."* – Finn.

As can be seen from the experiences of the participants, emotions are not black and white. Many participants had difficulty differentiating between their negative emotions, with several participants noting that they only recognised differences in emotion intensity, but not differences in emotion. This difficulty in differentiating emotions is akin to alexithymia, a phenomenon in which individuals have difficulty recognising and describing their emotions (Preece & Gross, 2023). Interestingly, Alexithymia is a risk factor that has been associated with both NSSI and ODI in the existing literature (Dong et al., 2023; Hahn et al., 2019; Tang et al., 2022; Velotti et al., 2016).

Additionally, many participants also acknowledged that their emotions rarely occurred in isolation. Accordingly, participant's coping behaviour remained largely the same, regardless of whether they were feeling anger, sadness or anxiety. These findings challenge the assumption that those who engage in self-harm are "sad", and that those who engage in ODH are "mad" or "bad". People may use the same coping behaviours regardless of the specific emotion that they are feeling, or people may be experiencing more than one emotion whilst engaging in their chosen coping behaviour.

Theme Six: Understanding the Risk, Doing It Anyway

This theme describes how participants would rationalise their engagement in behaviour that was objectively a risk to their health and safety. Whilst participants understood that many of the coping behaviours they described were unsafe, including self-harm and ODH; many still made the conscious decision to engage in the behaviour. Two sub-themes explore some of the reasonings or rationales for engagement in risky coping behaviour: *indifference to safety*, and *risk is worth the reward*.

6.1 Indifference to Safety

For many participants, they knew the risk involved with such behaviour but were not concerned with their personal safety as they did not particularly care about themselves. Damian discussed driving recklessly and how when he was feeling low, he did not care if he got into a crash:

> *"My guess as to kind of why it helps feel better is because, especially the reckless driving and that, especially if I'm feeling really like wanting to off myself. I'm like, "Oh well, if [I] get into a crash, good.""* – Damian.

Eleanor also acknowledges the risk involved in her various coping behaviours but states that at the time, she did not care about the harm they caused her as she felt indifferent about being around:

> *"So yeah, in the past, the things I did were like, very risky. Yeah, like lack of food intake led to many hospitalizations and things. And that's not good for you. Self-harm was definitely risky. I had to get quite a lot of medical intervention because of that. Yeah, it was quite, very risky actually. Could have ended pretty badly. And definitely the suicide attempts they had were risky, yeah. And like a lot of my behaviours, I was kind of like, I didn't really care. I was kind of ambivalent about being around. So yeah, like it didn't bother me."* – Eleanor.

Hailey described not considering her own personal safety, or the safety of those around her when engaging in her various coping behaviours:

> *"Yes, I do think that using sex as a form of self-harm is risky because I wasn't looking after my physical health, or even my mental health. And I guess even the physical assault when angry is risky just by causing harm to someone else and just a blatant disregard for like what happened to anyone or myself."* – Hailey.

In regard to interfering with the healing of her wound, Jessica explained that when she was mentally ill, she did not even consider the risk involved or the impact that it would have on her health:

> *"At the time I just had so little conscious regard for my body. But not in, like an actively hating it way just, you know, like there should have been something in there that said that, you know, treat your body better. But there wasn't."* – Jessica.

There was a general sense from participants that they had little conscious regard for their body or personal safety. However, this was only directly discussed by a few participants. There are similar findings in the previous literature. For example, Muehlenkamp et al. (2013) found that bodily regard, the amount of care one has for one's body, moderated the relationship between emotion dysregulation and NSSI.

The previous literature also indicates that the indifference to safety described by participants may be partially explained by low self-worth. As discussed previously, low self-worth is a known risk factor for NSSI and aggression (Forrester et al., 2017; Garofalo et al., 2015). However, some research suggests that low self-worth is also indirectly associated with NSSI through reduced bodily regard (i.e., less care for the body and an increased willingness to endure pain). This is because reduced bodily regard results in indifference to any physical injury or harm that is inflicted, and in turn, makes an individual more susceptible to engaging in NSSI (Hooley & St. Germain, 2013; Muehlenkamp & Brausch, 2012).

6.2 Risk is Worth the Reward

Many participants emphasised that they still chose to engage in their risky coping behaviour because of what they got from engaging in the behaviour. For Liam, the want to change the negative emotion he was feeling, outweighed the risk involved in having unsafe sex with men he did not know. He would rather take the risk knowing it will make him feel better, than to stay feeling the negative emotion:

"Yeah, definitely there's a certain degree, like, you know, there's a risk. And I do think about that, but then just kind of that desire or that urge, you know, to change that feeling outweighs [the risk]." – Liam.

For Finn, the desire to escape from his negative feelings outweighed the risk involved with heavy drinking:

"To escape reality…Yeah, when I was younger it was just, you get drunk, escape reality, not have to deal with shit. Like anxiety or social situations, just anything. Like a release, I guess you could say, yeah." – Finn.

For Gemma, the enjoyment that she got from engaging in physical fights with other people outweighed the risk involved in getting into a fight:

"And then other people, like, the random fights, were just like the thrill of like, I don't know. I used to like fighting people. I don't know how to explain it, I just like, hitting someone then have it like them trying to hit me back, I kind of liked that. Not right, but yeah." – Gemma.

Kendall described the immense relief she felt when she cut herself. At the time of the interview, Kendall no longer cut herself, largely due to the stigma associated with the activity, not the risk. Although she did not cut herself anymore, she explained that she had not yet found another alternative coping mechanism that she felt was as effective as cutting:

"And it's very controversial, but like, honestly, I'm gonna be fucking real with you, I'm still trying to find something that actually like relieves me as good as self-harming. And I know that it's scary, but like, it just like it just alleviates everything. All the sensory overload I feel becomes kind of like physical, fathomable, I don't even know if that's a word, kind of pain." – Kendall.

> *"I think I'm still in two minds about it [cutting], which is I know it's kind of iffy because I know it's bad for me. But if it's so bad, why does it feel good, I suppose."* – Kendall.

This sentiment was shared by Charlotte, who discussed how effective she felt cutting was for psychological pain relief. Although she no longer feels like the risk involved with cutting is worth the relief that it offers, she still thinks about how much cutting helped her to deal with her negative emotions:

> *"…it's still something now that it's like I'll think about like, oh, this is how I used to deal with it. And it really did help with, I mean like the emotions. And because it was so strong in helping with that, every now and then, I think about it still to this day. And I, not necessarily contemplate it, but it's like, I think about how much it helped, and then obviously I think about like the implications of what it would mean now, and that's probably the reason why I don't do it anymore."* – Charlotte.

Despite knowing the negative outcomes associated with their chosen coping behaviour, be it self-harm or ODH, participants felt that the benefit they gained from engaging in their coping behaviour outweighed the risk. This complicated and counterintuitive relationship between risky coping behaviour and perceived benefit may be partially explained by opponent-process theory.

For example, the relief felt by Kendall and Charlotte as a result of cutting themselves may be an opponent process. As discussed previously, cutting would be an unconditioned stimulus, the primary response to this stimulus would be pain, and following the termination of cutting the secondary response (opponent process) would be relief. The previous literature suggests that the relief following the opponent process transcends the physical pain, resulting in both decreased physical pain and decreased emotional pain (Eisenberger, 2012; Franklin et al., 2013; Hamza & Willoughby, 2015). After continued use of this behaviour, cutting would

become a conditioned stimulus that the individual would come to associate with relief from pain. This would account for the participants perceiving this behaviour as beneficial when it is objectively unsafe.

Opponent process theory is often used to explain thrill-seeking behaviour (Solomon, 1980) and accordingly, may explain why Gemma described enjoying the thrill of fighting other people after school. The unconditioned stimulus would be getting into a fight, the primary response to this stimulus would initially be fear. Following the termination of the fight the secondary response (opponent process) would be relief. Over time with continued engagement in the behaviour, getting into a fight would become a conditioned stimulus. The primary response of fear would develop into thrill and the secondary response (opponent process) would evolve into exhilaration (Solomon, 1980). Accordingly, Gemma would continue to seek out this positive feeling by repeatedly engaging in physical fights. In terms of opponent process, although thrill-seeking does not alleviate psychological pain in the same way as physical pain does (i.e., cutting induces relief, fighting induces exhilaration); however, this feeling of exhilaration would be a positive deviation from the state of emotional distress that Gemma felt prior to engaging in the fight (Solomon, 1980).

Another potential explanation for the above-mentioned behaviours is emotional cascade (distraction) theory. As outlined by Selby and Joiner (2009) individuals with high levels of emotional dysregulation tend to ruminate on their negative emotions, creating a negative feedback loop resulting in an extremely negative mood. Selby and Joiner called this process an “emotional cascade”. To effectively distract from this extremely negative mood, the distraction needs to be equally as extreme. All the behaviours detailed by participants above, cutting, fighting, getting drunk, and engaging in risky sexual activity could be considered extreme means of distracting oneself. However, they may be considered

proportionate to that individual in relation to the extreme negative emotion that they are feeling.

Whether lashing out at others or harming themselves, all the coping behaviour engaged in by participants was a risk to their health and safety. This theme and each sub-theme highlight two differing motivations for their engagement in risky coping behaviour. Participants either did not care or did not consider their own personal safety when engaging in their risky coping behaviour; or they were preoccupied with the "benefit" that they perceived they would get from engaging in the behaviour, that is, distracting them from or alleviating the difficult emotion they were feeling.

Theme Seven: Ambulance at the Bottom of the Cliff

This theme covers the general lack of prevention measures in place for those struggling with mental illness or difficult emotions, in terms of both education and support services. Two participants directly used this phrase when discussing their experiences, but the sentiment was shared by the majority of the participants. The naming of this theme may seem abstract but was quite intentional as it encapsulates the impacts of deficient prevention and intervention strategies in New Zealand. This will be explored in two sub-themes: *not struggling enough* and *it was all I knew*.

7.1 Not Struggling Enough

Participants discussed seeking help and support from services when they first started having emotional difficulties but being turned away. Brooklyn discussed being turned away from community mental health services three times within the space of a year, despite actively seeking help, as her depressive symptoms were not considered to be severe enough:

> *"I mean the ambulance at the bottom of the cliff is a very famous saying now, and it is just an absolute ambulance at the bottom of the cliff. I mean I got declined from the community mental health three times, in that the year when I was 17 and actively*

asking for help. But they couldn't, they wouldn't accept me because I wasn't depressed enough, or I wasn't displaying signs of depression cause I was still working." – Brooklyn.

Brooklyn explained that she felt she would only be taken seriously if her symptoms were at the extreme level, which was exactly her experience in the mental health system:

"If you're not actively hurting yourself, if you're not actively trying to kill yourself, if you have an eating disorder and you're not 20kg, then you're not struggling enough. Like I used to show up to my appointments, you know well-dressed, well not well-dressed but dressed. You know I showered regularly, and they were like well her appearance: she's well groomed, she smiles in interactions, she's pleasant, then she's fine. It's like, do I have to be jumping off a cliff for you to listen to me?... And I understand like the system is struggling so severely, short-staffed, long waitlists. It's just not enough to go around. And I was like but I do need support. I'm saying I need support, don't make me do something to prove that I need support because I will. If that's what I have to do I will." – Brooklyn.

Eleanor described a similar experience. Although she was accepted into the mental health system when she initially presented, she was not given a psychologist for a year and a half due to the long waitlists; by which point her symptoms had worsened, and the coping skills that the psychologist were trying to teach her were ineffective:

"So like, I went into the mental health system and like I remember reading my notes and stuff I was like, oh, I wouldn't like try to commit suicide like I know what it's like to lose someone, and I wouldn't do that to my mum kind of thing. And I had a key worker for a bit. And then I wasn't given a psychologist for, like, a year and a half. And by the time I actually got to the psychologist, I was like too unwell…so it was just like putting out fires the whole time. I couldn't really learn any of those skills. So

yeah…I probably by the time I got like past the waiting list it was like, a whole bunch of things that happened and like… I just became more and more and more unwell." – Eleanor.

Eleanor later reflected on her experience in the mental health system and acknowledged that had she received sufficient support sooner, the outcome for her would have been different:

"… I think about it now, and I'm like, yeah, actually, I had a lot to deal with, but really if it was like the ambulance at the top of the cliff, not the bottom of the cliff, I feel like the story could be quite different." – Eleanor.

For Gemma, it was not the health providers that turned her away, it was her parents that did not think it was necessary to seek help for her following several traumatic life events:

"Like, I think it was just like a buildup of, I've been through a lot. A lot of stuff and I didn't get help. My parents never got me help for any of what I went through, so there's, like, there was a lot of there. And then I was just left to try and like sift through my own feelings and stuff, yeah." – Gemma.

As evidenced by the experiences described in this sub-theme, there are significant barriers to accessing mental health services in New Zealand including an overworked and understaffed workforce, long delays, lack of clear information, difficulty navigating the system, and limited treatment options (i.e., over-medicalisation) (Kulshrestha & Shahid, 2022; Paterson et al., 2018).

He Ara Oranga, the report detailing the government inquiry into mental health and addiction in New Zealand, found that not only are there barriers to accessing the mental health services in New Zealand, but many users of the mental health service state that it is not fit for purpose and does not take into account the social and economic determinants of health,

such as, education, employment, inequity, poverty, discrimination, isolation, trauma, violence and housing (Paterson et al., 2018).

7.2 It Was All I Knew

Many participants explained that they engaged in risky coping behaviour as they did not realise that there were other healthier ways of coping with their negative emotions. Finn explained that it was only in the last few years since he went to counselling that he learned other coping mechanisms besides lashing out and abusing alcohol:

> *"First of all, I didn't know other coping situations. So, like when I was younger, I didn't know what other options to use. Since I've gotten older, I do know more coping strategies, I guess you could say after I did counselling and stuff. So yeah."* – Finn.

Gemma also explained that she engaged in risky coping behaviours as she did not know how to cope with her negative emotions. She went on to explain that in recent years she has learnt healthier coping mechanisms that she finds are just as effective at managing her negative emotions:

> *"And I had no other coping mechanisms… I wasn't given any coping mechanisms. Because I never got the help and I think that's what fucked me up. I was like, what am I supposed to do? I've got all this anger and no idea why I'm the way that I am, or why I'm behaving like I am. And when I got like, a little bit of insight into that, it made a whole like a whole lot more sense to me. And then I could like look at finding ways around it."* – Gemma.

> *"Or I've found something different for them now. Like, going for a walk, for me now feels the same as what cutting did. It was just like I just needed, like, the breath of fresh air. That's what I needed. And I didn't realize that I don't have to do that [cutting] to get to the end goal."* – Gemma.

When asked why she thinks she lashes out, Kendall explained that it was how she learnt to respond to anger and negative emotions as a child and the way she had responded since:

> *"After self-reflection, yeah. And I feel like I've always done that, like as a kid, I've always just been, an angry person. Angry dad. Learned that. Angry person."* – Kendall.

Eleanor, whose father passed away suddenly when she was 15 years old, explained that she felt she did not know any healthier ways to cope with the immense amount of sadness she experienced following her father's passing:

> *"I don't think I really had the skills to know [how to cope]. Like, I feel like I had quite a few big things happen in my life. Like my dad passed away suddenly and stuff and everything just kind of went downhill.… and like, I definitely think I had some resilience, but it kind of just everything got too much, and I was just, too sad and yeah. And it just surpassed the ability that I had, unfortunately."* – Eleanor.

Imogen referred to her risky coping behaviour as a band-aid approach to managing her negative emotions, as she did not know any healthier ways of managing these emotions:

> *"And it was kind of just like sticking a band-aid on it. Or like having feelings that I couldn't understand, didn't know how to manage, didn't have like a healthy outlet for. It was like I can't deal with this, let's just [motions to putting a band-aid on]. It's probably a bit of an oversimplification, but yeah."* – Imogen.

Jessica explained that she also did not learn how to manage negative emotions in a healthy way when she was growing up:

> *"And I think also it was because I just, no one had ever really taught me how to deal with issues. Like I think for example, a lot of times where I would do something bad, it was I needed validation and I needed someone to be like "you're doing OK and I love*

you", you know? That's all I needed. I didn't know how to say, "Oh, my gosh, I'm feeling insecure and sad today", so that someone would give me that. So, I would do weird little things that in my mind someone was gonna validate me. And you know or seek attention in some way to be validated. And cause yeah, I just, no one had ever really taught me, and I never really learned how to ask for what I needed, so I would find weird ways to get it." – Jessica.

Not only did participants acknowledge that they did not know any better when engaging in their risky coping behaviour; participants also emphasised the importance of providing young people with education services for managing their emotions and taking care of their mental health. Charlotte expressed that she thinks young people should be taught alternative coping mechanisms for self-harm:

"Maybe doing some sort of education around alternative coping mechanisms that are a lot better. So, if you're like thinking about harming yourself in these particular ways or whatever, maybe try doing this." – Charlotte.

Hailey echoed this sentiment, stating that schools should be providing education for young people on how to manage their emotions in constructive ways as well as implementing harm reduction strategies:

"I think they should, like everyone should know, like strategies on how to like approach and talk to like young people and children about their emotions and how to deal with them in constructive and safe ways rather than risky behaviors and things like that. I do think teachers could learn about, I guess, health in schools, not just focusing on like physical health and running. Same with PE, maybe working on more mental health things and why different emotions make you react certain ways. And not necessarily changing how you would react to them but giving ideas on how to, I guess

just be safe with your reactions. And just about like harm reduction. So, if you're going to do it like, what's the safest way to behave that way." – Hailey.

Hailey also emphasised the need for more mental health professionals, as they also play an integral role in the education of young people on how to manage their emotions in constructive ways:

"I think [we need] more mental health professionals because they actually will be able to help and be constructive with help for how you can deal with it." – Hailey.

Finn expressed that education for young people on how to cope with and manage negative emotions is important as he feels that education on this matter would have been beneficial for his younger self:

"Education about it, I guess as well is a big thing. …Yeah, cause I did not know how to cope with any emotions growing up, hence why I lashed out all the time. So, I think that would be like a good tool to learn when you're younger." – Finn.

The Health and Physical Education (HPE) curriculum is compulsory in all state and state-integrated schools in New Zealand from Year 0 through to Year 10 (Ministry of Education, 2024). The seven key areas of the HPE curriculum include mental health, sexuality education, food and nutrition, body care and physical safety, physical activity, sport studies, and outdoor education (Ministry of Education, n.d.). Despite mental health being a compulsory part of the school curriculum for young people in New Zealand, participants in the current study still overwhelmingly felt that they had not received sufficient education on how to constructively manage their emotions. These findings suggest that the current curriculum is not meeting needs of young people and may benefit from being revised.

In addition to the taught curriculum, students may also learn about mental health and emotional coping from their school counsellor. A study evaluating the effectiveness of counselling in New Zealand schools conducted by Manthei et al. (2020) found that

counselling in schools was largely effective. However, they also found that for the schools participating in their study, the ratio of students to counsellors was 1:668. This ratio far exceeds the New Zealand Association of Counsellors recommendation of 1:400 and the American School Counselor Associations recommendation of 1:250.

This indicates that school counsellors in New Zealand are understaffed. This notion is supported by Hughes et al.'s (2019) study which outlines significant delays between students requesting to see a counsellor and being seen. Just under half of students wanting to see a counsellor had to wait two or more days. 18.7% of students had a two day wait time, 11.6% had a three to five day wait time, and 17.3% had to wait six or more days before they could see a school counsellor.

Manthei et al. (2020) also found that across roughly 150 counselling cases, there were over 30 different types of presenting problems among students. Due to the broad range of behaviours to which school counsellors must respond, training on more specific issues such as self-harm and ODH should be provided to ensure youth can be supported adequately. The need for specific training on NSSI for school counsellors has been identified previously (Garisch et al., 2020), due to its high prevalence among young people and associated negative health outcomes. However, the findings of the current study indicate that specific training on outward-directed-injury and harm should also be provided to school counsellors.

Overall, this theme and each sub-theme highlight the reactive approach taken to supporting young people to manage their emotions and mental health in New Zealand. The participants in this study overwhelmingly advocated for a change, from a reactive "ambulance at the bottom of the cliff" approach to a proactive "ambulance at the top of the cliff" approach. Participants reflected on their own experiences and generally felt that had they known healthier ways to cope and/or received sufficient support earlier on, their outcomes would have been better. Participants heavily emphasised the need for an increase in

educational resources for emotional management and mental health, as well as an increase in the number of professionals working in support services.

Summary

The aim of this study was to explore to what extent self-injury (NSSI) and outward-directed-injury (ODI) are ways of dealing with the same issues, especially in terms of dealing with negative emotions. Although the study was initially primarily interested in self- and other-directed injury, there were many experiences described by participants that did not involve physical injury but were still harmful. Accordingly, the findings of this thesis focused more broadly on self-harm and other-directed harm (ODH). Seven themes were developed in the analysis of the current study's data. Theme one *hurt people, hurt (other) people* and theme two *self-harm comes in many different forms* outline the outward-directed-harm and self-harm discussed by participants, respectively. Themes three through seven *adverse life challenges; people are a product of their environment; difficulty differentiating emotion; understanding the risk, doing it anyway; and ambulance at the bottom of the cliff* all outline risk and protective factors that were common between self-harm and outward-directed-harm.

The ODH described by participants consisted of both physically and verbally aggressive behaviours. Most of this behaviour was hostile/reactive in nature as it was more impulsive and engaged in with the intention of harming another person or object; however, some participants did discuss instances of more instrumental aggression, where their outward directed behaviour was more deliberate and purposeful than impulsive (Bushman & Anderson, 2001; Dodge, 1991; Little et al., 2003; Parrott & Giancola, 2007). Despite the differing motives, all participants discussed using ODH as an emotion regulation tool, which is consistent with the existing literature in which negative affect, emotion dysregulation and aggression have an established association (Donahue et al., 2014; Garofalo & Velotti, 2017; Velotti et al., 2016). Also, in line with recent research (e.g., Fitzgerald & Curtis, 2017;

Kimbrel et al., 2018; Mann et al., 2022), the findings of the current study suggest that ODH served as a form of self-injury, both inadvertently and intentionally.

Engagement in various self-harmful behaviours was extensive among participants in the current study, from indirect self-harm, such as substance abuse, to direct self-injury, such as cutting. Much of the self-harmful behaviour engaged in by participants was predictable and fit within the current definition of NSSI in the literature (Klonsky, 2011; Klonsky et al., 2014; Lurigio et al., 2023; Nock, 2010; Nock & Favazza, 2009). However, some of the self-harmful behaviour described by participants was more surprising and challenged the status quo of the predominant self-injury literature; and instead supported emerging ideas in the literature, such as, sexual activity, restrictive eating and substance abuse being used for self-harm purposes (Fox et al., 2019; Kingi et al., 2017; Mann et al., 2022; Mellin et al., 2024; St. Germain & Hooley, 2012). These findings alongside the literature indicate that the definition for NSSI should be expanded beyond only acts that deliberately and directly damage one's own body tissue.

Adversity was a common experience among participants in the current study. Many discussed adverse life challenges that contributed to their engagement in self-harm and/or ODH. Being a minority was a significant stressor for some participants, one discussing this in reference to their gender identity, whilst another participant discussed her vision impairment. Although being LGBTQ+ or having a disability are known risk factors for NSSI and suicidality (e.g., Akram & Batool, 2020; Peters et al., 2020; Speer et al., 2022; Tseng & Ditchman, 2024), there is no research in the existing literature investigating the relationship between these factors ODH related behaviours such as aggression and violence.

Also common among participants was having experienced significant trauma in their life. Participants discussed sexual abuse, the unexpected death of a close family member and child-parent separation, which is consistent with the previous research that has identified

these traumatic experiences as being risk factors for NSSI, violence, aggression, and criminality (Briere & Gil, 1998; Carr et al., 2020; Curtis, 2016b; Curtis, 2017; Estévez et al., 2016; Hawton & James, 2005; Norton-Baker et al., 2019; Swanston et al., 2003). Another challenge discussed by participants were strained relationships with close family members. Participants reported that these dysfunctional relationships were a significant stressor which contributed to their engagement in self-harm and ODH. This is in line with previous research that identifies family dysfunction as risk factor for self-harm and ODH (Andreas & Watson, 2009; Kelada et al., 2018; Pérez-Fuentes et al., 2019; Wang et al., 2022). The previous literature along with the current findings indicate that interventions aimed at the familial level as well as the individual level would be beneficial in reducing engagement in self-harm and ODH.

Consistent with the existing literature, participants outlined their struggles with low self-worth (Forrester et al., 2017; Garofalo et al., 2015). Interestingly, some participants acknowledged the relationship of their low self-worth to their engagement in self-harm or ODH, whilst others could acknowledge the low self-worth but not it's influence on their subsequent coping behaviour. Depression, anxiety and suicidality were also significant challenges for participants and have a well-documented association with self-harm and ODH related behaviours in the literature (Bentley et al. 2015; Claes et al., 2010; Coppersmith et al., 2017; Curtis, 2016a; Desmarais et al., 2014; Gratz et al., 2015; Little et al., 2003; Nock & Favazza 2009; St. Germain & Hooley, 2012). Self-harm and suicidality are inextricably linked to one another as they frequently co-occur in individuals (Hamza et al., 2012), with some research even suggesting that NSSI serves as a protective factor for suicidality (e.g., Curtis, 2017). Research is limited on the relationship between ODH and suicidality, however, multiple participants in the current study who experienced suicidality also engaged in ODH.

The close relationships that participant's chose to have and maintain played a pivotal role on their engagement in self-harm and ODH. These relationships served as both risk factors and protective factors. Consistent with previous findings on NSSI, the current findings indicated that young people's engagement in both self-harm and ODH is heavily influenced by their peers (Curtis, 2017; Heilbron & Prinstein, 2008; Klonsky, 2011). This finding suggests that the implementation of prevention and intervention measures to reduce negative peer influence may also reduce self-harm and ODH engagement. Some participants also mentioned learning their risky coping behaviour from a parent. This is in line with Bandura's (1977) social learning theory and suggests that targeting intervention and education measures at parents who are engaging in self-harm or ODH may reduce the risk of these behaviours being observed and then imitated by their children. Conversely, the existing literature highlights good social support as a protective factor against engagement (Hamama & Ronen-Shenhav, 2013; Scarpa & Haden, 2006; Yuan et al., 2024; Zhou et al., 2024). This research was supported by the current findings in which participants emphasised the positive impact of supportive friends and family on their emotional wellbeing.

Many participants had great difficulty in differentiating between their emotions. Some participants described only recognising emotion intensity, not the emotion itself. Other participants described feeling numb to their emotions, as well as desensitised or overwhelmed by their emotion. All these experiences described by participants bear a striking resemblance to alexithymia, a phenomenon in which individuals have difficulty recognising and describing their emotions (Preece & Gross, 2023). This finding is significant as it supports the existing literature in which Alexithymia has been identified as a risk factor for both NSSI and ODI (Dong et al., 2023; Hahn et al., 2019; Tang et al., 2022; Velotti et al., 2016). As emotions were difficult to distinguish, coping behaviour remained largely consistent for participants, despite the emotion they were feeling. This finding is also significant as it

challenges the assumption that self-harm is engaged in by those who are “sad” and that ODH is engaged in by those who are “mad”.

Feeling indifferent towards their personal safety was one rationale described by participants for engaging in behaviours that were objectively a risk to their health and safety, i.e., self-harm and ODH. Previous research indicated similar findings. Low bodily regard, that is, having little care for one’s body, is associated with higher rates of NSSI (Muehlenkamp et al., 2013). Low self-worth has also been associated with both NSSI and aggression (Forrester et al., 2017; Garofalo et al., 2015). Some research suggests that low self-worth is also indirectly associated with NSSI through reduced bodily regard (i.e., less care for the body and an increased willingness to endure pain). This is because reduced bodily regard results in indifference to any physical injury or harm that is inflicted, and in turn, makes an individual more susceptible to engaging in NSSI (Hooley & St. Germain, 2013; Muehlenkamp & Brausch, 2012). The findings of the current study suggest that indifference to personal safety was not limited to those participants who engaged in NSSI specifically but was also a risk factor for engagement in other types of self-harm and ODH.

Participants also discussed feeling that the benefit they gained from engaging in their risky coping behaviour outweighed the potential risk or consequence. A potential explanation for this phenomenon is Solomon’s (1980) opponent-process theory. Previous studies have suggested that the relief that is felt following the termination of the opponent process (e.g., stopping cutting oneself) transcends the physical pain, resulting in both decreased physical pain and decreased emotional pain (Eisenberger, 2012; Franklin et al., 2013; Hamza & Willoughby, 2015). Another proposed explanation for participants feeling that the benefit gained from engaging in self-harm or ODH outweighed the risk is Selby and Joiner’s (2009) emotional cascade or distraction theory. This theory posits that ruminating on negative thoughts can lead to extremely negative thoughts that require and equally extreme

distractions (i.e., cutting, abusing drugs and alcohol, fighting, punching walls). Although these theories have only been applied to self-harm in previous studies, they are also applicable to ODH.

Deficiencies in mental health education and support services were highlighted as contributing to engagement in self-harm and ODH. Discontent with New Zealand's mental health support services was described by multiple participants as an "ambulance at the bottom of the cliff" model of care. There are significant barriers to accessing mental health support services in New Zealand that are evident in both the current findings and previous literature including long delays, difficulty navigating the system, an overworked and understaffed workforce, lack of clear information, and limited treatment options (i.e., over-medicalisation) (Kulshrestha & Shahid, 2022; Paterson et al., 2018). Participants also overwhelmingly felt that they had not received sufficient education on how to constructively manage their emotions and mental health; despite mental health being a compulsory part of the New Zealand curriculum (Ministry of Education, n.d.), suggesting that the mental health curriculum may benefit from being revised. The existing literature also indicates that school counsellors in New Zealand are understaffed leading to delays in students receiving support (Hughes et al., 2019; Manthei et al., 2020). Previous research also suggests that school counsellors should receive NSSI specific training due the breadth of presenting problems they encounter and the high prevalence of NSSI among young people (Garisch et al., 2020). However, the current findings also suggest that specific training on ODH should also be provided for school counsellors.

Chapter Five: Conclusion

This research aimed to explore to what extent self-injury and outward-directed-injury are ways of dealing with the same issues, especially managing negative emotion. Previous research had identified emotion regulation as a key function of both self-injury and behaviours potentially related to outward-directed-injury such as aggression and antisocial behaviour. Previous research had also identified overlaps in risk and protective factors between these behaviours. Despite these apparent similarities, the literature showed that service providers and researchers alike conceptualised and treated self-injury and outward-directed-injury as distinct. In addition, little research had been conducted that directly compared the two behaviours. Accordingly, the primary goal of the current study was to fill this gap in the literature by providing a comparison of self-injury and outward-directed-injury.

It became evident whilst conducting and then analysing the interviews that there was a spectrum of "injurious" behaviours; from behaviours that physically injured oneself or others (i.e., cutting, skin-picking), to behaviours that physically harmed oneself or other (i.e., substance abuse, restrictive eating), to behaviours that emotionally or psychologically harmed oneself or others. Accordingly, the scope of the analysis and subsequent findings focused more broadly on self- and other-directed harm, rather than solely on physical injury.

Twelve semi-structured interviews were conducted with a diverse range of participants aged between 18-35. Reflexive thematic analysis was used to determine seven main themes and twenty sub-themes. Participant's experiences with and perspectives on self-harm and ODH were diverse in both extent and severity. Some participants engaged exclusively in self-harm or ODH, some participants engaged in both.

Theme one, *hurt people, hurt (other) people*, outlined participant's experiences with outward-directed-harm (ODH). ODH consisted of physical and verbal aggression towards

other people or objects. This involved a range of behaviours from punching a wall, getting into physical fights and yelling verbal abuse. Although those who engage in ODH are typically viewed as being unlawful, unruly or immoral due to the association of the behaviour with criminality and deviancy; the experiences described by participants indicated that emotional distress was the driving force behind their engagement in ODH. This suggests that the current conceptualisation is unhelpful as it is further stigmatising an already vulnerable group. It also suggests that treating such behaviour as a mental health issue rather than a criminal or deviancy issue may be more effective in supporting those engaged in the behaviour and subsequently reducing the behaviour.

Theme two, *self-harm comes in many different forms* outlines participant's experiences with self-harm. Although eight out of the twelve participants reported engaging in cutting and other methods of NSSI, there were various other self-harmful behaviours discussed by the participants. They reported using restrictive eating, sexual activity and substance use as forms of self-harm. Accordingly, a spectrum of self-harm behaviour was explored in this study, ranging from harmful to injurious, with most participants reporting engagement in both. Although some of the behaviours did not cause direct or immediate physical injury, does not mean that the impact for that individual was any less detrimental. This suggests a more holistic approach to prevention and intervention may be more beneficial in helping those self-harming due to the breadth of behaviour discussed by participants.

Theme three, *adverse life challenges* outlined a number of antecedent factors including nonconformity to social norms, traumatic events, strained relationships with close family, low self-worth, and depression, anxiety and suicidality. These were sources of distress for participants, which in turn contributed to their engagement in self-harm and ODH. This suggests that these antecedent factors are overlapping risk factors for engagement in self-harm and ODH.

Theme four, *people are a product of their environment* highlighted the predisposing, precipitating, perpetuating and protective role that family and friends have in influencing an individual's engagement in self-harm or ODH. Participants discussed how those closest to them could be their biggest sources of support and their worst influence. The negative role that some peers had in influencing and encouraging negative coping behaviour indicated that that negative peer influence was a significant risk factor for engagement in self-harm and ODH. The positive role that many families and friends held in participants' lives indicated the importance of a strong support network in reducing self-harm and ODH. Some participants also explained that that they learned their risky coping behaviour from their parents. This suggests that intervention strategies should also target parents of young children who are engaging in self-harm and/or ODH to reduce the risk of these behaviours being observed and then subsequently imitated by young people.

Theme five, *difficulty differentiating emotion* outlined participant's experiences with negative emotion and the impact this had on their subsequent coping behaviour. Participants that engaged in self-harm and ODH consistently reported difficulty in differentiating the emotions that they felt. Many explained that they could only identify differences in intensity, not differences in the emotion itself. Participants also discussed feeling numb or overwhelmed by their emotions, both of which made it difficult to identify what they were feeling. Participants also acknowledged that emotions rarely occurred in isolation and that they often felt multiple emotions at one time. Accordingly, it suggests that the same coping behaviours may be used regardless of the specific emotion an individual is feeling whether that be anger, sadness or anxiety. This challenges the assumption that those who engage in self-harm are "sad", and that those who engage in ODH are "mad". In addition, as emotions are nuanced, an individual may be experiencing more than one emotion whilst engaging in their chosen coping behaviour which also challenges the "sad" vs "mad" dichotomy.

Theme six, *understanding the risk, doing it anyway* described participant's reasoning for engaging in coping behaviours that were objectively a risk to their health and safety. Many participants reported that they felt that the perceived benefit they gained from engaging in their chosen risky coping behaviour (i.e., distracting themself or briefly alleviating the negative feeling) outweighed the risk. Participants also discussed feeling so low that they became indifferent about their own safety and the safety of others. Therefore, they either did not care or did not consider their personal safety or the safety of those around them, if harming outwardly. Indifference towards one's personal safety indicates low self-worth. This suggests that improving self-worth may subsequently reduce the risk of engagement in self-harm and ODH by transforming feelings of indifference to care.

Theme seven, *ambulance at the bottom of the cliff* highlighted the reactive nature of the prevention and intervention strategies used in New Zealand. In general, participants who engaged in self-harm and ODH felt that there was a glaring deficiency in both education and support services. Multiple participants referred directly to this as the "ambulance at the bottom of the cliff" model of care. Participants recounted experiences in which they were unable to access support services when necessary due to barriers outside of their control. Participants also reported feeling like they were never given the skills or knowledge to cope with difficult emotions or mental illness. Many participants also explained that since learning healthier coping skills, they no longer engaged in self-harm or ODH. This suggests that engagement in self-harm and ODH could be substantially reduced if education and support services were more readily accessible.

Overall, the findings from this study suggest that self-harm and ODH are similar ways of dealing with the same issues. Participants consistently cited emotional distress and emotion regulation as reasons for engaging in these behaviours. In addition, as discussed in

themes three through seven, participants discussed similar predisposing, precipitating and perpetuating factors that contributed to their engagement in self-harm and ODH.

Strengths and Limitations

First, this research was limited by the retrospective reporting of participants' experiences with self-harm and ODH. Although some participants were still engaging in self-harm and ODH at the time of their interview, the majority of participants were no longer engaging in the behaviours. Therefore, the participants spoke retrospectively about their engagement in the behaviours, and these recounts may have been subject to memory bias. One way to mitigate the problems involved with retrospective reporting is the use of ecological momentary assessment (EMA), a method of data collection in which participant's thoughts and behaviours are sampled in their natural environment in real time.

The broad age range of participants included in this study was both a strength and a limitation. As discussed previously, the decision was made to extend the initial age criteria (16-25) and include those over the of 25. A potential drawback of including participants aged over 25 was that there was a greater amount of time between engagement in the behaviour and reporting of their experience. In turn, due to memory bias, their perceptions and attitudes towards their experience may have shifted, becoming more positive or more negative. Further, as all the participants engaged in the behaviour at different ages, stopped engagement at different ages, and were different ages when they were interviewed about their experience, there were likely varying degrees of memory bias among participants.

However overall, the inclusion of older participants aged over 25 in this study was advantageous. Due to the greater amount of time that had passed between engagement in self-harm and/or ODH and the recounting of their experience, the older participants aged over 25 seemed to have more ability to reflect and in turn, had greater insight into their experiences.

Another limitation of the current study was that not all participants engaged in both self-harm and ODH. As engagement in both self-harm and ODH was not a pre-requisite for participation in this study, some engaged in only self-harm whilst others engaged solely in ODH. Accordingly, participants were not asked to directly compare their coping behaviours which limited the scope of comparison able to be undertaken. The comparison undertaken in this study was also limited by the fact that there were more participants that engaged in self-harm than ODH. Subsequently there was an abundance of data on self-harm but limited data on ODH. Equal engagement in self-harm and ODH among participants might have provided more insight into ODH and in turn, a more thorough comparison. Future research should be conducted with participants who engage in both self-harm and outward-directed-harm to enable a more rigorous comparison to be completed.

The qualitative approach to this research was a significant strength. Given the qualitative nature of this study, it was not intended to be generalisable to or representative of the general population. However, it did provide in-depth insight into the form and function of self-harm and ODH; and how these two similar, but separate coping behaviours were ways of dealing with similar issues. It allowed the researcher to develop a more nuanced understanding of self-harm and ODH that would not have been possible using a quantitative method of data collection.

An interviewer effect also may have impacted the data collected. This is because a qualitative interview is not just a source of data, but an interaction in which data is actively created between the interviewer and interviewee (Curtis & Curtis, 2011). Accordingly, each interview is a unique experience that could not be replicated. In relation to the interviewer effect whilst collecting data, the researcher's perspective undoubtedly had an impact on the subsequent analysis of the data. Reflexive thematic analysis is an inherently subjective process. The analysis is not only a reflection of the experiences of the participants, but the

researcher's situated understanding of those experiences. Although this may be viewed as a limitation by some, the researcher's situated perspective was a strength of using reflexive thematic analysis (Braun & Clarke, 2021).

The exploratory nature of this study meant that it included a vast range of behaviours. The questions in the interview schedule were intentionally broad so as not to limit the experiences of the participants. Accordingly, the notion of injury and harm as reported by the participants was quite broad. The open approach taken in the interview schedule led to interesting findings that otherwise may not have been discussed, such as sexual activity as self-harm, NSSI by proxy via cat scratching and other-directed harm via verbal aggression. That being said, future research may also benefit from focusing on a narrower scope of behaviours, for example, conducting research with only those engaging in physically injurious behaviour, self- or other-directed.

The perspectives and experience shared by participants in this study may be more extreme or unusual than what is typical in the general population, as the participants who volunteered to take part in this study may have chosen to do so because they felt particularly strongly about the topic. Given that self-harm and ODH are both heavily stigmatised behaviours, the interviews may have been influenced by social acceptability, meaning that participants may have responded based on how they thought they should feel or think, rather than how they actually felt or thought.

Despite the limitations of the current study, this research provides valuable in-depth insight into the experiences of young people engaging in self-harm and ODH in New Zealand. Though the scope of the current study is broad, it provides a starting point for research comparing these two types of coping behaviours with similar antecedents.

Implications for Future Research, Policy and Practice

Some future directions for this research have already been discussed when relating the findings to the literature and in response to some of the limitations. However, there are still some areas for future directions that are yet to be discussed that will be outlined in the following section.

Most apparent from the current study is that more research on ODH needs to be conducted. It is evident from this study that ODH shares many similarities with self-harm. As discussed in the findings section there are numerous shared risk factors, protective factors and functions. Although there is an extensive literature on aggressive behaviour, this literature tends to frame the behaviour through a criminal or deviant lens. The current study highlights that ODH is primarily a means of coping with difficult emotions, and accordingly, more research should be conducted from this perspective, with ODH framed as a mental health issue, rather than a criminal or deviancy issue.

Future research should continue to compare self-harm and ODH. As evidenced in the findings of the current study, self-harm and ODH have several overlapping antecedent factors. Future studies may benefit from exploring specific antecedent factors in more detail as this would provide clinicians and researchers with more information on the level of risk these antecedent factors posed. For example, measuring the prevalence of self-harm and ODH in a sample of people with an anxiety disorder to assess if the risk of an individual engaging in self-harm is the same as the risk of an individual engaging in ODH.

A predominant finding from the current study was that those who engage in self-harm and ODH described having difficulty in differentiating the emotion they were feeling. Participants reported a number of challenges they encountered in identifying their emotions. This included only recognising different emotional intensities not different emotions, being unable to identify an emotion due to feeling numb and being too overwhelmed by emotion to

differentiate what emotions they were feeling. As participants could not tell the difference between their emotions, their coping behaviour stayed the same whether they were feeling sad, angry or anxious. This finding challenges the assumption that self-harm is a response to sadness and that ODH is a response to anger. However, if it is not emotion that determines an individual's chosen coping behaviour, further research should be conducted focusing on what drives one person who is feeling angry to engage in self-harm, and another person who angry to engage in ODH.

The current study explored young people's experiences engaging in self-harm and/or ODH and found that young people felt there were glaring deficiencies in New Zealand's mental health education and support services. Therefore, the logical progression for this research would be to evaluate the effectiveness of the current education and support services available in New Zealand.

Te Pakiaka Tangata Strengthening Student Wellbeing for Success is a report issued by the Ministry of Education (2017) providing guidelines for effective pastoral care, guidance and counselling in New Zealand Secondary Schools and Wharekura. These guidelines were developed following a nationwide evaluation conducted by the Education Review Office (ERO) which was initiative of the then Prime Minister's Youth Mental Health Project (YMPH). The YMPH was implemented to develop initiatives aimed at improving mental health outcomes for youth aged 12-19 years old in New Zealand. Prior to the implementation of these guidelines, the ERO evaluation found that a growing number of secondary school students were seeking counselling services however, only 61% of schools reported guidance counselling to be working well.

Future research could be conducted to assess whether the implementation of these guidelines has improved the education and support services young people engaging in self-harm and ODH are receiving at school. Further research could also explore New Zealand

service providers' perceptions of and experiences with young people engaging in self-harm and ODH and establish whether they think the mental health education and support services in New Zealand are performing sufficiently.

In closing, 12 participants shared their diverse experiences engaging in self-harm and ODH. The insight obtained through the sharing of these experiences allowed these two behaviours to be compared in-depth. It is hoped that this study will encourage others to conduct further research into this area to advance the understandings of two serious social and health issues among young people and potentially develop new and enhance current prevention and intervention measures.

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Appendices

Appendix A: Interview Schedule

INTERVIEW SCHEDULE

1. **Introductions: whakawhanaungatanga**

2. **Refreshments**

3. **Check with participant, and if approved, start recording**

4. **Review Participant Information Sheet**

5. **Consent form process**

6. **Invite opening Karakia (in English or te reo Māori)**

7. **Broad overview of the interview structure**

'There are some things that I'm interested in about your wellness, emotions, and risky behaviours – things that could harm you. This could be things like what you do to feel better if you're unhappy or anxious. I have some questions, but you don't have to answer any that you don't want to. At the end I will summarize some of the key points that I've heard from what you've shared, and you can add anything that you think I may have missed. Please feel free to ask me any questions at any time or provide any feedback that you think may be useful. I hope at the end of the interview you feel that you've been heard and know that your participation in this study is valued and greatly appreciated.'

MAIN AREAS TO COVER:

The questions below will change according to the individual conversation and answers given. The following questions are intended as a guide to ensure key areas are covered.

8. **What types of things make you feel upset?**
   - Are there particular things or people in your life?

9. **When you're feeling upset (sad, anxious, angry, overwhelmed), what sort of things do you do to try to make yourself feel better? (both risky and non-risky)**
   [If necessary, 'Thinking about the last time you felt upset, what did you do?]

10. **Some people do different things according to the emotion. Do you do that too? Maybe if you're really angry, you do different things to if you're sad or anxious? Or does that not make a difference?**

11. **Do you think any of the things you do are potentially dangerous or risky?**
    - How do these things make you feel better?
    - Do they ever make you feel worse?

12. **Why do you think you use these risky behaviours?**
    - Why do you use these behaviours over other strategies?

13. **Some people self-harm, deliberately hurting themselves. Have you ever done anything like that?**

14. **Other people might lash out at others, verbally abusing, picking fights or punching things. Have you ever done anything like that?**

15. **Do your friends do these things too?**

16. **How do people react when you do potentially harmful things? – Friends? Family?**

17. **What do you think is important for people (parents, teachers, mental health professionals) to know about these types of behaviours?**

18. **What's important to you in terms of your emotional wellbeing?**

19. **[Review:]**
    - Is there anything else you would like to add?
    - If you think of anything else, you have my email address from when I confirmed our meeting today, and also on your copy of the consent form.
    - I'm just going to take a couple of minutes to check through my notes to make sure that what I've written makes sense.

20. **And I just need to check that I've got all the information about you that I need: [confirm age, ethnicity, if at school/uni/working/other, gender]**

21. **Do you have any questions?**

22. **Ok, I think that's everything. If you do think of anything else though, you can email me. Also, if you know anyone else who you think might be interested in this research, they can contact me too.**

23. **Invite closing Karakia**

Appendix B: Recruitment Poster

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

The SHInE Project: Emotional Well-Being Research

Tēnā koe, Talofa Lava, Bula Vinaka, Malo e Lelei, Fakalofa Lahi Atu, Nihao, Namaste, Kia orana, as-salāam alaikum, greetings.

You are invited to take part in a study about mental health and well-being, and the ways in which people deal with difficult emotions.

This part of the study will be in-depth interviews, which will take about an hour and can be face to face in Hamilton, Tauranga or Rotorua, or Zoom.

Please note that it includes questions of a very sensitive nature.

This research has been approved by the University's Human Research Ethics Committee [HREC(Health)2023#16].

For more information please contact the team or, see the project website :

- **Website:** https://theshineproject2023.wordpress.com/
- **Research team:** shine.project@waikato.ac.nz
- **Lead Researcher:** cate.curtis@waikato.ac.nz

Appendix C: Participant Information Sheet

Emotional Health Research: The SHInE Project (Interviews)

Tēnā koe, Talofa Lava, Bula Vinaka, Malo e Lelei, Fakalofa Lahi Atu, Nihao, Namaste, Kia orana, as-salām alaikum.

Sometimes life gets difficult, and people cope with this in different ways. Some people have friends, family or other people who can help them, some seek professional help such as counselling or therapy, some use drugs or alcohol to cope, some self-harm and there are lots of other ways of coping. This research is about the difficult emotions that young people (16-25 years of age) face, and how they cope with them. The project is led by Dr Cate Curtis, of the School of Psychology at the University of Waikato. Cate has worked at the university for 15 years, and was a youth worker before going to university, as well as various other things before that. She's NZ-born of Dutch descent.

This information sheet is to tell you more about one aspect of the research, one to one interviews. You can find out about the other aspects of the research, such as a survey, here: https://theshineproject2023.wordpress.com

Who could take part?
People aged between 16 and 25 who would be interested in talking about the difficult emotions they face, and how they deal with them. Cate's previous research has been on self-harm, anti-social behaviour and suicide among young people, and these are the sorts of problems we're particularly interested in finding out more about. We hope that through better understanding problems and the ways young people cope with them, it will be easier to offer helpful services and support.

What do research participants do?
One of the researchers on this project meets with individual research participants for about **one hour** or so to talk about problems and difficult emotions, ways of coping and getting past those problems. All the information is **anonymous** (though sometimes people decide to have some aspects of their identity known – this is always by individual choice), and the meeting is arranged at a place and time to suit the research participants – in person if in or near Rotorua, Hamilton or Tauranga, or via Zoom. We would like to make a recording of the discussion, so that it can be written about accurately. Interviews will take place somewhere that suits you and the interviewer, such as a private room at the University, or a room in a community centre.

Sometimes talking about problems can be upsetting, so please think carefully about whether taking part is right for you. We don't want this research to cause another problem for you! ☺ If you think it might be upsetting but want to take part anyway, you might like to arrange a fun thing to do afterwards. You can also bring a friend or support person with you – but please let us know beforehand, if you would like to do this.

If you choose to participate, you can refuse to answer any questions, or stop the interview. You can also contact the research administrator, Nicky, up to four weeks after the interview if you change your mind and don't want your information to be used.

We would also like to send you a written copy of what you said, to make sure it's correct. If you would like, we will send you a summary of the findings from all the interviews combined. You would also receive a $40 Warehouse voucher to say 'thank you' and if appropriate, a $10 voucher to acknowledge any costs (e.g. childcare, travel).

Who are the researchers?

In addition to Dr Curtis, there will be a masters student who will be conducting interviews.

Most of the interviews will be with Olivia McIntyre (Māori, Pakeha), as part of her masters research at the University. Olivia is currently undertaking a Master of Social Sciences in Psychology at the University of Waikato. Olivia was born and bred in the Bay of Plenty. After suffering from depression and anxiety as a teenager, she decided to pursue a career in which she could help young people struggling with mental illness, as she had been helped. Ultimately, she hopes to register as a clinical psychologist, to help those with mental illness across Aotearoa. Whilst undertaking her masters, she is also working as a support worker at a mental health residence. In this role, she works with clients from a variety of backgrounds, with high and complex needs. In her free time, Olivia enjoys yoga, reading, and walking her dog. Olivia will conduct face to face interviews in Rotorua and nearby areas, or you could choose to take part via Zoom. If you would like to have a face to face interview and are located in or near Hamilton, you could choose to have your interview with Cate.

What happens next?
Once the research is complete, all the information will be combined and written up into reports and published – but your information will be anonymous.

Some other things you should know:
You can contact the research team by emailing shine.project@waikato.ac.nz
This research has been approved by the University of Waikato Health Research Ethics Committee; application number 2023#16. If you have concerns about the ethics of this research, you can contact the committee secretary: humanethics@waikato.ac.nz.

If you agree to take part you will be asked to complete a consent form, to make sure that you know everything about the research that you need to, and that you are happy to take part. You will receive a copy to keep.

Emergency Help Services:
If you find taking part in this research upsetting, you might like to contact one of these support services:

Depression Helpline	0800 111 757 http://www.depression.org.nz/
Lifeline (all ages)	0800 543 354 http://www.lifeline.org.nz/corp_Need-Help_555_2001.aspx (also has links to other services)
The Lowdown (depression help for young kiwis)	free text 5626 http://www.thelowdown.co.nz/#/home/
Victim Support	0800 842 846 http://www.victimsupport.org.nz/get-help/your-help-lines/
Whats up	0800 942 878 http://www.whatsup.co.nz/teens
Youthline	0800 376 633 http://www.youthline.co.nz/ free text 234

Appendix D: Consent Form

Emotional Health Research: The SHInE Project

INTERVIEW CONSENT FORM

In signing this consent form, you are stating that:
You have received a copy of the Information Sheet describing the research project. Any questions relating to the research, have been answered to my satisfaction. You understand that you can ask further questions about the research at any time during your participation, and can withdraw my participation at any time ***up to four weeks*** after the interview.

You understand that you do not have to answer questions during the interview. You can stop the interview at any time, and you can ask to have the recording device turned off at any time.

When you sign this consent form, you will retain ownership of the interview, but you give consent for the researcher to use the interview for the purposes of the research outlined in the Information Sheet.

Please complete the following checklist. Tick [✓] the appropriate box for each point.	**YES**	**NO**
I have read the Participant Information Sheet, or have had it read to me in a language I understand, and I fully understand what it says.		
I have been given sufficient time to consider whether to participate in this study.		
I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet.		
I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study (unless I request otherwise).		
I wish to receive a summary of the findings.		

Participant :		Researcher :	
Signature :		Signature :	
Date :		Date :	
Contact Details :		Contact Details :	

Appendix E: Ethics Approval Letter

The University of Waikato
Private Bag 3105
Gate 1, Knighton Road
Hamilton, New Zealand

Human Research Ethics Committee
Roger Moltzen
Telephone: +64021658119
Email:humanethics@waikato.ac.nz

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

6 June 2023

Cate Curtis
School of Psychology
DALPSS
By email: cate.curtis@waikato.ac.nz

Dear Cate

HREC(Health)2023#16 : Injuring oneself, injuring others: Distinctions and commonalities (The Meliora Project)

Thank you for your responses to the Committee feedback.

We are now pleased to provide formal approval for your project.

Please contact the Committee by email (humanethics@waikato.ac.nz) if you wish to make changes to your project as it unfolds, quoting your application number with your future correspondence. Any minor changes or additions to the approved research activities can be handled outside the monthly application cycle.

We wish you all the best with your research.

Regards,

Emeritus Professor Roger Moltzen MNZM
Chairperson
University of Waikato Human Research Ethics Committee