

The presentation of self-harm recovery: A Thematic Analysis of YouTube videos

Abstract

Little is known about how recovery from self-harm is understood by individuals with personal experience of self-harm. YouTube is an important online venue for posting and discussion of user-generated self-harm videos. Drawing on this material, this study explores how self-harm recovery is presented on YouTube. The 30 most highly-viewed videos about recovery from self-harm were thematically analysed. Three themes were identified: 1) a desire for change, 2) control over change, 3) implementing change. This study identifies multiple understandings of self-harm, which in turn shape individuals' understandings of self-harm recovery. This has implications for self-harm advice or support.

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Compared to other aspects of self-harm, research exploring individuals' understandings of recovery is scarce and limited in scope (Gelinas & Wright, 2013), relying on narrow samples of either students (e.g., Gelinas & Wright, 2013; Shaw, 2006) or clinical populations (e.g., Kool van Meijel, & Bosman, 2009). It is therefore necessary to explore a broader range of individuals' views (Gelinas & Wright, 2013; Hawton, Rodham, Evans, & Harriss, 2009). Additionally, existing research has relied on retrospective self-reports with participants' most recent incidence of self-injury typically occurring three to five years prior to the research (Kool et al., 2009; Shaw, 2006) rendering their accounts of self-injury susceptible to biased recall or forgetting. Social media has the potential to overcome these limitations and provides an important setting to investigate the experience of self-harm recovery. The majority of those who self-harm do not seek professional help (Michelmores & Hindley, 2012), instead relying on advice and support from peers who self-harm (Hawton, Rodham, & Evans, 2006), particularly online (Jones et al., 2011). YouTube is increasingly used for this purpose (Lewis & Baker, 2011). YouTube is the second most visited website on the Internet (Alexa, 2016), is popular among those who self-harm (Lewis, Heath, St Denis, & Noble, 2011) and is consequently of growing importance to researchers of self-harm, as well as health-professionals more generally (Lewis & Knoll, 2015). As long ago as 2011, it was reported that that the top 100 self-harm related YouTube videos were viewed over two-million times (Lewis et al., 2011). With the greatly expanded reach of YouTube, we would expect this number to be much higher today. Drawing on this large body of user-generated videos, the current study explores the experience of self-harm recovery as presented on YouTube.

1.1 Self-harm prevention, cessation and recovery

With respect to terminology, it is important to point out that in the US the term ‘deliberate self-harm’ has been largely replaced with the term non-suicidal self-injury (NSSI) (e.g. Claes & Vandereycken, 2007). NSSI is defined as purposely damaging one’s own body tissue without suicidal intent, for non-socially sanctioned purposes (Nock & Favazza, 2009). Common forms include cutting or burning oneself, or punching objects (Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007). In contrast, in the UK self-harm refers to any purposeful non-lethal self-injurious act performed with or without suicidal intent, and would therefore include the act of taking an overdose as well as acts of attempted suicide. We use self-harm throughout this paper, unless making explicit reference to NSSI.

In an early interview-based study with female college students who had ceased self-harming, Shaw (2006) found that a number of factors may be implicated in recovery: including a decrease or elimination of catalysts to self-harm (such as depression); social support; professional treatment; coming to see self-harm as problematic or unhelpful; not wanting to worry others; and a desire to care for oneself. Similarly, Kool et al. (2009) interviewed 12 women exploring how they had stopped self-harming. They report that the cessation of self-harm involved six phases, each involving learning either how to cope with their inner selves or to better cope with those around them. The authors highlight several interconnected factors important to the recovery process. These include feeling connected and receiving support, as well as developing a greater understanding of one’s emotions and behaviour. These findings must be treated with caution, however. Participants were patients with dissociative identity disorder and/or personality disorder in psychiatric care, and all had a history of severe self-harm, inflicted several times a week and/or requiring medical treatment. Nonetheless, these findings are consistent with similar research using small patient populations (Lindgren, Wilstrand, Gilje & Olofsson, 2004). Similarly, a recent survey of 54 undergraduates found that substituting self-harming behaviours with alternative coping strategies and reaching out to others for support or formal help, were described as important to recovery (Gelinas & Wright,

2013). Additionally, respondents listed reasons for having stopped self-harming, including: realising the futility or ‘stupidity’ of self-harm; distress associated with scarring and negative attention; not wanting to hurt family members; and a desire for wellness.

In the Gelinas and Wright (2013) study, participants also stated barriers to cessation. These included the perception of self-harm as addictive; stress; mental illness and distress (usually depression or self-hate). The functionality of self-harm also reportedly made it difficult to cease. This is consistent with theoretical and functional models which propose that self-harm is reinforced to the extent that it effectively serves certain purposes for the individual. Such functions may be multifaceted, but the most commonly reported are emotion-regulation (for instance, where self-harm provides alleviation from overwhelming negative emotions) and self-punishment (Klonsky, 2009). This suggests that individuals may cease to self-harm if they no longer perceive a need for the particular function(s) self-harming serves for them, or if they develop alternative means to fulfil that function (Turner, Chapman, & Gratz, 2014).

1.2 Self-harm and recovery online

Despite low formal help-seeking rates for self-harm, many self-harmers seek and offer advice and support around NSSI and recovery online (Jones et al., 2011). In a recent one-year period, terms related to self-harm (including self-injury, self-harm, self-mutilation and self-cutting) were searched on Google over 42 million times (Lewis, Mahdy, Michal, & Arbuthnott, 2014). Personal webpages and self-harm forums feature a range of self-help advice and information, including advice on recovery (Adler & Adler, 2013; Prasad & Owens, 2001). Some who self-harm have stated that self-harm websites facilitate recovery “better than any therapy” (Baker & Fortune, 2008, p.121). Others express concern that online self-harm content may trigger or reinforce self-harm (Lewis & Baker, 2011; Whitlock, Powers, & Eckenrode, 2006). Debate regarding potential risks and benefits notwithstanding, online communication around self-harm is “prolific” (Duggan & Whitlock, 2012, p.776).

YouTube has become a popular online venue for individuals to share information and advice around health related issues (Vogel, 2011). Typically, YouTube users upload video monologues sharing their experiences of a particular health-related condition (Burgess & Green, 2009; Madathil, Rivera-Rodriguez, Greenstein, & Gamopashye, 2014). Accordingly, YouTube represents an ecologically valid research setting in which to explore individuals' views (Konijn, Veldhuis, & Plaisier, 2013). Indeed, it is now recognised that YouTube videos provide a “valuable source of qualitative data”, uninfluenced by researchers, to investigate the views of those affected by various issues (Gao, Hamzah, Yiu, McGrath, & King, 2013. p.2). This is particularly applicable in relation to self-harm because young people, among whom self-harm is most frequently reported, are the most common YouTube users (Ofcom, 2014a; 2014b).

As previously mentioned, self-harm related videos are widely viewed on YouTube (Lewis et al., 2011). In a study of the content of such videos, Lewis et al. (2011) found variations in tone; including factual, educational, hopeful, melancholic, as well as videos emphasising the possibility of self-harm recovery. Videos also varied in purpose, ranging from discouraging to encouraging self-harm or offering reasons for and against the behaviour. In a follow-up study, Lewis, Heath, Sornberger, and Arbuthnott (2012) analysed viewers' online comments on these videos. Comments frequently featured self-disclosure of self-harm and positive feedback for the video or video-uploader. Although these studies offer important preliminary insight into self-harm content on YouTube, both studies had a broad focus and were largely descriptive. Analysis focused on 100 highly-viewed videos which varied in purpose and tone, rather than specifically focusing on a subset of self-harm videos with a particular purpose, such as those focused on recovery.

Just as the “internet represents an accessible and preferred method of communication for many who self-injure” (Baker & Lewis, 2013, p.234), it also provides researchers with opportunities to access the views of these individuals, who may not seek formal help offline or

who may be otherwise difficult to access (Wilkinson & Thelwall, 2011). The content posted by such individuals can be analysed using a covert, observational approach (Moreno, Goniou, Moreno, & Diekema, 2013). Observational analysis of online content facilitates “access to the immediacy of the experience” (Bryman, 2012, p.657) because such content is posted online by individuals at a time pertinent to them. Therefore, analysis of recovery-related content online could address the two key limitations of prior qualitative research into self-harm recovery. That is, in contrast to prior research, individuals who post such content represent a non-clinical, non-student sample and have posted their views about recovery of their own accord, rather than being prompted by researchers to recall experiences which have occurred a considerable time ago.

Aims and research question

Despite the increasing use of YouTube as a form of seeking and disseminating health information, and the prolific posting of user-generated self-harm content, there has to date been no specific analysis of YouTube videos which feature discussion or advice on self-harm recovery. As noted above, these videos represent a rich, naturalistic data source (Gao et al. 2013; Konijn et al. 2013), and an in-depth qualitative analysis of this subset of videos could give voice to individuals who have been affected by self-harm, furthering understanding of what is perceived as relevant and helpful for recovery. Therefore, this study asks:

How is self-harm recovery presented in self-harm related YouTube videos?

Method

The study employed a cross-sectional, observational design in which YouTube videos related to recovery were thematically analysed. YouTube videos are in the public domain and are accessible by anyone with internet access without a password (unless videos are deemed suitable for those over the age of 18 only, in which case a password is required). Consequently,

YouTube videos can be analysed without gaining consent from video-uploaders as long as the data is anonymised (British Psychological Society 2013; Rodham and Gavin 2011). Accordingly, a covert approach was adopted; the researcher did not interact with video-uploaders, informed consent was not sought and video-uploaders were not debriefed. It was not possible to exclude videos posted by under 18 year-olds. However, this does not have significant ethical implications because, regardless of age, no interaction took place with these individuals (Moreno et al. 2013). Any potentially identifiable details, including names and usernames, have been anonymised. Pseudonyms have been assigned. The study was approved by the Psychology Ethics Committee of the corresponding author's University, in accordance with British Psychological Society ethical guidelines (British Psychological Society 2013).

Video Search and Screening

The following twelve searches were made using the default search function on YouTube, where results are sorted by relevance: 1) how to stop self-harming; 2) ways to stop self-harming; 3) help to stop self-harming; 4) how to recover from self-harm; 5) ways to recover from self-harm; 6) help to recover from self-harm. The first three searches were repeated replacing 'self-harming' with 'self-injuring' and the latter three searches repeated replacing 'self-harm' with 'self-injury'. By using a large number of searches and simple search terms, the aim was to emulate various ways in which individuals might search for recovery-related self-harm videos. Terms relating to both 'self-injury' and 'self-harm' were employed because they are common self-harm referents (Whitlock 2010). Terms relating to 'recovery' and 'stopping' were both employed because they have been used interchangeably in prior recovery research (Gelinis and Wright 2013; Kool et al. 2009).

As individuals rarely browse beyond the first few pages of search results on YouTube (Syed-Abdul et al. 2013), videos from the first three pages of each search were pooled. All videos

were downloaded and screened for eligibility. Videos were excluded if they: 1) had been uploaded less than six months prior to the time of data collection (this was for ethical reasons; in case any problematic disclosures were encountered they would be historical, not current, issues); 2) were duplicate videos, appearing more than once in any of the twelve searches; 3) were irrelevant, featuring no discussion or content focusing on recovering from/stopping self-injury/self-harm; 4) only featured professionals' views, to maintain focus on the views of those with personal experience of self-harm; 5) had inadequate audio-visual quality to enable transcription; 6) were restricted access, only accessible by viewers with a YouTube account confirming the viewer is over 18 years-old; 7) finally, if a video featured descriptions of self-harm reportedly motivated by a desire to die we excluded them from the analysis since our focus was on self-harm, not suicidal ideation or suicide.

720 videos were retrieved. 479 videos (66.5%) were duplicates and were excluded. After screening, 66 (27.4%) of the remaining 241 videos were eligible (see Figure 1). It was beyond the scope of the study to include all eligible videos, so the 30 most-viewed were retained for analysis. We chose the most viewed as viewership provides an indication of reach, as well as attraction to and identification with the videos (Lewis et al., 2011).

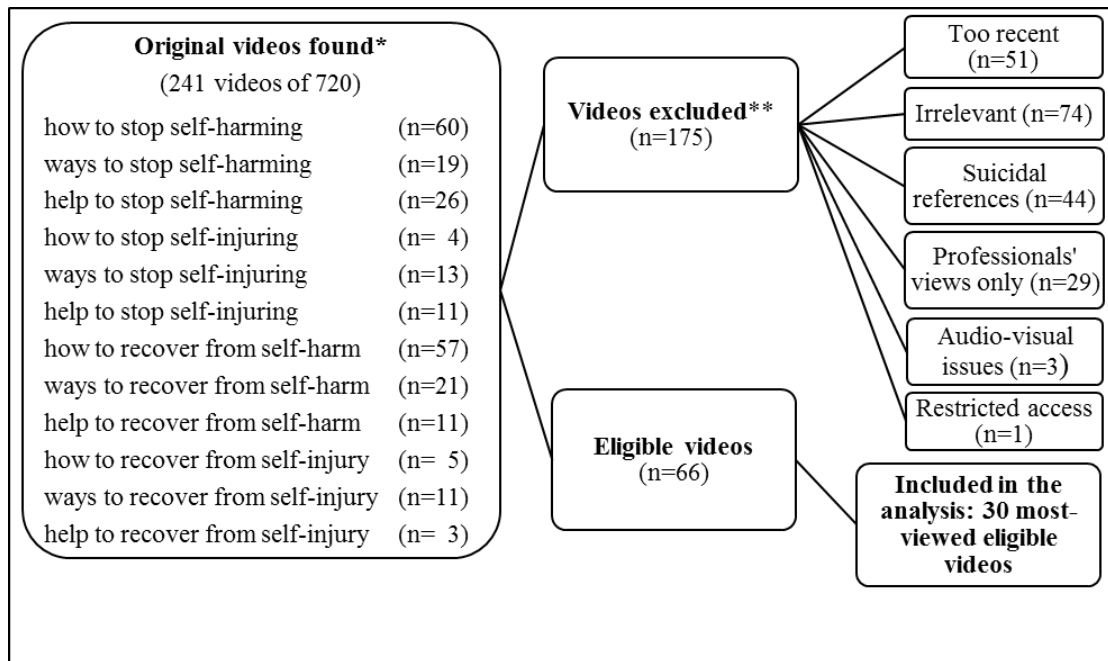


Figure 1: Video search and screening process.

Video and Video-Uploader Characteristics

Thirty videos were analysed. Of these, 26 featured a live individual delivering a monologue to the camera. The other four either featured on-screen text only or an individual holding up written notes to the camera but neither appearing, nor speaking in, the video. Twenty-five of the videos featured, or had been uploaded by, females and five by males. Where videos did not feature a live individual, gender was discerned from video-uploaders' display pictures and/or user-names. Several of the videos had been uploaded by the same individuals; one individual had posted three of the videos, three individuals had posted two each. Thus the videos had been uploaded by 25 different individuals (21 females; 4 males). Due to the observational nature of the research, demographics such as age and ethnicity cannot be verified. Median video length was 6 minutes 37 seconds, all videos had been viewed at least 187 times and videos tended to be rated favourably by viewers. See Table 1 for descriptive statistics of the videos.

Table 1

Descriptive statistics of analysed videos

	Median	Minimum	Maximum
Video length	6 min 37 sec	2 min 55 sec	13 min 58 sec
View count	851	187	372045
Number of comments	14	0	2596
Number of 'likes' ^a	18	2	4835
Number of 'dislikes' ^a	1	0	118

Note. ^a'Likes' and 'dislikes' refer to an option on YouTube allowing viewers to rate videos positively (with a 'thumbs up') or negatively ('thumbs down').

Analytic Procedure

Bailey (2008: p128) states that “verbal and non-verbal data together shape communicative meaning.” With this in mind, the 30 videos were transcribed using guidelines adapted from Bailey (2008) for audible talk (including pauses and emphasis), and any textual material included in the videos was noted word for word and included at appropriate points within the transcripts. For videos featuring on-screen text, original spelling and punctuation have been retained. The words spoken (and subsequently transcribed) in YouTube videos are not searchable. Only video titles, usernames, and user generated hashtags are searchable, and as such have been anonymised by us. Therefore no data presented in this paper is searchable, thus complete anonymity of video uploaders quoted in this paper is maintained.

We analysed the textual data by following the version of Thematic Analysis outlined by Clarke and Braun (2013). Their approach is ideally suited to our needs as it is atheoretical. As they say, it “only provides a method of data analysis; it does not describe methods of data collection, theoretical positions, epistemological or ontological frameworks” (2013, p. 175). Thus it is flexible enough to be used with pre-existing data derived from social media, in this case YouTube.

After transcribing the videos, we developing an intimate familiarity with the dataset by reading and re-reading the text, noticing and noting anything that might be relevant to the research question, and then comparing notes with the other researchers. According to Clarke and Braun, this stage is not a part of the systematic analysis, although the data are read in an active, analytical and critical way. We asked ourselves what the data might mean: How do posters make sense of their experience? What are the different ways that they present and make sense of self-harm recovery? Why might they be presenting and making sense of recovery in these ways? What assumptions do they make when talking about or presenting their self-harm recovery? This stage laid the groundwork for the next stage, generating initial codes.

“A code is a word or brief phrase that captures the essence of why you think a particular bit of data may be useful” (Clarke & Braun, 2013, p. 207). Codes included, but were not limited to: developing self-worth, challenging irrational beliefs, substitution of self-harm, distraction, dealing with impulsivity, releasing feelings non-injuriously, tolerating negative emotions, and finding alternative ways of coping. We then developed candidate themes. At this stage we looked for similarity or overlaps between codes, and for concepts, ideas, topics or issues that relate to one another. In this way we started to develop our themes. For example, several codes (self-harm as addiction, believing you can stop self-harming, self-control, breaking the self-harm cycle) formed the theme ‘taking control over self-harm’. We then reviewed the candidate themes by asking ourselves a number of questions: do the themes answer the research question, are they distinct and coherent, do they hang together meaningfully? During this stage themes were revised, refined, and rejected, before the final set of themes were named and defined for final analysis and write up.

Results

Three key themes were identified, which constructed self-harm recovery as a process: 1) *a desire for change*; 2) *control over change*; and 3) *implementing change*

A Desire for Change: In 20 videos (66.7%), video-uploaders understood recovery as a process that began with a desire to stop self-harming. For instance, Sian (video 16) stated “*the only time I’ve been able to stop is when I wanted to (.) because everything else seems pointless if you don’t want to*”.

Video-uploaders typically derived motivation for recovery from the negative ramifications of self-harm. Here, several video-uploaders described how their perception of self-harm shifted; from something perceived as helpful – a way “*to cope*” (Matthew, video 24) or a means of “*alleviating pain*” (Anne, video 11) – to something perceived as causing suffering in its own right. For example, Marie (video 23) stated:

“I just got to a point where self-harm was not serving any purpose anymore...stopping self-harm was (1) the only thing I could really do I couldn’t continue self-harming because...it was just shit I hated it (.) I didn’t want to do it”

For Marie, self-harm is conveyed as something which she came to feel was futile, whilst for others the perceived short-term benefits of self-harm remained strong, but came to be outweighed by the long-term negative effects. For example, Jess (video 25) recounts how, despite self-harm feeling like it “*fixes all your problems*” at the time, it was “*complete and utter hell to deal with in the long-term.*” Jess further described how, on reflection, the guilt and shame she experienced after self-injuring made her feel that it was no longer “*worth it*”:

“I’d feel...guilty because I self-harmed and I have all these scars that I’m ashamed of and like all these negative emotions would...be lingering after the self-harm [. . .]. I just kinda...had a good hard look at myself and said...do you want to continue doing

this like is this worth it?...is what you get from the short-term worth all of the suffering in the long-term?...the answer was no.”

Video-uploaders mentioned deriving motivation to stop self-harming not only from personal negative effects, such as exacerbated negative emotions, but also from effects on loved ones.

For example:

“My dad actually found out last year and (.) the kind of effect that it had on him and the way he...reacted when he found out I thought it was just horrible to see that I had caused that and that was my reason to (.) stop self-harming.” (Jennifer, video 13).

Control over change: In 20 videos (66.7%), self-harm was conceptualised either explicitly or implicitly, as having become an addiction; something over which they felt they had little control and felt compelled to do:

“You have the feeling that I’ve got to do this I’ve got to go and do it.” (Tony, video 21).

“It became an addiction and I had to do it more and more often to get the same results and it started to take control over me and I was losing myself.” (Ryan, video 8).

However, 15 video uploaders who had constructed self-harm as an addiction, explicitly disputed or questioned the link between addiction and loss of control in their video and shared their recognition of the need to proactively challenge their belief that they had to self-harm, in order to not self-harm:

“The one thing that self-injurers do and me included is kinda say that you couldn’t help it and you had to do it...well guess what you don’t (.) and that is like the biggest lie that

I've ever...told myself or anyone else (1) it is really hard to resist...but it's not impossible." (Rachel, video 9).

In so doing, they refute their prior beliefs that self-harm is outside of their control, and instead accept personal responsibility for their behaviour. Although Rachel still concedes it is "*really hard to resist*" self-harm, she portrays doing so as possible, thereby reclaiming a sense of agency over self-harm. Indeed, recovery was often conceptualised as a process of taking back control over one's behaviour. In seeking to regain control over self-harm, it was commonly stressed that this should be a process of gradually reducing the behaviour, as one might wean oneself off a drug: "*going cold turkey is not really how it's done*" (Amelia, video 14). Accordingly, video-uploaders described various techniques to reduce the frequency and/or severity of their self-harm, to bring it under their control. For example:

"Another thing I did was timing it (.) limiting myself that if I was actually going to cut that I would time how long I did it for so it wasn't so much as a routine and it was more (.) more in my control." (Sophie, video 29).

Implementing Change: Although numerous video-uploaders emphasised *wanting* to change, wanting to stop self-injuring did not mean doing so was (perceived as) easy. Implementing change was something which involved a battle for control in three different areas: substituting self-injurious practices; developing self-worth; and encouraging help-seeking.

Substituting self-injurious practices

Self-harm was recognised as something that had been an unhealthy coping strategy: Rachel (video 9) stated "*there are healthier ways of coping*". Accordingly, recovery was understood as entailing the development, or use of, alternative ways of coping. Common strategies included causing pain without injury or tissue damage (such as snapping an elastic band against

the skin), or distracting oneself from urges (such as going for a walk or listening to music); anything to “*busy yourself in some way*” until “*the urge passes*” (Michelle, video 5).

“When you’re angry there’s no point punching a wall (.) you might as well just get your pillow and punch the shit out of your pillow because I’ve done that before and it really really works for me because you’re not going to hurt yourself (.) you can’t hurt your pillow (.) so it’s kind of a match made in heaven really.” (Jennifer, video 13).

Here, Jennifer implies that releasing one’s emotions (anger, in this instance) is necessary, but not via hurting oneself. Video-uploaders discussed numerous ways of controlling precipitating emotions, or externalising them instead of directing them at oneself. For instance, Nicole (video 19) stated:

“If you self-injure to deal with anger that you cannot express openly, try working through those feelings by doing something different – running, dancing fast, screaming, punching a pillow, throwing something, ripping something apart. [. . .] If you inflict physical pain to calm yourself, try taking a bubble bath, doing deep breathing, writing in a journal, drawing, or doing some yoga”

The physical, high-activity strategies contrast with the self-soothing techniques advocated. In other words, if alternatives to self-harm are to be effective, they should match the specific emotion(s) catalysing self-harm.

Developing Self-Worth

In eight videos (26.7%) recovery was understood as being contingent on developing a sense of self-worth, for without self-worth, cessation of, and recovery from, self-harm was considered impossible. For instance, Rebecca (video 15) described how she previously stopped self-harming for a limited time, because she had been threatened with hospitalisation by her parents.

After she moved away from her parental home, and the threat of hospitalisation was no longer present, she began to self-harm again:

“Self-injury came right on back and that’s because my self-worth didn’t improve (.) I hadn’t loved myself anymore from when I was self-injuring”

Rebecca attributed her sustained recovery from self-harm to feeling that she now *“love[s] myself more”*. In contrast, Kelly’s route to self-worth was via implementing a therapeutic suggestion to hurt a doll instead of hurting herself. She described how after drawing *“wounds”* on the doll to mimic her own scars, she felt that because the doll looked *“so broken and pitiful”* that she could not hurt her. This prompted self-reflection:

“Why did I wanna keep her [the doll] safe when I was still hurting myself? How much of a greater value am I worth or should I be worth and should I consider myself to be worth? Because I am and (sighs) nobody deserves to hurt themselves.”

Here the wounded doll represents, for Kelly, a mirror-image of herself. Accordingly, she implies her feelings of compassion for the doll (*“so broken and in need of help”*), enabled her to see herself from a different perspective; providing insight into her own self-worth and allowing her to refute the implicit view that she deserves self-harm. Thus recovery from self-harm is understood as almost inevitable if one develops a sense of self-worth which challenges a negative, hateful self-perception. As self-worth increases the perceived need for self-punishment – in the form of self-harm – dissipates: *“if you had...love towards yourself then (.) you know self-injury wouldn’t be an issue”* (Rebecca, video 15).

Encouraging Help-Seeking

In 21 videos (70%), informal and formal sources of help and support were mentioned and were described as important for recovery. Most common, was talking about problems with friends

and family, or seeking help from online sources of support. In contrast, counselling, medication and psychiatric help were rarely mentioned. Video-uploaders typically discussed their experiences in a way designed to encourage viewers to seek help, framing help as necessary:

“I could probably just say the word talk for ten minutes of this video if I wanted to just to emphasise the message you know you can’t get the help unless you open up.”

(Matthew, video 24).

Discussions of almost all sources of help tended to be underpinned by the notion that talking about one’s feelings and problems was critical to recovery. Help was rarely portrayed negatively (only in three videos, 10%); typically, this was when it had not been their choice to disclose their self-harm or when help had been imposed. This relates to the notion of having to personally want change (see Theme 1: *a desire for change*). For example, Amy (video 17) relayed how a friend, upon seeing Amy’s injuries:

“...told her teacher and the teacher contacted my guidance-counsellor and when the school found out and threatened to tell my mom (.) that was one thing I didn’t want.”

Discussion

This study sought to explore how self-harm recovery is presented on YouTube. Three key themes were identified: 1) *a desire for change*, where video-uploaders conveyed coming to see self-harm as problematic, and expressed their desire to stop; 2) *control over change*, whereby tensions between perceptions of self-harm as an addiction and as something you could control were highlighted; and 3) *implementing change*, where video-uploaders shared the strategies they used to resist and reduce their self-harm behaviours.

In terms of video-uploaders’ understandings of recovery, these related to particular understandings of self-harm; for instance, those who discussed recovery in terms of developing

an increasing sense of control over one's behaviour, tended to conceptualise self-harm as addictive and difficult to resist. Alternatively, those who stressed the importance of a developing sense of self-worth and self-compassion conceptualised self-harm as a form of self-punishment. Although individuals often drew on multiple understandings of self-harm, this would nonetheless suggest advice around recovery should be targeted to the particular way(s) in which individuals conceive of self-harm. For example, advice or interventions targeting self-hate or a lack of self-worth may be perceived as helpful if individuals understand their self-harm as a form of self-punishment, but might be perceived as irrelevant or unhelpful by individuals who primarily conceive of self-harm as an emotion-regulation strategy.

Video-uploaders' emphasis on having to personally *want* change in order to stop self-injuring is also important. Whilst the value of readiness for change has been extensively highlighted in research on recovery in other fields (e.g., Dawson, Rhodes and Touyz 2014), it has not been highlighted in extant qualitative research into recovery from self-harm. That is, although prior qualitative studies have identified similar *reasons* individuals have for wanting to change, there has been almost no emphasis on the importance of wanting to change in itself. Thus our findings highlight the importance of not imposing help; something video-uploaders depicted as detrimental to recovery. Indeed, it is clear that individuals may feel ambivalent about self-harm, seeing it as both problematic and helpful. As such, support will need to be tailored so that it fits with an individual's level of desire for change (perhaps drawing from the 'Stage of Change' model proposed by Prochaska and DiClemente 1982).

In addition to actively wanting to change, video-uploaders' emphasised recovery as something which entailed both a controlled effort to resist overwhelming self-injurious urges *in the moment* and as something which was an ongoing process. This duality has not been reported in previous research, possibly because previous studies have typically asked participants to

discuss their recovery years after self-injury cessation (e.g., Shaw 2006). Therefore, the accounts obtained in prior studies may be somewhat removed from the immediate experience of cessation, rather than being reflective of the day-to-day experiences we captured, of the attempts to recover from self-harm.

Although the video-uploaders' emphasis on developing alternative strategies to cope with overwhelming feelings is consistent with prior research (Kool et al. 2009; Gelinas and Wright, 2013; Shaw 2006), what was novel was the emphasis placed on learning to *tolerate* negative emotions without self-harming. Whilst this is consistent with research suggesting that individuals who self-harm may also have low levels of distress tolerance (Chapman, Gratz and Brown 2006), our findings demonstrate recognition on the part of the video-uploaders of tolerating negative emotions as a focus for prevention and intervention practices (Chapman et al. 2006). This indicates that for individuals attempting to cease self-harming, other viable emotion-regulation strategies do not just need to be known, available and practiced (Gelinas and Wright 2013), they need to be tailored in accordance with the specific emotion(s) catalysing a given individual's self-harm (e.g. physical activity as an alternative release for anger).

Our findings suggest three levels of change experienced during the process of self-harm recovery. First was a changing perception of the behaviour itself; whereby it came to be recognised as a problem and thus as something warranting help-seeking and/or the use of alternative 'healthier' ways of coping. Second was a changing perception of oneself; from someone deserving of self-harm, to someone worthy of *not* self-harming. Third was a changing perception of the relationship between self-harm and oneself; from feeling controlled by, to in control of, the behaviour. This raises questions as to whether any one level of change may be necessary for recovery or whether all three types of change are required before the behaviour

ceases. Other questions are raised concerning the mechanisms of such changes and how such changes might unfold over time.

Limitations

The videos analysed in this study demonstrate a marked gender imbalance, with 26 (87%) uploaded by females. It is not clear whether this gender imbalance is an artefact of the search terms used to obtain the videos, or is representative of gender differences in self-harm more generally. This gender imbalance is consistent with research indicating that self-harm is more common in females than males (e.g., Carr et al. 2016; Hawton et al. 2002), as well as research specifically on self-harm videos on YouTube, indicating that 95% of the hundred most viewed videos were uploaded by women (Lewis et al. 2011). Another possibility is that using search terms relating to ‘self-injury’ and ‘self-harm’ may not have captured videos in which more ‘male-typical’ forms of self-harm are discussed. Further research is needed to clarify this gender disparity, and to explore males’ presentations of self-harm recovery.

Conclusion

Our findings show that video-uploaders present recovery from self-harm as a process which entails a shifting perception of, and relationship with, self-harm as well as a shifting perception of oneself. For those providing support to individuals who self-harm, our findings highlight the need to take into account an individual’s level of readiness for change. We also suggest that interventions will need to be individually tailored in order to ensure that they match the way in which a given individual understands their own self-harm.

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