

An Open Secret

Self-Harm & Stigma in Ireland & Northern Ireland



March 2023

SAMARITANS
Ireland

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Further resources for support can be found at the end of this document.

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An Roinn Sláinte
Department of Health



Mental Health
Ireland

The *elle*
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Thank you to the team of researchers for their hard work, dedication, and compassion throughout the entire project.

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To all the research participants across our island of Ireland, thank you for giving your time and sharing your voice, your views and your story.

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Foreword

Samaritans is renowned for its helpline service, where volunteers listen without judgement, to anyone who is in distress, lonely, struggling to cope, or feeling suicidal. This includes supporting those who self-harm as we know it is critical that everyone has access to emotional support and that no one ever feels alone.

In 2022, our volunteers engaged in almost 9,000 conversations (5,000 in Ireland and 4,000 in NI) about self-harm, indicating that someone spoke about this issue with one of our 21 branches across the island of Ireland on average once every hour.

Self-harm is a multifaceted issue that poses a high-risk factor for suicide, but, self-harming does not necessarily result in suicidal thoughts, and this affects the support people require.

In Samaritans Ireland's 2020 report, *Self-Harm and Support Seeking in the ROI and NI*, we found that stigma also impedes individuals from seeking support, whether from family, friends, or healthcare professionals.

For that reason, we centred this research on the stigma attached to self-harm and people's views and perceptions of those who self-harm. We sought input from people with lived experience, their loved ones or caregivers, healthcare professionals, and members of the public with no connection to the issue.

The findings of this report - *An Open Secret: Self-Harm and Stigma in Ireland and Northern Ireland* - are staggering and reveal that society frequently inflicts stigma, and its effects on those who self-harm are profound. Nobody should have to bear the stigma and discrimination outlined in this report.

Samaritans Ireland would like to thank all those who contributed to this research, especially those who completed the survey, shared their experiences and opinions on stigma and self-harm, and participated in discussions. Their insights into people's beliefs, thoughts, feelings, and attitudes are valuable.

Our objective is to use the findings from this research to inform our future efforts and provide support for those who self-harm and those who care for them.

We express gratitude to all members of the research team, particularly for their time and empathy towards people with lived experience of self-harm.

Lastly, we would like to acknowledge the support of our funders: the Mental Health Grants Scheme 2022, funded by the Department of Health (Ireland) and the HSE administered by Mental Health Ireland, and the Department of Health's Mental Health Support Fund (NI) managed by the Community Foundation for Northern Ireland.

This report presents new evidence of the reality of stigma and shame associated with self-harm and sets out a compelling case for change in how society views self-harm.



Mark Kennedy

Assistant Director
Samaritans Ireland

Executive Summary

Stigma and shame are issues commonly associated with self-harm and wider mental health difficulties. Findings from Samaritans Ireland's 2020 report, *Self-Harm and Support Seeking in the ROI and NI*, indicate these stigmas exist across society, including amongst the medical community.

Anecdotal evidence from Samaritans volunteers also shows callers who self-harm, tend not to talk about it with family or friends as they are "worried about their reactions". The 'shame' they feel also means those who self-harm are often more worried about someone finding out than they are about seeking help.

Overview

This research - ***An Open Secret: Self-Harm and Stigma in Ireland and Northern Ireland*** - is a deeper look into the impacts of stigma and self-harm and details the findings of a research project carried out between March – December 2022. A first of its kind, this pioneering project collected insights from a diverse group of sources within a single survey, including the general public, individuals with lived experience of self-harm, loved ones of those who self-harm, and professionals who work with individuals who self-harm.

Through a mixture of qualitative and quantitative research, this project explores:

- Personal accounts from those with lived experience of self-harm.
- Insights from loved ones and those who have personally cared for people who self-harm.
- The manner in which service providers/ mental health professionals approach the topic of stigma in both the treatment of self-harm and communications around self-harm.
- The general public's understanding of self-harm and stigma.

Participants

A total of 769* individuals took part in this research, completing all the required screening questions. All participants were required to live in Ireland or Northern Ireland and be over the age of 18. The majority of participants were from Co. Dublin and Co. Antrim respectively and ranged in age from 18 to 80.

Some survey questions were adjusted based on participants' experiences, and they were asked to select an option they predominately identified with: individuals with lived experience of self-harm (n=226), individuals who have personally supported someone who has lived experience of self-harm (n=148), professionals who supported someone with lived experience of self-harm (n=175), OR as a member of the general public (n=220).**

To understand self-harm and stigma, it is important to look at how society defines them.

*A further 36 people started the survey but did not pass the screening process because of location, age, or chose not to proceed.

**Each identity is colour coded throughout this document.

Defining self-harm

Self-harm, also sometimes called self-injury, is complex and the experiences and intentions behind self-harm can vary from person to person. **Samaritans define self-harm as: any deliberate act of self-poisoning or self-injury carried out without suicidal intent.**

Self-harm is often considered to be a way of 'releasing' or 'coping with' difficult emotions. In this research, many people also associated it with feelings of control.



"Self-harm is where someone deliberately hurts themselves as a release of pain or a form of self-punishment. It can also be a form of self-soothing where people feel hopeless or depressed and [self-harm] gives them a sense of control over their lives." **Professional**

There are standard depictions of self-harm across society, but many acknowledge it is more than that, with one participant with lived experience explicitly acknowledging how much society's perspectives are impacted by TV and movies, saying "*... I would emphasise that there are many forms of self-harm beyond the ones represented in media.*" Many participants thought of self-harm on a broader scale describing it as an "*umbrella term*" and not defined strictly by physical acts.



"...entering knowingly dangerous scenarios with a disregard for your own safety..." **Person with lived experience**

Defining stigma

The dictionary definition of stigma describes it as a set of negative and often unfair beliefs that a society or a group of people have about something. In exploring the data from this research, stigma was generally described in relation to 'othering', silencing, shaming, disgrace, and stereotyping.

"...I think stigma is something that's being silenced even though everyone knows it's there, you don't really talk about it..."

Focus group participant

There was another underlying sense that stigma exists because of a lack of knowledge or understanding.

"...my definition of stigma puts the fault of the issue onto society, our services and carers who have perhaps failed [and] make talking and seeking help for anything a hard or problem process for someone..."

Person with lived experience

This raises concerns about who is accountable for the stigma associated with self-harm.

Stigma is often caused by people making judgements based on incomplete or incorrect information. This is harmful to individuals who are already struggling with self-harm and other mental health issues, and society needs to take responsibility for addressing this issue. This means promoting accurate information about self-harm and mental health and taking steps to counteract harmful attitudes and beliefs. By working together, we can create a more supportive and understanding environment for those who are affected by self-harm.

Stigmatising views on self-harm

Responses to self-harm and stigma varied greatly. It is interesting to note the diverse range of comments between the different groupings. For example, a retired mental health professional spoke strongly against the way self-harm is often described and the stigmatising words that are still used in clinical practice today.

Conversely, some individuals' understanding of self-harm, whether intentional or not, was inherently stigmatising.



"Self-harm can often be a cry for attention..."
Person from general public

"Someone who hurts themselves to feel pain." **Family/Friend/Carer**

"While I would be sympathetic, I would be embarrassed to admit I think it's a selfish act and I wonder if it was done for attention although I'm aware a lot of people who self-harm do it privately and don't care."
Family/Friend/Carer

Dangers of stigma

Responses from the survey and focus groups start to corroborate the role stigma has in silencing, shaming, and pushing those who self-harm into secrecy.

"I feel like stigma itself is intensifying and naturally making you more isolated and alone, so it's driving up the impulse or urge [to self-harm]..." **Focus group participant**



The research data provides a clear picture of the dangers related to stigma. It affects individuals seeking help, the quality of care they receive, and their ability to live their lives. Stigma turns self-harm into a taboo – an open secret – everyone is aware of its existence, but no-one wants to acknowledge it. The most effective way to combat stigma is for individuals to acknowledge their role and responsibility in sustaining it, and to confront the underlying issue, which is stigma is perpetuated by society as a whole.

"Stigma exists because it has been allowed to."
Person with lived experience

Disconnect between good intentions and action

The 'Alex' study carried out as part of this research presented participants with real-world scenarios of self-harm to gauge their responses. While 77% of participants stated they would be willing to help Alex, who self-harmed, they were less willing to share everyday activities when faced with a tangible scenario, such as sharing a carpool (64%) or renting an apartment (56%).

The findings from 'Alex' raise an interesting difference between good intentions and following through with action. Quotes shared by those with lived experience of self-harm clearly demonstrate the stigma they feel.

An important factor to consider when addressing this issue is that good intentions do not alleviate the stigma people who self-harm face. Individuals who self-harm are aware when others are avoiding interactions with them, even indirectly, which exacerbates the cycle of stigma. A question for policy makers is how to ensure good intentions are followed up with action.

"...I think people just dance around the issue, just see it as too dark for everyday conversation... for a lot of people it's going too deep into people's problems... don't want to open Pandora's box."

Focus group participant



Anyone can self-harm

The data shows that the onset of self-harm varied greatly, with some individuals reporting instances of self-harm as early as the age of four and others starting to self-harm at age 50. On average, participants were 16-years-old when they first began self-harming.

The duration of self-harm also varied widely among individuals, with some reporting it lasted a year or less while others engaged in self-harm for 53 years.

For most, self-harming behaviours last for around 13 years.

"People associate self-harm mostly with teenage girls cutting themselves. Anyone can be impacted by self-harm at any time. This stereotype and the stigma that people only self-harm for attention prevents people from recognising they need and deserve help." **Professional**



The research clearly illustrates that self-harm is not limited to young people and for many is not a temporary phase. It can start at any age and persist for a lifetime. It is crucial to consider this when conducting further research and framing policies.

Key findings

- The results of this research laid bare the disconnect between participants' willingness to help someone who self-harms and their actual behaviour.
- It revealed how people would remove themselves from everyday scenarios to avoid someone who self-harmed (i.e. car sharing, new relationships, employment).
- The age at which participants first started to self-harm varied widely, with some self-harming as young as four and others not starting until they were 50.
- The duration of self-harming behaviours varied. Some reported self-harming for a year or less, while others struggled with it for a lifetime.
- The majority of those who self-harmed reported their self-harming behaviours lasted an average of 13 years.
- Family, friends and caregivers felt most impacted by their own thoughts and emotions related to someone who self-harms.
- Professionals strongly believe they provide warm and understanding care and listen to the problems and experiences of those they work with who self-harm, despite some individuals expressing opposing views.
- Three healthcare professionals (featured as case studies) all revealed they would not feel comfortable telling their employer they self-harmed, and two would not enter a relationship with someone who had self-harmed.
- The portrayal of self-harm in film and TV significantly impacts society's perception of the issue.

Of all participants...

- 77% indicated willingness to 'help' someone who self-harmed.
- 64% would not carpool and 56% would not rent out an apartment to someone who self-harmed.

Of those without first-hand lived experience of self-harm...

- 88% recognised the difference between self-harm and suicide, with 90% seeing self-harm as a coping mechanism.
- 80% felt unsure or knew they could not speak to their employer about self-harm without fear of judgment or stigma.
- 76% would feel comfortable if a close friend or family member confided in them that they self-harmed.
- 71% had observed, in passing, someone they believed may self-harm.
- Over 50% agreed visible signs of self-harm would impact their willingness to enter a new relationship.
- 45% felt they would be judged or stigmatised by their GP or other healthcare providers.
- 42% said knowing about or seeing visible signs of self-harm would impact their perception of someone.
- 30% agreed visible signs of self-harm would impact their willingness to hire someone.

Of those with lived experience of self-harm...

- Nearly 90% reported sometimes, often, or always thinking that others will have a lower opinion of them if it is known that they self-harm.
- 55% felt the average person is often or always afraid of someone who self-harms.

Conclusion

The findings of this study reveal the significant impact of stigma and discrimination on those who self-harm, as well as their caregivers and loved ones. Stigma is frequently inflicted by society, as well as by our own thoughts, decisions, and actions, often without us fully comprehending the extent of its impact on others.

While the majority of participants recognised self-harm as a coping mechanism and felt comfortable talking to close friends or family members about it, visible signs of self-harm were still met with hesitancy and judgement. The study also sheds light on the variability of age and duration of self-harming behaviours, indicating the need for individualised and comprehensive support for those who self-harm.

It is concerning that many participants, including healthcare professionals, felt uncomfortable disclosing their self-harming behaviours or entering into relationships with those who self-harm. This highlights the need for increased awareness and education about self-harm, and the importance of combating harmful portrayals of self-harm in the media.

Despite the challenges, the study also reveals the potential for positive experiences in seeking professional help, with professionals reporting concern and desire to care for those they work with who self-harm. It is crucial to continue efforts to reduce stigma and discrimination surrounding self-harm and to provide accessible and compassionate support for those who self-harm and their loved ones.

Summary of recommendations

This research has uncovered a range of issues and challenges that individuals who self-harm face, including stigma and discrimination in various areas of life. Based on the findings, below are several recommendations which aim to address the root causes of stigma and create a more inclusive and compassionate society for those who self-harm.

Ireland

- ◆ **Start talking about wellbeing early:**
Self-harm can begin at a very early age, so it is important education about mental health and wellbeing begins as young as possible with age-appropriate lessons in school.
- ◆ **Mandatory workforce training for health professionals and general workforce:**
Mandatory training should be co-developed with those with lived experience and involve speaking directly with mental health ambassadors who can share their first-hand experiences.
- ◆ **Clear pathways to report stigma:**
The public needs to know where and how to report if they are stigmatised or shamed when presenting for help at hospitals or GP offices. Workplaces should also develop clear policies outlining zero-tolerance for stigma and a process for employees to report any issues.
- ◆ **Compliance with Samaritans' Media Guidelines:**
All media, film and TV production companies should adhere to Samaritans' media guidelines when reporting on self-harm or developing plot lines related to self-harm.

◆ **Increase political and public awareness to reduce stigma:**

Led by the Department of Health, a whole-government approach should be taken to reduce stigma including Samaritans media training to all public officials to ensure appropriate language is used when speaking about self-harm or suicide.

◆ **Keep those with lived experience of self-harm, as well as their carers, family and friends at the core of all research:**

Engaging with individuals who self-harm and their broader support networks is a critical step in creating policies and services that are more responsive, effective and inclusive.

◆ **Collect timely and accurate data:**

Accurate and reliable data needs to be available in order to inform policy decisions and resource allocation. The National Suicide Research Foundation should be supported to ensure all hospitals are collecting and sharing data in a consistent and timely manner.

◆ **Fulfill recommendations made in national strategies and policies:**

Continued support and focus is required on self-harm within the National Suicide Prevention Strategy, *Connecting for Life*, and key prioritisation of recommendations 22, 23, and 91 from the National Mental Health Policy, *Sharing the Vision*.

◆ **Foster a positive school and university environment:**

Schools and universities should be equipped with the resources and knowledge to identify and address self-harm.

◆ **Develop workforce training:**

To support individuals who engage in self-harm, mandatory training should be developed and delivered to all healthcare professionals, teaching staff and community workers.

◆ **Improve co-operation and cross-departmental working:**

Government departments, the statutory sector, and the voluntary and community sector must work together to address issues around self-harm. The Department of Health should take a co-ordinating role to ensure relevant and timely information is shared on evidence-informed interventions.

◆ **Engaging with those with lived experience of self-harm, as well as their carers, family and friends:**

Prioritise the voices and experiences of those with lived experience of self-harm so policymakers and service providers can help to create a mental health system that is more supportive, empathetic, and effective for all.

◆ **Ensure all media, film and TV production companies use Samaritans' Media Guidelines when reporting on self-harm or developing plot lines related to self-harm:**

These guidelines provide valuable insight into how to approach the subject matter sensitively and accurately, without perpetuating harmful stereotypes or contributing to stigma.

◆ **Collect timely and accurate data:**

It is important to collect accurate and reliable data to inform policy decisions and resource allocation.

Northern Ireland

◆ **Increase public awareness and reduce stigma:**

The Department of Health and the Public Health Agency should undertake a public education campaign to raise awareness to reduce the associated stigma of self-harm.

◆ **Address root causes of self-harm:**

Protect Life 2, the Suicide Prevention Strategy and Mental Health Strategy should be prioritised and fully funded to ensure that services are available and enhanced for those who self-harm.

Setting the Context

The concept of mental health stigma has been explored from a wide range of perspectives in recent years. Some studies have found that stigma is reducing in some specific areas of mental health through psychoeducation programmes¹, but a large body of the population outside of academic institutions or those availing of mental health services, may not be able to access these programmes.

Research on mental health difficulties in Ireland, such as that by Dunne et al. (2018)², identifies a “culture of concealment of mental health issues in Ireland” that contributes to significant ramifications, such as “stigma and discrimination” (pg. 15).

Researchers have argued stigma and discrimination can create barriers for individuals struggling with their mental health in accessing treatment, employment, housing, and personal relationships.³ This indicates social stigma, self-injury and shame are areas that policymakers and service providers need to give more attention to.⁴

Self-harm is defined by Samaritans as being **“any deliberate act of self-poisoning or self-injury carried out without suicidal intent.”** Research indicates a growing prevalence of self-harm among general populations,⁵ with numerous studies identifying specific demographics showing significantly higher rates.^{6,7}

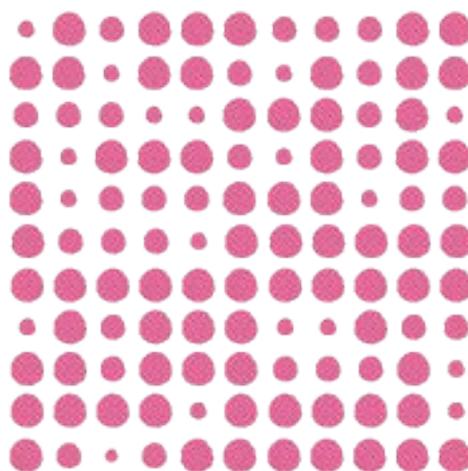
Most recent estimates from the National Self-Harm Registry (NSRF) suggest 1 in 500 people self-harm,⁸ while for specific demographics of individuals it may be up to 1 in 118.⁹

Particular attention needs to be placed on growing our understanding of self-harm and the stigma that envelops it.

Research typically focuses on specific demographics, such as students in third-level education or individuals within a specific population.

It is difficult to determine the exact prevalence of self-harm across the island of Ireland as the available data is reliant on individuals who come forward and present to mental health services or emergency departments.

Recent research shows that almost half of participants (49%; Samaritans, 2020) did not seek help¹⁰ suggesting that stigma may have been a significant barrier to seeking help.



About this Report

In October 2020, Samaritans Ireland published a report titled *Self-Harm and Support Seeking in the ROI and NI*, which provided insight into the experiences of individuals who have self-harmed. The report highlighted the issue of stigma and the negative impact it had on participants' willingness to seek help. Participants expressed feeling judged and criticised, which discouraged them from seeking further assistance. They also noted that their initial experiences of seeking help were often negative, further reinforcing feelings of shame and reluctance to seek support.

The issue of stigma is not unique to self-harm but extends to the broader mental health field. The report's findings indicated that stigma existed within the medical community, creating additional barriers for those seeking mental health support.

Samaritans' volunteers also reported that callers who disclosed self-harm were often reluctant to talk to family or friends out of fear of judgement or negative reactions.

This report delves deeper into the impact of stigma on self-harm, examining the wider public's awareness and understanding of self-harm, with a particular focus on stigma while also exploring the impact of internal stigma and how individuals with lived experience describe it.

The report evaluates the approaches of different service providers and mental health professionals towards stigma in the treatment of self-harm and how communication around self-harm may perpetuate stigma.

The report highlights the need for increased awareness and understanding of self-harm to combat stigma and create a safe environment for those seeking support.

It emphasises the importance of creating supportive and non-judgemental spaces for individuals to seek help, both within the medical community and among friends and family.

The report's findings serve as a call to action for policymakers and mental health professionals to address the issue of stigma and promote a more compassionate and inclusive approach to mental health support.



Literature Review

Stigma and self-harm have been discussed in various research contexts over the last number of years. Complications can arise when trying to navigate precise definitions across the literature. These concerns may seem isolated to academics and researchers, but considering the implications of stigma and self-harm for society, an awareness of their meaning is crucial.

Historically, stigma was defined as a form of guilt or shame that causes an individual to deeply discredit a characteristic or attribute about themselves.¹¹ While this definition may appear clear, modern research has uncovered far more complex and nuanced interpretations of this definition.

What is self-harm?

Navigating the literature can be difficult given the many inconsistent phrases and definitions used to describe self-harm and its association with various forms of behaviour.

Long, Manktelow, and Tracey (2013)¹² highlighted implications of using inconsistent terms and how stigmatising and labelling this can be for individuals. Some terms such as "parasuicide" (Kreitmann, 1977)¹³ or "self-mutilation" (Favazza, 1996)¹⁴, were originally used to describe suicidal behaviours, but were then later applied to explain non-suicidal behaviours as well.¹⁵

Commenting on research conducted by Ward and Curran (2021)¹⁶, Wilson and Ougrin (2021)¹⁷ identify the problems with operational definitions of self-harm and provided guidance on how to approach definitions in research. Long et al. (2013)¹⁸ also discussed the impact of this lack of clarity on public perception, which can further increase stigma and distress for people struggling with self-harm.

The definition of self-harm adopted in this report is based on the definition used by Samaritans: "any deliberate act of self-poisoning or self-injury carried out without suicidal intent".

With advancements in our understanding of self-harm, definitions like Samaritans' have become more widely accepted. However, given inconsistent methodological approaches and classification systems of self-harm across research, it hinders the ability of researchers to make comparisons between countries, regions and organisations (Muehlenkamp et al., 2012).¹⁹

Similar to the definition of self-harm adopted by Samaritans, recent research also refers to self-harm as a complex clinical behaviour that will reflect some motivation to inflict intentional harm onto oneself without the intent of ending one's life.²⁰

Regardless of the many definitions and research areas, researchers have tended to focus on specific behaviours associated with self-harm. In Non-Suicidal Self-Injury (NSSI) research, Ammerman et al. (2017)²¹ found that in relation to self-harm, specific behaviours of individuals included banging of a head, biting, cutting, or burning. Other studies reported additional behaviours, such as hitting oneself, manipulation of a pre-existing wound or pulling of hair.²³

These behaviours are often influenced by a range of factors, including emotional and psychological factors, stress, trauma, and social and cultural influences.^{24,25,26}

Self-harm is a complex behaviour that is widely recognised as a significant public health concern and a leading risk factor for suicidal ideation and completion of suicide.^{27,28} However, it is important to understand that not everyone who self-harms wants to end their life.

Factors which influence self-harm are varied and multi-faceted. The Sutton Model (2007)²⁹, identifies six stages in the cycle of self-harm, but it primarily focuses on the individual and does not consider the role of others in supporting recovery.



Sutton (2007) Cycle of Self-Harm

Research by Mannekote, Thippaiah et al. (2020)³⁰ reviewed 1,094 articles related to understanding the impact of cultural and geographical factors on self-harm, but found that self-harm, is equally prevalent worldwide, with differences only in the specific factors influencing the behaviour.

Figures from the 2020 National Self-Harm Registry for Ireland show a total of 11,932 presentations to hospitals for self-harm, involving 9,063 individuals.³¹ Although these figures may be lower than in previous years, they must be understood within the context of the COVID-19 pandemic. The figures also fail to capture the presentations to one hospital in Dublin.

In Northern Ireland, the 2019-2020 Registry for Self-Harm recorded 8,945 presentations to emergency departments for self-harm, involving 6,176 individuals.³² These figures were recorded during the period April 2019 to March 2020, which includes the weeks immediately prior to the first COVID-19 lockdown.

International research on self-harm and non-suicidal self-injury has found varying trends, with some countries showing an increase, decrease, or stabilisation in the prevalence of self-harm.^{33,34,35,36} However, there is concern that the use of different definitions, questionnaires and average scores, may obscure significant differences within certain groups and communities.

What is stigma?

According to Goffman (1963)³⁷, stigma is an undesired characteristic or difference in a person that does not align with society's expectations of what a person should be. Fox, Earnshaw, Taverna, and Vogt (2018)³⁸, noted a lack of consistency and clarity on how mental health stigma should be defined and measured. Different studies have looked at various forms of stigma, such as those related to an individual's weight,^{39,40} ethnicity,⁴¹ age,^{42,43} or a positive COVID-19 test,^{44,45} whilst other research also examines the internalisation of stigma, which leads to a form of self-stigma.

Determining the exact number of people in need of mental health support is challenging due to limited information. Sickel, Seacat, and Nabors (2014)⁴⁶ noted that mental health stigma is a significant barrier to seeking and obtaining mental health treatment. Interestingly, stigma is also witnessed as a barrier when receiving support – Bharadwaj, Mallesh, and Suziedelyte (2017)⁴⁷ found that even when seeking support, people are still likely to under report their mental health issues due to stigma.

Previous research within Ireland and Northern Ireland

Samaritans conducted research in Ireland and the United Kingdom to explore the barriers that prevent people with lived experiences of self-harm from receiving support. Focusing exclusively on data from Ireland and Northern Ireland, a low number of participants sought support, and those who did, found it to be either slightly helpful or not helpful (Samaritans Ireland, 2020)⁴⁸. As one of its key recommendations, the research emphasised the need for further investigation into the connection between stigma and self-harm.

For this research, a systematic search was undertaken across four research databases (PsychArticles, PubMed, Science Direct and Web of Science) to identify articles that met the following criteria: published in a peer-reviewed journal; recruited participants from Ireland or Northern Ireland; published between January 1, 2011 and May 31, 2022; used the terminology related to self-harm and stigma as defined by Samaritans and assessed self-harm and stigma in some way. As a result of this search, 1,904 articles were identified.

These articles employed a range of approaches, definitions and measurement scales. The qualitative studies, for example, utilised a specific group of participants^{49,50,51}, while the others relied on established scales such as the Strengths and Difficulties Questionnaire⁵², the General Help Seeking Questionnaire⁵³, or the Lifestyle and Coping Questionnaire.⁵⁴

There is no universal definition or assessment of stigma within research but often relies on definitions from established researchers (Goffman, 1963; Corrigan, 2004).^{55,56}

For instance, Long (2018)⁵⁷ cited Pescosolido et al. (2008)⁵⁸ who defined stigma as a separator between individuals based on a social judgement that some people or groups are considered inferior.

The methods used to measure stigma varied depending on the definition and perspective of the research. For example, Nearchou et al. (2018)⁵⁹ used the Peer Mental Health Stigmatisation Scale.⁶⁰

The key findings of these studies indicated a lack of consistent mental health education in schools and the need for more support to teach children and adolescents where to seek help.⁶¹ The study by Nearchou et al. (2018)⁶² found that older adolescents were less likely to seek help for mental health issues compared to younger ones, and male participants reported a higher intent to seek help for self-harm compared to female participants.



Methodology

The purpose of this project was to examine the characteristics, extent, impact, and nuances of internal versus external stigma in relation to self-harming behaviours, as well as the potential responses to self-harm related stigma in Ireland and Northern Ireland.

Samaritans' Research Ethics Policy ensured the confidentiality of participants by following the legal requirements of the General Data Protection Regulations 2016, The Data Protection Acts 1988-2018, and the Privacy and Data Protection Policy currently being used within the South-East Technological University (Carlow Campus). Ethical approval for this project was submitted to and approved by South-East Technological University Ethics in Research Committee.

Research objectives

The study aimed to achieve the following research objectives:

- 1.** Determine the nature and scope of stigmatising attitudes towards self-harm, both internal and external.
- 2.** Examine how stigma impacts individuals' ability to openly discuss self-harm or offer support to those who self-harm.
- 3.** Investigate the effect of stigma on individuals' engagement with support services.
- 4.** Evaluate the general population's level of awareness regarding self-harm and the available support services.

Research pilot and feedback

Before the public dissemination of the survey, 40 participants were selected through a purposive sample to review the questions and provide feedback. These participants represented a diverse demographic. They were given full information on ethics, received a briefing and debriefing document, and were also encouraged to provide feedback to the researchers. Out of the 40 participants, 35 provided feedback.

Based on the pilot, the following changes were made to the survey:

- i.** The academic titles of the questionnaires were removed as they were perceived as intimidating by some participants, with one commenting they were *"very scary to those who don't work in this [mental health] field."*
- ii.** The wording of the questions were edited to make them uniform and consistent. For example, the term 'self-harm' was used instead of 'mental illness'.
- iii.** As many leading questions as possible were removed, such as asking about the participant's sexuality.

Dissemination and sampling

The main survey was self-selecting and promoted across Samaritans Ireland and Samaritans NI Twitter, Facebook, and LinkedIn pages. To maximise the number of participants, additional support was sought from other third sector organisations, academics, university student organisations, and Samaritans Ireland staff used email correspondence to individuals, organisations and networks asking for assistance in the dissemination of the survey.

Survey

An online survey was conducted among 769* adults living in Ireland or Northern Ireland using the Qualtrics platform. The survey was conducted between September and October 2022. Before participating in the survey, all participants read an information sheet, confirmed their understanding of the survey and provided their consent before proceeding with any questions. The survey collected demographic information including age, gender, and employment status. Participants were then shown Samaritans' definition of self-harm before completing the Level of Familiarity scale⁶³.



*A further 36 people started the survey but did not pass the screening process because of location, age, or chose not to proceed.

**Not all questions/scales are displayed within this report.

The participants were asked to identify themselves in relation to their predominate experiences with self-harm through one of four categories:

- 1 As someone with lived experience of self-harm
- 2 As someone who has personally supported someone who has lived experience of self-harm, e.g., a family member, carer, or friend
- 3 As someone who has professionally supported someone who has lived experience of self-harm, e.g., a health professional
- 4 As a member of the general public who has no lived experience of self-harm, nor experience of supporting someone personally or professionally with lived experience of self-harm.

Participants were then given a specific set of questions based on their selected category.

Overview of survey questions/scales as seen by participants:**

- A. Level of Familiarity Scale (pg. 29)
- B. Warwick-Edinburgh Mental Wellbeing Scale**
- C. Questions on Reducing Stigma (pg. 54)
- D. Attribution Questionnaire (pg.39)
- E. Deliberate Self-Harm Inventory**
- F. Internalised Stigma of Mental Illness Inventory (pg. 42)
- G. Inventory of Stigmatising Experiences Scale (pg. 44)
- H. 15-item Stigma Questionnaire**
- I. Questions on Self-Harm from Samaritans Ireland (pg. 31)
- J. Self-Harm Antipathy Scale (pg. 50)
- K. Caregivers of People with Mental Illness Scale (pg. 47)

Debrief

At the end of the online survey, participants were presented with a debrief sheet which provided information on how to reach Samaritans for support through the freephone helpline **116 123** and email jo@samaritans.ie (Irl) or jo@samaritans.org (NI).

Focus groups

After completing the survey, participants were offered the opportunity to participate in a focus group/roundtable to delve further into the relationship between stigma and self-harm. Those interested provided their email addresses for follow up by a researcher.

A series of focus groups (n=5) were conducted online using Zoom and involved 11 participants. Before each focus group started, participants were given an information sheet and again asked for their consent.

The focus groups followed a structure of engagement, exploration, and exit questions related to self-harm and stigma.

To maintain anonymity if desired, participants could use pseudonyms and turn off their cameras. Check-ins and signposting to Samaritans occurred throughout the focus groups.

Participants were also advised they could leave at any time. After each focus group, participants received debrief information and a follow-up from a researcher to confirm their wellbeing. The survey data was analysed using IBM SPSS v.29 and the focus group data was analysed through thematic analysis.⁶⁴

Limitations of project

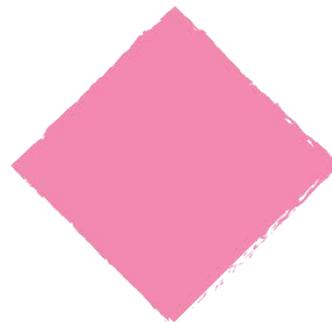
Demographics:

Although sexuality was excluded based on feedback from the pilot study group, targeted research looking at intersections of self-harm stigma and sexuality should be considered for future research.

While the current survey was limited to individuals aged 18 and above, previous studies and responses within this research suggest that self-harm behaviours often begin earlier in adolescence. It is crucial to recognise the impact of stigma on this younger cohort, who may experience disproportionate rates of stigma from classmates or family, given that they must attend school and typically still live with their families.

Accessibility of data collection:

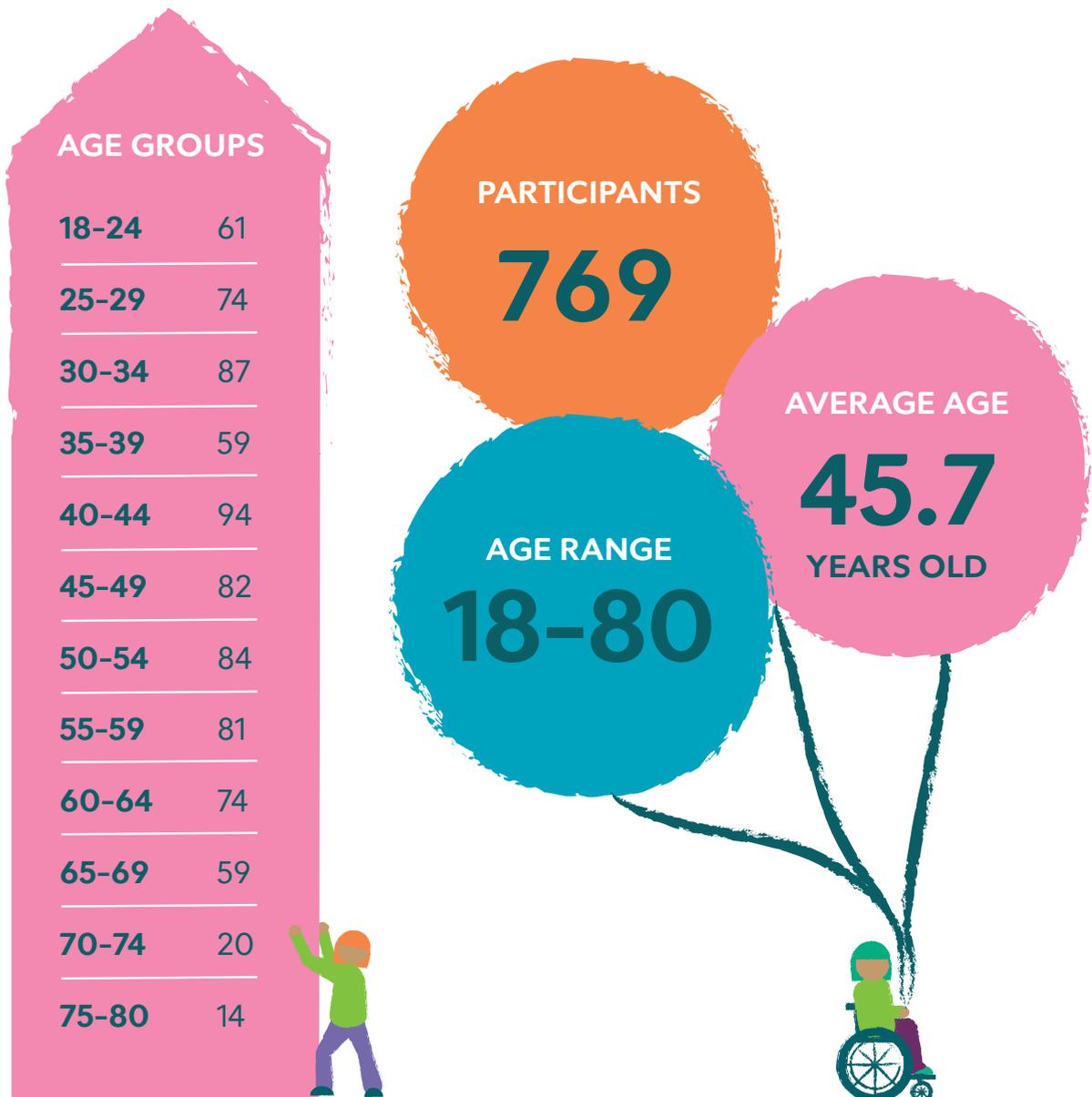
The online nature of the survey and its digital promotion may have excluded certain demographics and populations from participating. To ensure equitable access to participation, future research should consider employing multiple methods of survey collection.

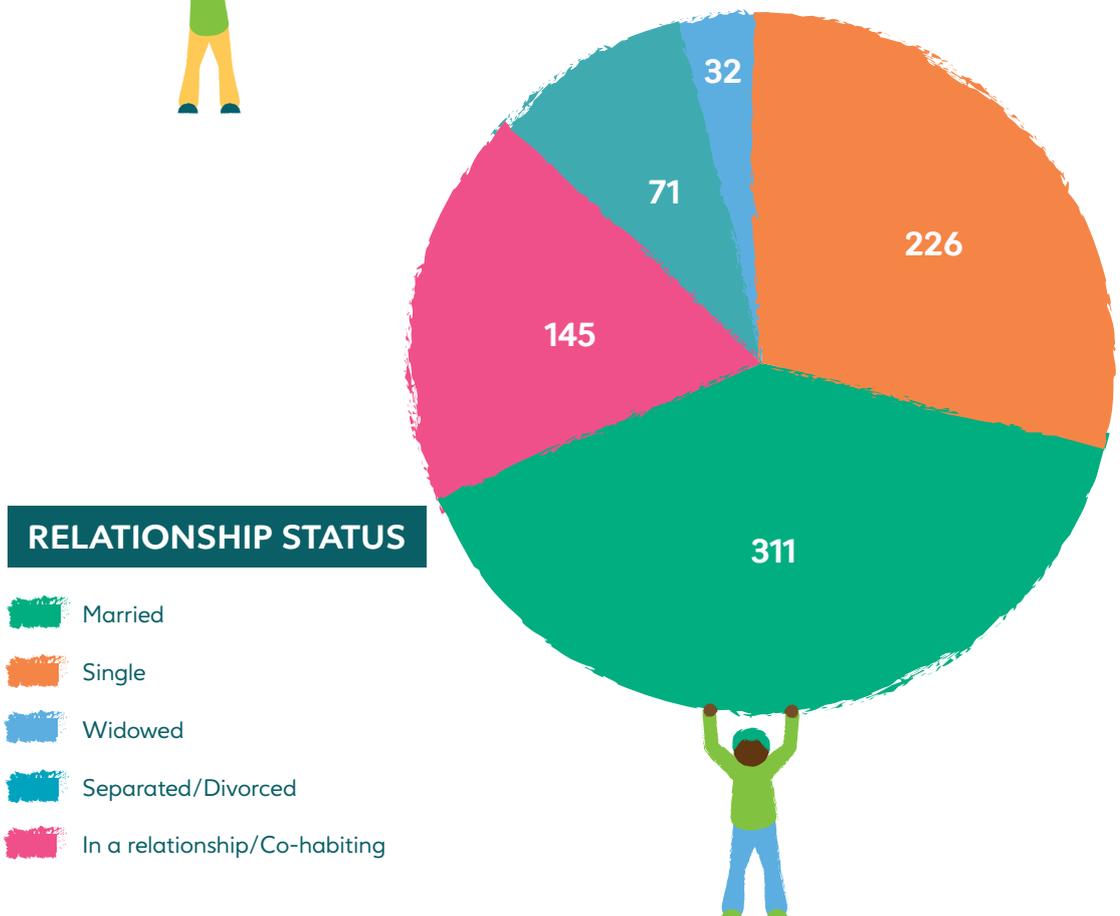
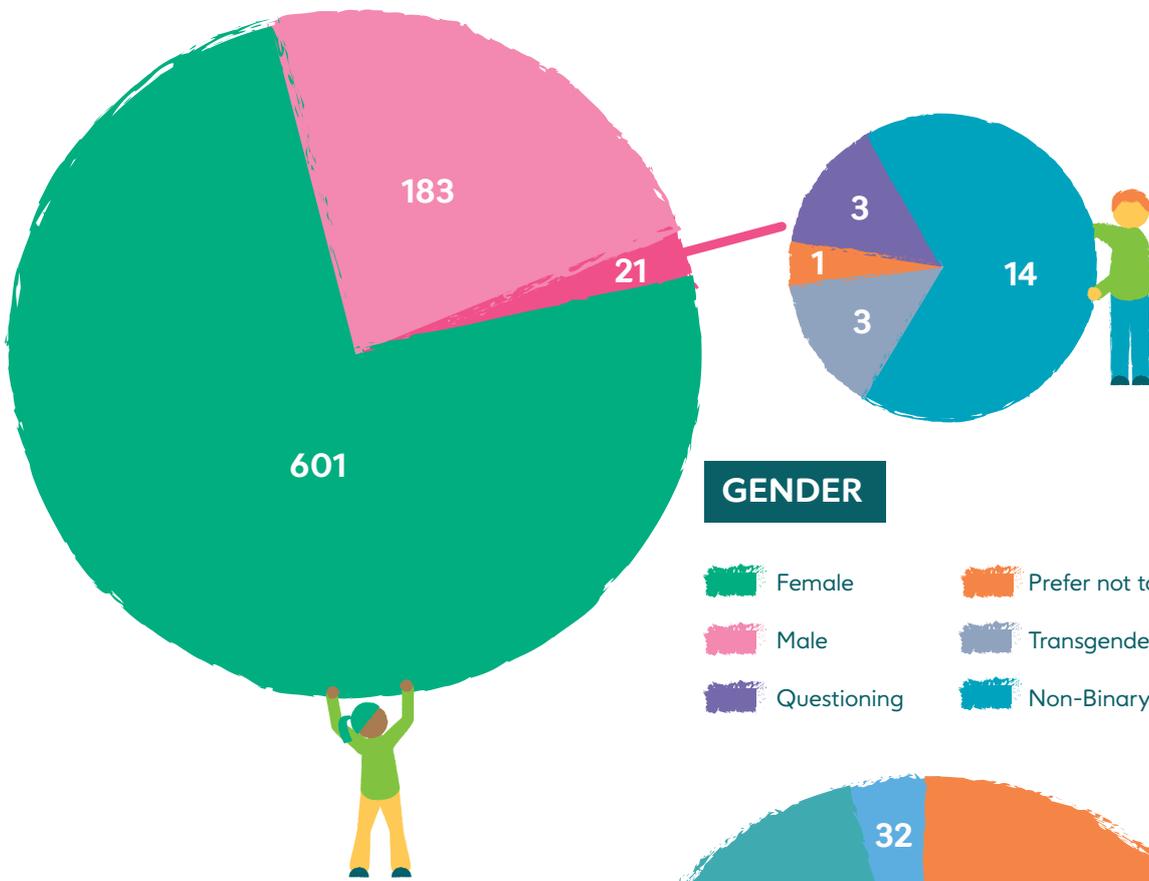


Demographic Overview

Demographics play a crucial role in understanding the characteristics and behaviour of a particular population. The following graphics provide an overview of the age, gender, ethnicity, educational background, income, employment status and marital status of respondents.

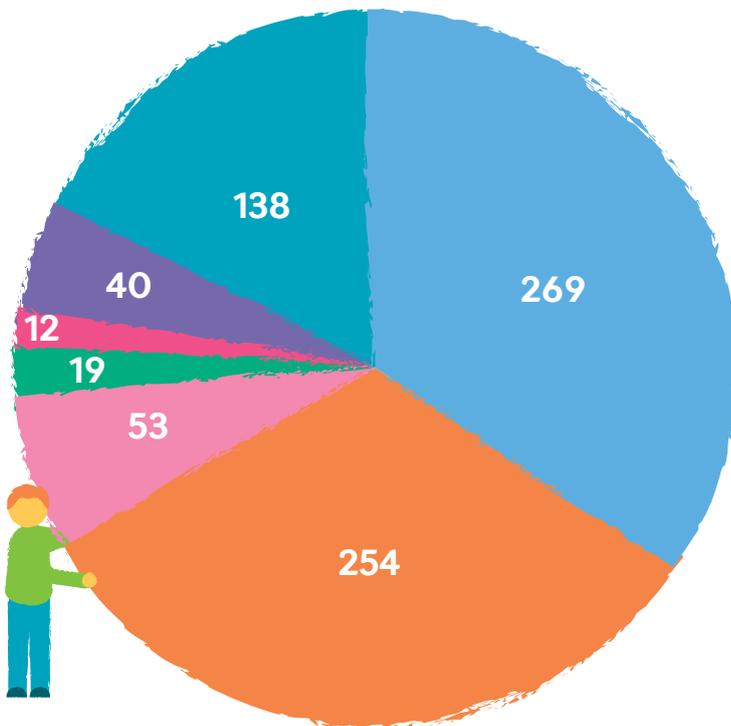
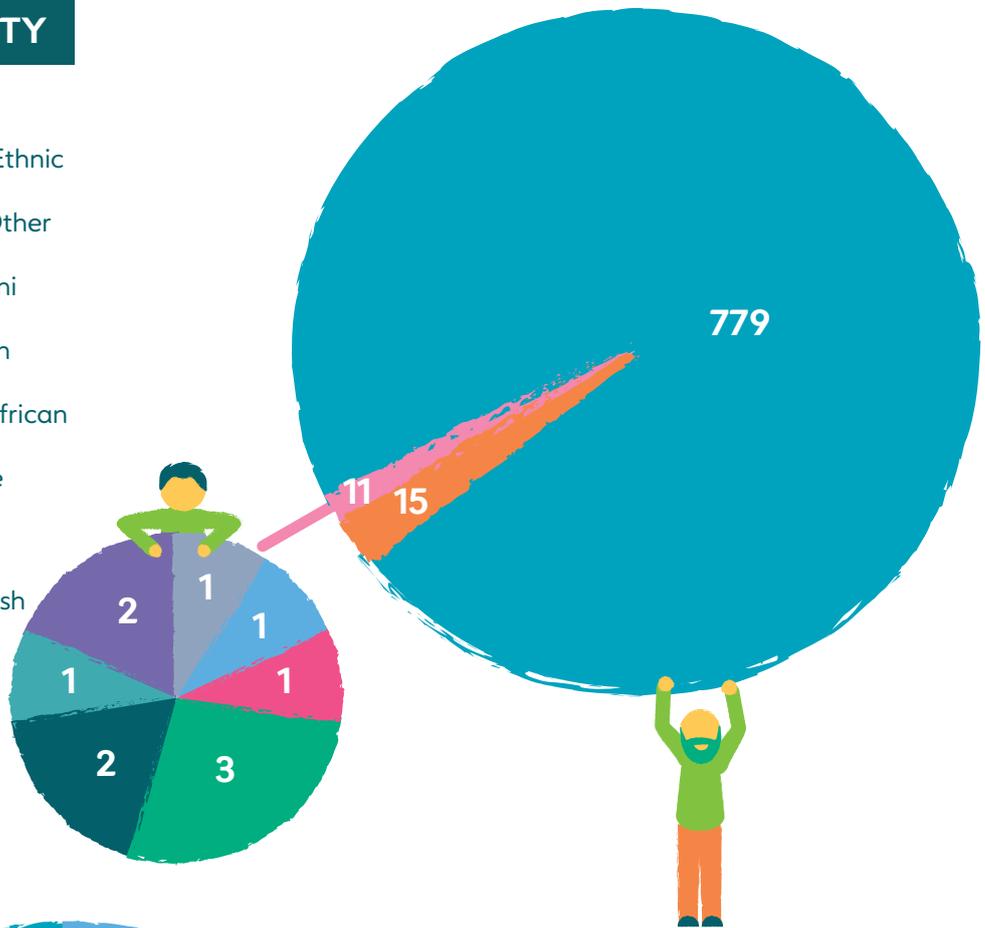
This information provides valuable insights into the make-up of the sample used in this research. By understanding the demographic characteristics of the participants, we can ensure that the findings are representative of the population as far as possible.





ETHNICITY

-  White
-  Mixed Ethnic
-  Black Other
-  Pakistani
-  Mexican
-  Black African
-  Chinese
-  Indian
-  Black Irish

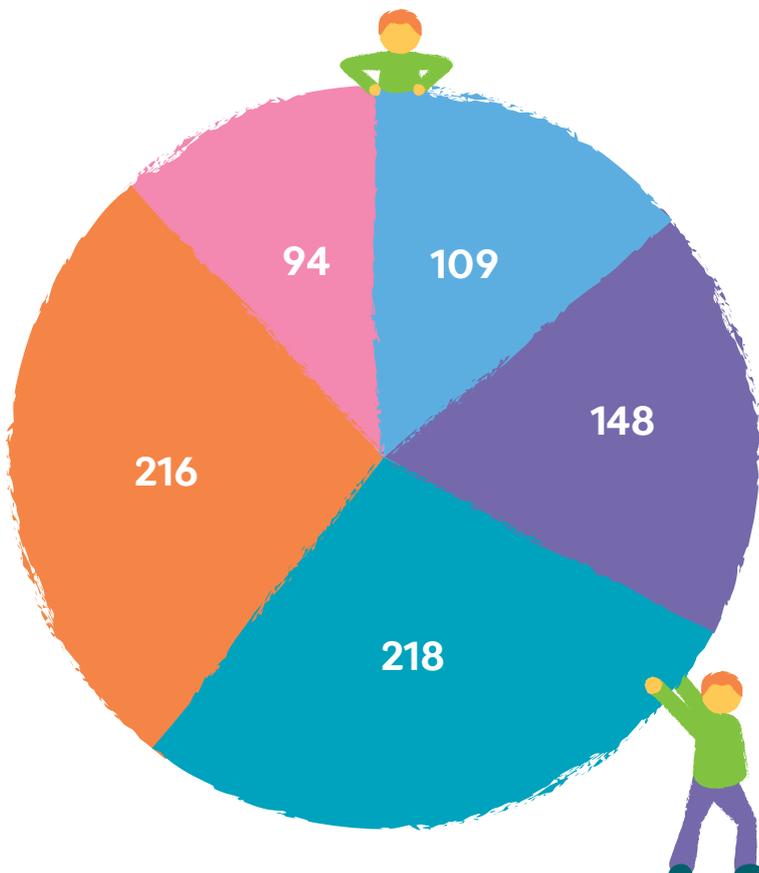
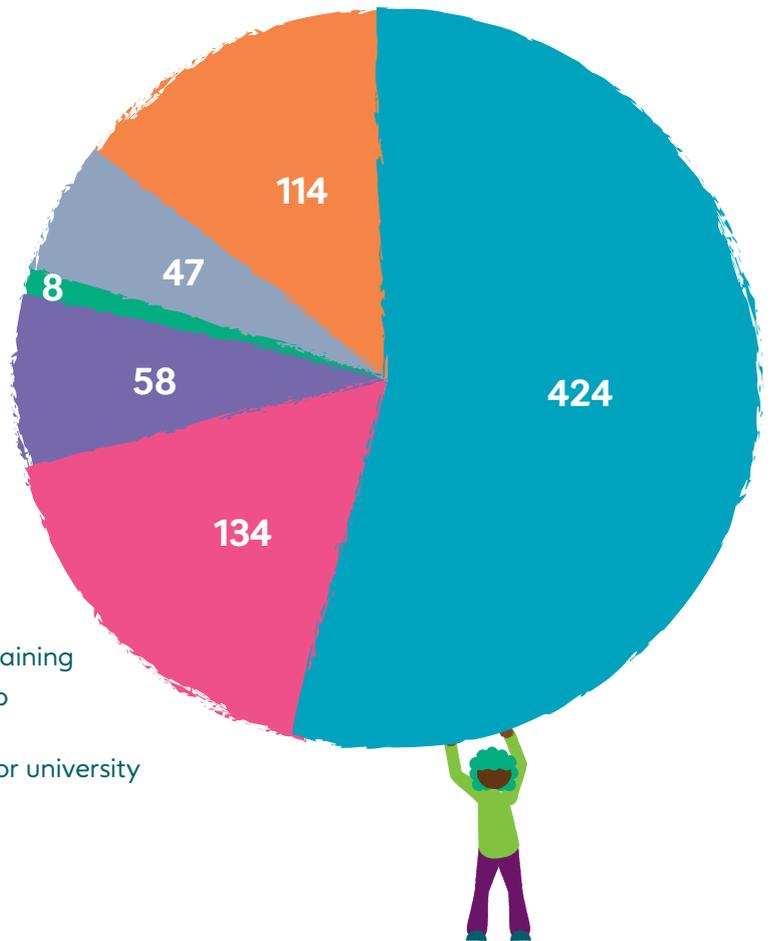


EDUCATION LEVEL

-  Undergraduate Programme
-  Postgraduate Programme
-  PhD or Doctoral degree
-  Other
-  Primary School
-  Junior Cert / GCSEs or Equivalent
-  Leaving Cert / A-Levels or Equivalent

EMPLOYMENT

-  Working full-time (or 30+ hours a week)
-  Working part-time (or under 30 hours a week)
-  Unemployed
-  On a government supported training programme, eg. apprenticeship
-  Full-time education at college or university
-  Retired



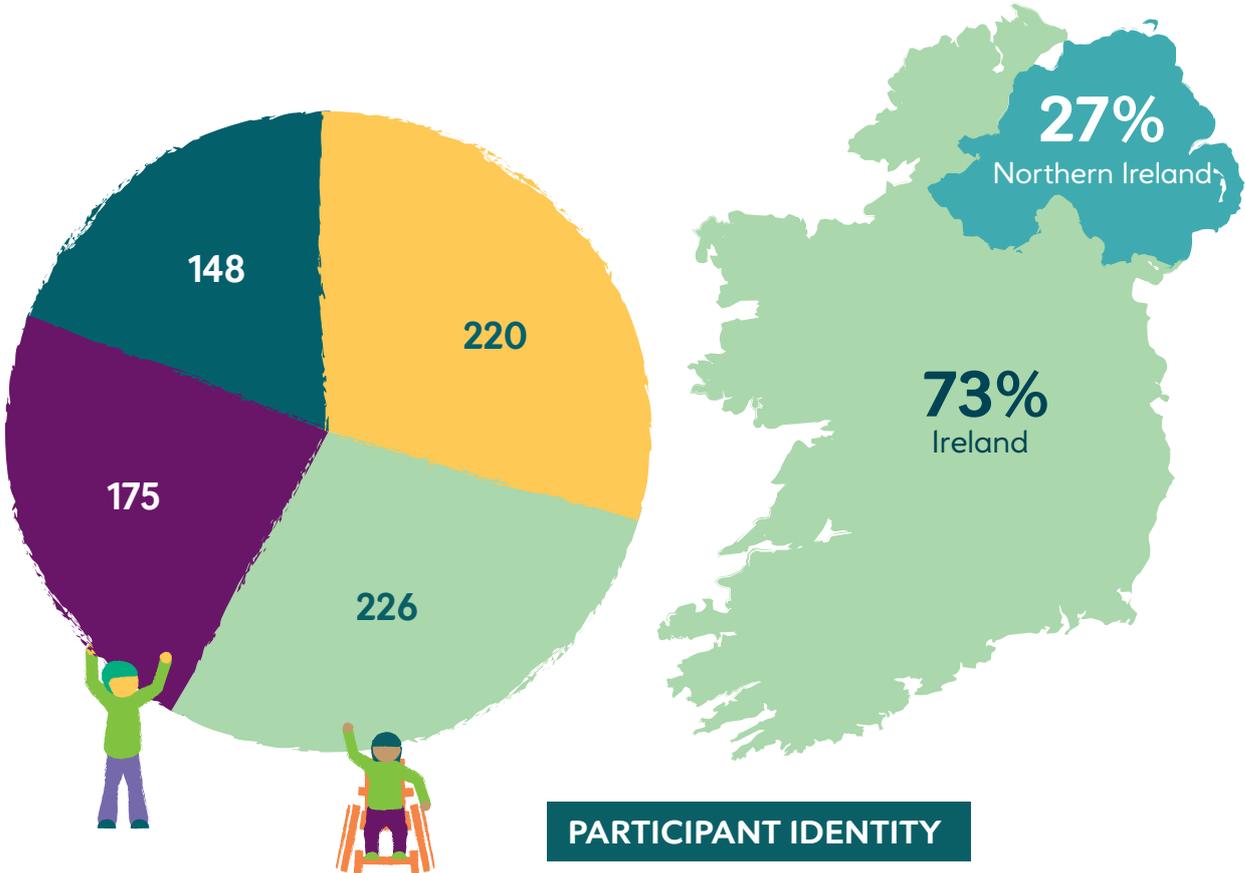
INCOME

-  Below €18,000/£15,000
-  €18,000 - €35,000/£15,000 - £30,000
-  €35,000 - €53,000/£30,000 - £45,000
-  €53,000 - €71,000/£34,000 - £60,000
-  Above €71,000 /£60,000

Findings

This research, which focused solely on those living on the island of Ireland, aimed to gain a comprehensive understanding of self-harm and stigma by including individuals from diverse backgrounds and experiences.

To achieve this, the study required participants to reside in either Ireland or Northern Ireland, and while the majority lived in Co. Dublin or Co. Antrim, all 32 counties were represented. To cater to differing experiences and familiarity with self-harm, certain sections of the survey were also modified, and participants were asked to identify which category they predominately associated with before beginning the survey.



PARTICIPANT IDENTITY

- As someone with lived experience of self-harm
- As someone who has personally supported someone who has lived experience of self-harm
- As someone who has professionally supported someone who has lived experience of self-harm
- As a member of the general public

Self-Harm: An Open Secret

At the beginning of the survey, all participants were shown Samaritans' definition of self-harm, then asked to consider their own definition. The focus group discussions and responses within the survey provided a rich and in-depth understanding of the attitudes and opinions of participants as outlined below.

How participants defined self-harm

While self-harm is often considered to be a way of 'releasing' or 'managing' difficult emotions, many participants associated it with feelings of control.

"Self-harm, as I understand it, is when someone who is in emotional distress harms themselves intentionally, often in order to feel that they have some control over the distress that they are feeling." **Person from general public**

Media plays a key role in the way self-harm is perceived. Examples of self-harm can be found across literature, film, television, amongst celebrities, etc., with those examples being the main and sometimes only point of reference for many people.

For instance, one participant from the general public stated, "*I think of Princess Diana when I think of self-harm.*"

However, media rarely provides a complete picture of self-harm and it's essential to take a holistic approach and consider the complexities and realities of the issue. One participant acknowledged the influence that TV and movies have on societal perspectives.

"...I would emphasise that there are many forms of self-harm beyond the ones represented in media." **Person with lived experience**

Many participants felt self-harm should be viewed as a broader concept rather than being limited to just physical acts of injury. They saw self-harm as an "*umbrella term*" that encompasses a range of behaviours and experiences. This further highlights the importance of taking a holistic approach to understanding self-harm and recognising it is diverse and complex.



"...wilful self-sabotage"
Person from general public

"...entering knowingly dangerous scenarios with a disregard for your own safety..."
Person with lived experience



However, some participants had opposing views on a broader definition of self-harm.

One focus group participant warned that, "*the larger the blanket term, the less helpful it is to the individual*".

A few participants also discussed the inclusion of generational traumas and self-sacrificing behaviours within the definition of self-harm. These discussions highlight the ongoing debate about the definition and understanding of self-harm.

Level of Familiarity Scale

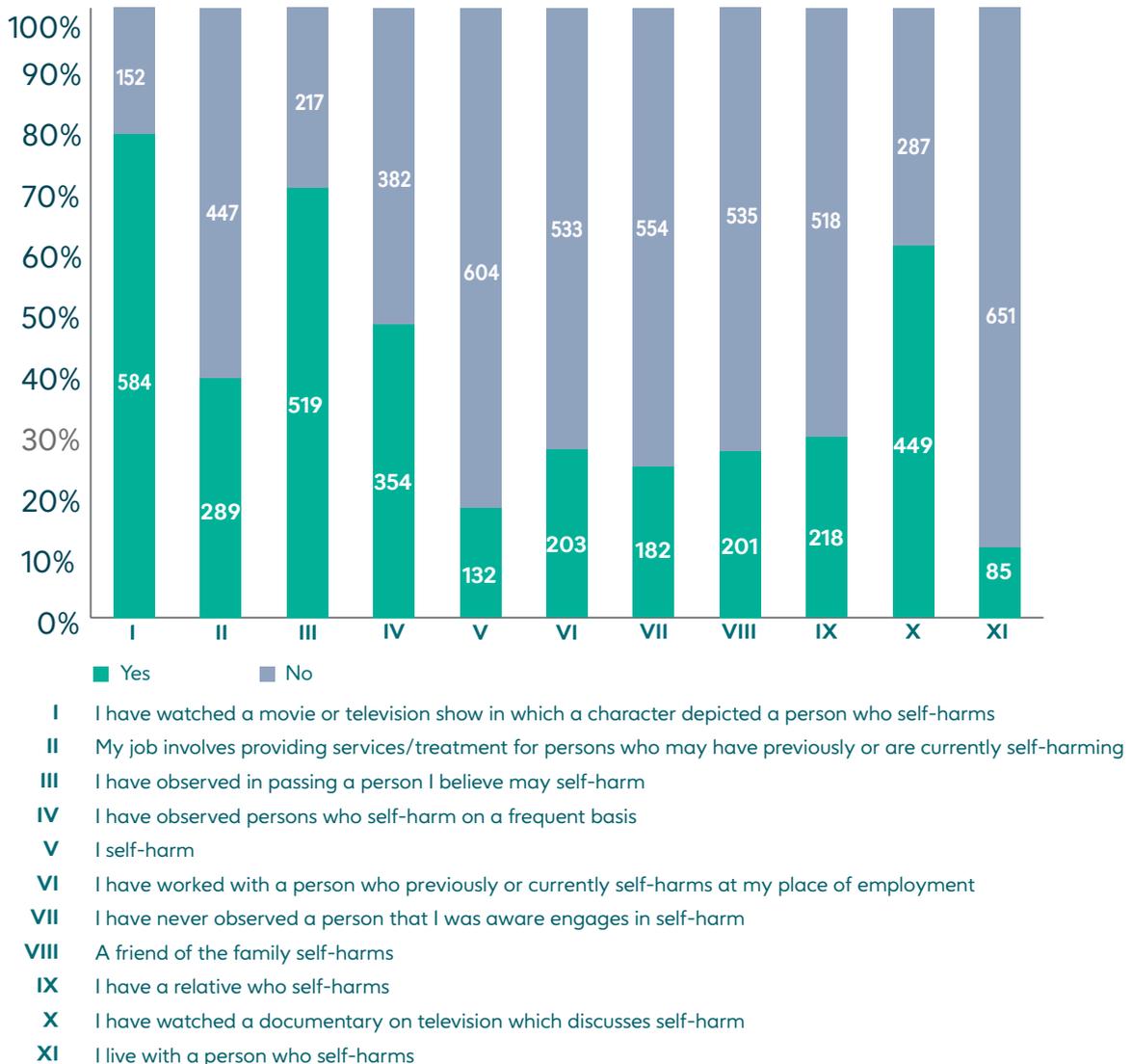
The Level of Familiarity scale was used to assess participants' level of contact with an individual who self-harms. The scale ranges from 1 (least intimate contact) to 11 (most intimate contact) and provides a ranked score for each participant.

The average score was 4.6, indicating that most participants reported having at least four points of contact with self-harm.

Graph A yielded two important findings: the frequency of self-harm and the impact of self-harm in the media.

Determining the frequency of self-harm is challenging, but 71% reported observing or encountering someone 'in passing' who they believe self-harms. Nearly 50% reported observing someone who self-harms on a 'frequent basis'. These observations are based on physical manifestations of self-harm. It is possible even more people have come into contact with individuals who self-harm in other, less visible ways.

A. Level of Familiarity Scale



Some 79% of participants reported having watched a movie or TV show where a character self-harms, and 61% reported having watched a documentary about self-harm on TV. This suggests that for many people, their understanding of self-harm is shaped primarily by media representation. The influence of media on society's perception of self-harm was a concern for one focus group participant in particular.

"...what I think is media, Netflix – any movie – self-harm is always people cutting themselves... I haven't seen anything else other than that... if you do anything else then you think you're odd, and other people will too..." **Focus group participant**

How common is self-harm?

Previous research in Cork and Kerry, comparing hospital presentation statistics with self-reported self-harm statistics, found that only 5% of people who self-harm seek medical treatment at the hospital.⁶⁵ This means that the actual number of self-harm cases is likely much higher than what is recorded, as those who do not seek medical help are not counted in the statistics.

Graph A shows just less than 25% of respondents believe they have never observed/encountered a person who self-harms.

There is a strong sense of secrecy surrounding self-harm, as expressed by a participant in a focus group who said, *"I have a feeling that a lot of stuff is being kept inside families"*. This lack of visibility and available data makes it difficult to accurately measure the prevalence of self-harm.

What do people think about self-harm in principle?

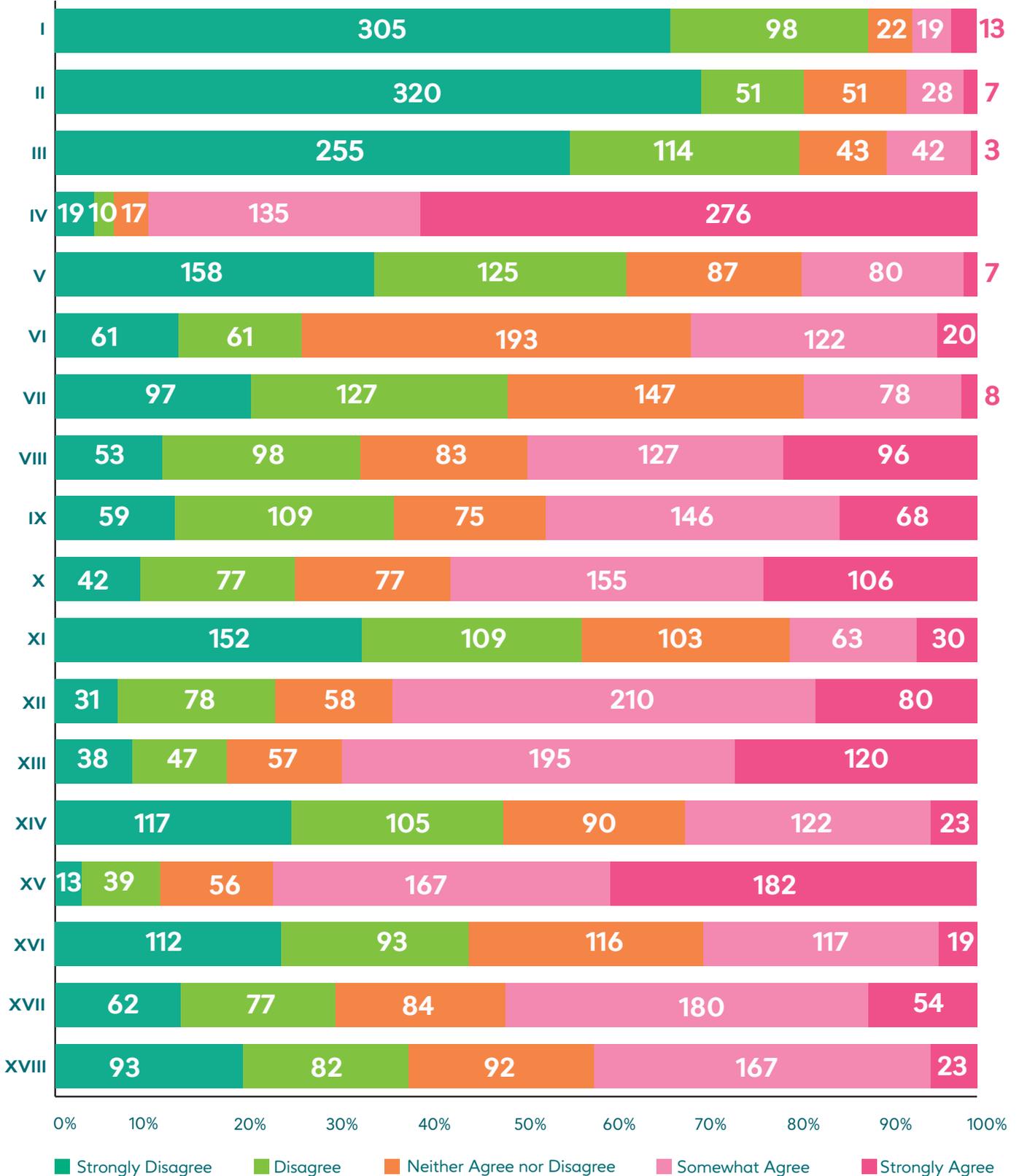
The participants were asked to rate their agreement with various statements related to self-harm on a Likert Scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree).

The statements were designed to provide a quick overview of the participants' understanding of self-harm, their perceptions of being stigmatised by others, and their own tendencies to stigmatise. It's important to note that the statements are not directly comparable as some are phrased in the affirmative and others in the negative.

Graph I Questions

- I** Self-harm & suicide are the same thing
 - II** Self-harm is shameful
 - III** People self-harm because they want attention
 - IV** People use self-harm as a coping mechanism when they are dealing with difficult emotions or experiences
 - V** Self-harm is mostly something young people do
 - VI** Self-harm is more common in females than males
 - VII** Self-harm is often a passing phase
- I feel I could...**
- VIII** ...openly talk to my partner or close family member about self-harm without fear of judgement or stigma
 - IX** ...openly talk to my friends about self-harm without fear of judgement or stigma
 - X** ...openly talk to my GP or other health care services about self-harm without fear or judgement or stigma
 - XI** ...openly talk to my employer about self-harm without fear of judgement or stigma
 - XII** If someone close to me was self-harming, I would know how to personally support them
 - XIII** I have the skill set or know where to find resources to safely speak to someone about self-harm
 - XIV** It would impact my perception of someone if I knew about or saw signs of self-harm
 - XV** I would feel comfortable if a family member or close friend confided in me that they self-harmed
 - XVI** If I were an employer, visible signs of self-harm could impact my willingness to hire someone
 - XVII** Visible signs of self-harm could impact my willingness to enter into a new relationship with someone
 - XVIII** It would impact my perception of someone if I knew about or saw signs of them self-harming

I. Samaritans Ireland Questions



The first seven statements on **Graph I** evaluated the participants' general knowledge and views on self-harm.

The results showed **over 85% of participants recognised that self-harm and suicide are different and 90% saw self-harm as a coping mechanism.**

While there is still much work to be done to raise awareness and reduce stigma around self-harm, it is encouraging to see that the majority of people have a basic understanding of it.

The four statements that started with "I feel..." were a measure of participants' perceived stigma.

The results of these statements were nearly identical, indicating that participants did not have a preference for discussing self-harm with a partner/close family member or with friends. It is worth noting that the average age of participants in the survey was around 46-years-old; when this topic was brought up in focus groups, where the average age was younger, discussions suggested a preference for speaking with peers.



"...friends and peers... the only reason I didn't tell them was that I thought I'm only 13/15/19, they're not professionals, who are they going to talk to? It's not fair to them - that's the only reason I didn't tell peers..." **Focus group participant**

Disclosing and speaking about self-harm with employers without fear of judgement or stigma scored notably low with only 20% of participants indicating this is something they would feel comfortable with. This fear of disclosure to employers, when many adults would spend 35+ hours per week at their job, indicates a strong need for more workplace training and a general shift of societal undertones to managing mental ill health in the workplace.

Overall, while the GP or other healthcare service was perceived to be the best place to access care without judgement or stigma, the mid-to-low scores indicated most people were aware that no matter where they went, they were likely to face judgement or stigma if discussing self-harm.

Around 40% of respondents felt unsure or knew they would be judged or stigmatised by their GP or other healthcare service and less than 50% of people believed they could talk to their partner, close family member, or friend.

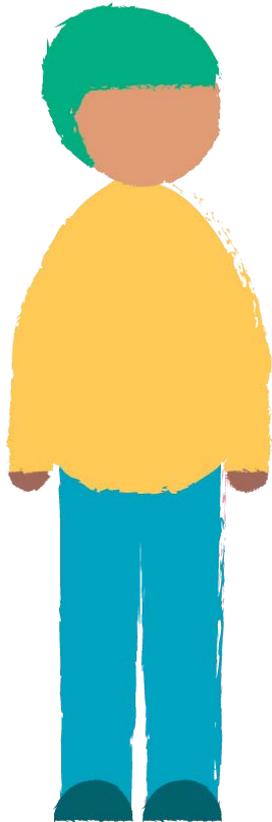
The final seven statements had participants answer questions to unearth potential unconscious biases and tendencies to stigmatise. The survey revealed that participants showed a relatively positive attitude towards friends or family members who self-harm, with **around 75% saying they would feel comfortable if a close friend or family member confided in them.**

However, their attitudes were not as understanding when faced with scenarios involving self-harm in strangers, with **50% indicating that visible signs of self-harm would impact their willingness to enter a new relationship or hire someone.**

This suggests that there is still a significant amount of stigma surrounding self-harm, especially towards those with visible signs with **four out of ten stating that knowing about or seeing signs of self-harm would impact their perception of someone**

The findings in **Graph I** highlight the waves of stigma that spread across society. There is an obvious need for more education and support in the workplace for those dealing with mental health issues, including self-harm.

Despite most participants viewing healthcare services as the best place to access care without stigma, they also reported feeling judged or stigmatised by these services, with 42% indicating this would be the case – this means there is more work to be done with health professionals as well.



Case Study Fergal*

Fergal identifies as a male in his 40s from Ireland and does not have experience in any capacity with self-harm.

When asked to define self-harm Fergal said: *"In addition to direct acts such as cutting oneself, I would include excessive alcohol consumption or risky behaviour as part of a pattern of behaviour that could be understood as self-harm."*

He also spoke against the stigma surrounding self-harm, stating: *"I reject the idea that people who self-harm could always choose to do otherwise, meaning that I support a view that external circumstances can drive a person to a situation where self-harm occurs. Stigma in this context is an unfair characterisation and lacks empathy towards a person who self-harms."*

He went on to add that: *"stigma is the unfair characterisation of people based on a physical, mental or emotional condition that can often be outside of their control."*

Fergal was unsure if self-harm and suicide were the same thing and if self-harm was a coping mechanism for managing difficult emotions or experiences. Fergal strongly disagreed that self-harm was shameful and felt somewhat confident that he would be able to talk to his family, friends or employer about self-harm without fear of judgement or stigma. Fergal felt more confident that he would be able to talk to his GP without fear of judgment or stigma.

Fergal felt that he had the skills and resources to speak to someone about self-harm, but was uncertain if he would feel comfortable if a friend or family member confided in him that they had self-harmed.

*This name has been randomly selected.

The existence of stigma was also attributed to the shortage of awareness and knowledge. This means that the negative perception or attitudes towards a person is caused by a lack of information or understanding about their circumstances or characteristics.

The participants in our research acknowledged that it is difficult to break down the stigma associated with self-harm when people are not well-informed or educated about the topic. This highlights the importance of educating people and creating a better understanding of self-harm and mental health to reduce the stigma and negative attitudes towards those who struggle with it.

Respondents' definitions of stigma clearly highlight the need to take responsibility for addressing and reducing stigma. Stigma often stems from the acceptance and dissemination of incomplete or inaccurate information, leading to biased judgements.

This is harmful to those who are vulnerable to stigma, and it is important for society, especially those in positions of authority, to make a conscious effort to educate themselves while acknowledging existing tendencies of stigma, and to address and reduce instances of possible stigma moving forward, with the end goal of eliminating it.

"Stigma can be internal or external from personal beliefs or beliefs enforced through family/friends/media."

Person with lived experience



Stigmatising views of self-harm

The opinions on self-harm and the associated stigma varied greatly among the participants. One participant, a retired mental health professional, expressed strong opposition to the language and terms used in the current clinical setting to describe self-harm, noting that they contribute to stigmatisation.

Some participants showed a negative and stigmatising view towards self-harm, indicating that their understanding of it, whether intentionally or unintentionally, was skewed or oversimplified and not always based on accurate information. This further highlights the need for education and awareness about self-harm to reduce the stigma attached to it and to promote a more supportive and understanding society for those who self-harm.

"It's a negative, selfish, unnecessary act carried out." **Person from general public**

"Pathetic attention seekers who are an absolute drain on our health services." **Professional**

The participants' perceptions of stigma and self-harm highlight the close relationship between the two, but the impact of stigma on personal and public views of self-harm can have real consequences, particularly for those who require assistance.

Dangers of stigma

Participants' views on the dangers of stigma are outlined in the comments below. They highlight that stigma has the power to silence, shame, and push those who struggle with self-harm into secrecy, which can have serious consequences for their wellbeing.

"[Self-harm] is a silent subject. People are uncomfortable talking about it. The stigma intensifies because people judge and then the person covers up."

Person from general public

"Stigma around self-harm means it's not discussed as openly as it exists. People keep it hidden for fear of what others might think."

Person with lived experience

The actual number of individuals seeking support for mental health reasons is difficult to determine due to the prevalence of mental health stigma, which acts as a barrier to seeking and obtaining treatment.⁶⁶

Research has shown that stigma can also be a barrier when receiving support, leading individuals to under-report their mental health difficulties.⁶⁷



"[Self-harm is] seen as self-inflicted... it's seen as not as important."

Focus group participant

Some participants in this study disclosed they were often conscious of the severity to which they self-harmed as they did not want to require professional/hospital care and face stigma there. Those who did seek help, however, reported negative experiences such as stereotyping, lack of understanding, and problematic language.

"I was sent to hospital after all overdoses... I wasn't treated very well by some nurses. They were bi***** to me."

Person with lived experience

"...as many problems as there are in CAMHS, it's even worse in Adult Mental Health Services...they tend to look less at family and background...just dismiss or medicate... without looking into why."

Focus group participant

"...people are afraid to be misunderstood... go to a GP to pay €50 for them not to get it..." **Focus group participant**



This research highlights that stigma is a significant barrier to seeking and obtaining help for self-harm. By driving secrecy, individuals who may be in need of help are less likely to reach out, and even when they do, they are not always met with proper care and understanding.

Language can also contribute to the framing of help-seeking, which can impact how it is perceived by the public and professionals. One participant suggested shifting the language from 'attention seeking' to 'care seeking'.

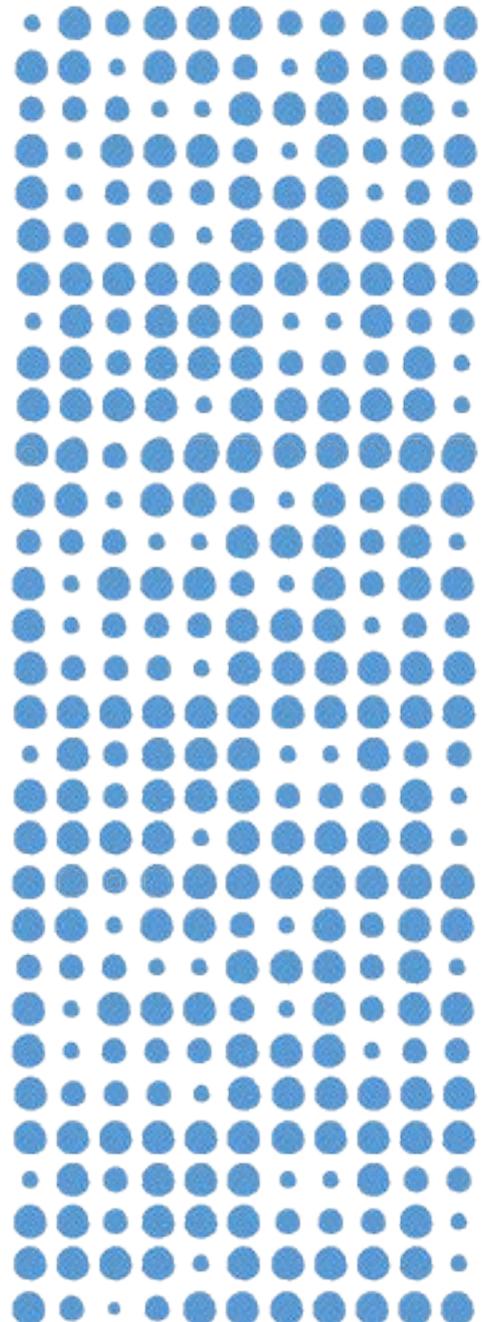
It is important to consider how different intersections of identity, such as age, gender and socioeconomic status, can impact societal and cultural views and lead to even greater stigmatisation for already stigmatised populations. Further research is needed in this area.

"...teenagers, but also older people who self-harm, are dismissed... society's attitudes to older people and teenagers... both dismissed..." **Focus group participant**

The findings of the survey and focus groups indicate that stigma poses significant dangers. It affects those who seek help, the quality of care they receive, and their overall quality of life. Stigma also causes self-harm to be widely known but rarely discussed. To counteract this issue, it is crucial for individuals to recognise their role and responsibility in sustaining stigma and to confront and address the underlying problem, rather than perpetuating society's stigmas.



"Stigma exists because it has been allowed to." **Person with lived experience**



Learnings from Attribution 'Alex'

Alex is an adult who struggles with their mental health. Sometimes they self-harm. They live alone in an apartment and work as a clerk at a large law firm. They have been hospitalised six times as a result of their difficulties. Now answer each of the following questions about Alex...

The survey participants were presented with 27 statements about an individual named 'Alex' who has self-harmed and asked to rate their level of agreement on a scale of 1 (not at all) to 9 (very much).

The total score for the survey ranged from a minimum of 3 to a maximum of 27, with responses being grouped into 9 sub-scales to gain a deeper understanding of the participant's perceptions of Alex. These are outlined in **Graph D**.

Graph D.1 illustrates that the participants have a strong desire to **help** Alex, but also exhibit feelings of **pity** towards them. At the same time, there is a noticeable tendency to **avoid** Alex, likely due to the discomfort with the situation.

However, low numbers said they would **coerce** or **force** Alex into seeking treatment or taking medication, or felt they should be **segregated** in some way.

This suggests that participants generally have a desire to **help** those who self-harm, but their motivation and approach are based on **pity**.

It is crucial to consider the motivation and approach to assisting individuals who self-harm, as someone with lived experience can attest as noted by the comment below:



"People are uncomfortable [that I self-harm] and want to save me."

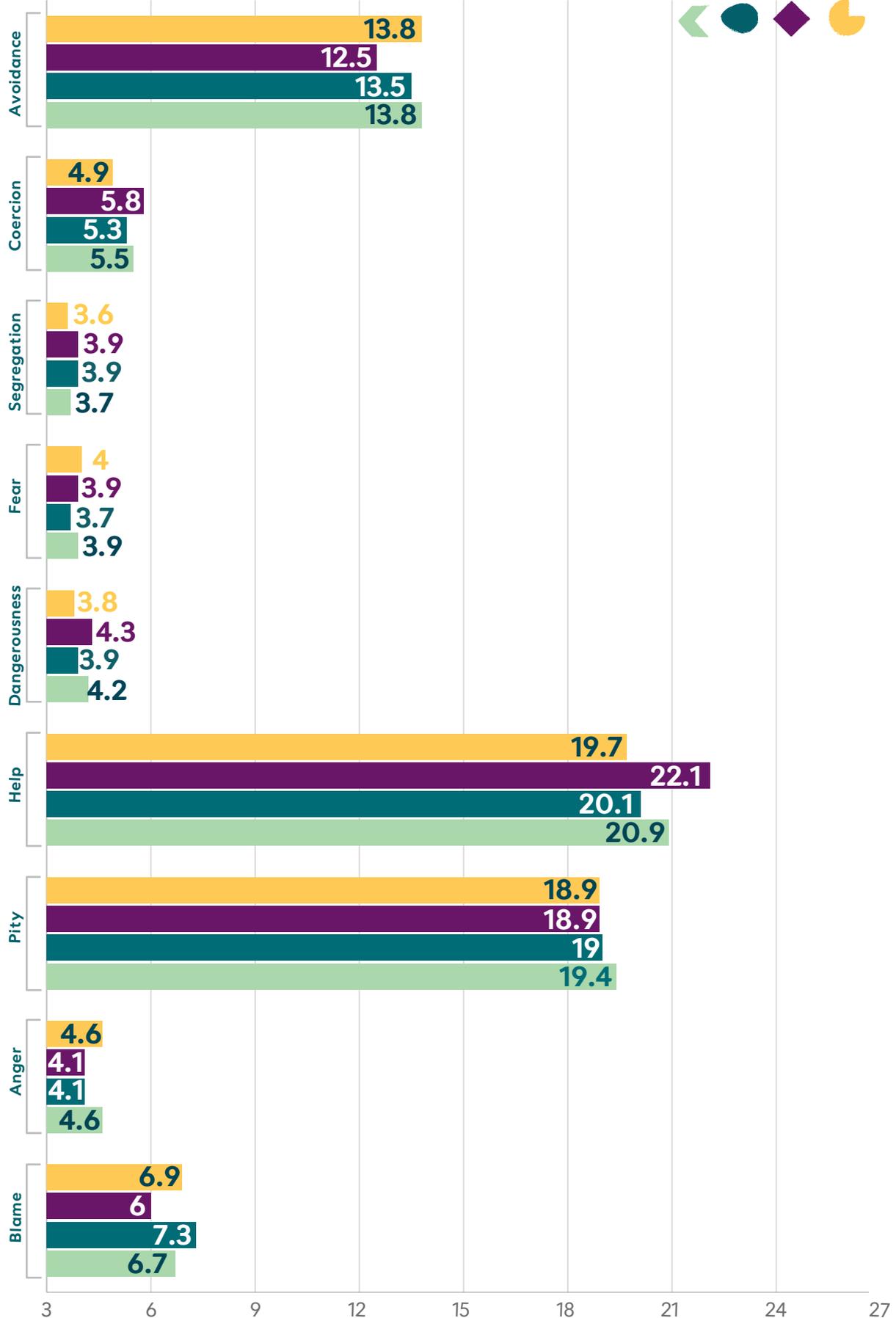
Person with lived experience

"...I think people just dance around the issue, just see it as too dark for everyday conversation... for a lot of people it's going too deep into people's problems... don't want to open Pandora's box."

Focus group participant

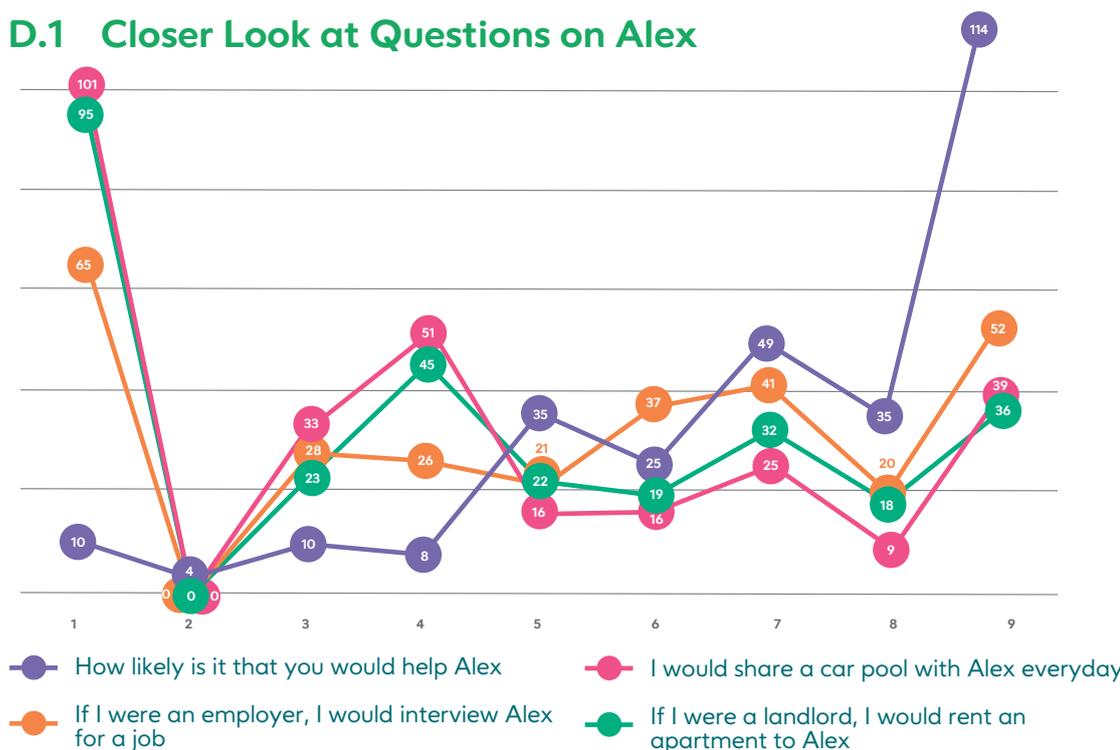


D. Attribution Questionnaire (Alex)



- As a member of the general public
- As someone who has professionally supported someone who has lived experience of self-harm
- As someone who has personally supported someone who has lived experience of self-harm
- As someone with lived experience of self-harm

D.1 Closer Look at Questions on Alex



The quotes and definitions from participants show that avoidance is closely linked to stigma and discomfort. The graph above compares questions in the 'avoidance' category to a single question in the 'help' category (represented in purple).

Graph D.1 demonstrates a disconnect between participants' hypothetical willingness to help and their actual behaviour.

While 77% of participants selected 6 or higher when asked if they would help Alex, when faced with a tangible scenario like sharing a carpool or renting an apartment, 64% and 56% respectively selected 4 or lower, indicating that they would not do so.

Additionally, about 41% of participants indicated that they would be unlikely to interview Alex for a job, which is consistent with the trend of stigma and avoidance shown in **Graph D** and **Graph I**.

It is crucial for people to reflect on their own behaviours and tendencies, as good intentions do not eliminate the stigma faced by those who self-harm. To make a positive impact, good intentions must be followed by actions. Those who self-harm are aware when others are avoiding interactions with them, even indirectly, and this contributes to the cycle of stigma.

The results of the study suggest that people generally express a willingness to help, but further research is needed to fully understand the discrepancy between individuals' self-perceived helpfulness and acceptance, and their actual behaviours of avoidance.

In order to gain a more complete understanding of this issue, additional studies that incorporate real-life scenarios or qualitative elements will be needed. This will provide a deeper insight into the disconnect between individuals' stated intentions and their actual behaviour in regard to those who self-harm.

Stories to Tell: Lived Experiences

It is crucial to include the voices of those with lived experience of self-harm. This study allowed for their participation.

Overview of lived experience participants

Participants with lived experience were between the ages of 18 and 68, with an average age of 37. This is the youngest cohort within the study, with the other groups in the research having an average age between 46-52.

The ages at which participants first started self-harming varied widely, with some identifying instances of self-harm as young as four-years-old and others not starting until they were 50. On average the participants reported starting to self-harm at the age of 16.

A range of self-harm methods were shared by participants, many of whom discussed their experiences with using multiple methods that changed over time. **Some participants reported self-harming for a year or less, while others have struggled with it for a lifetime, with one participant reporting 53 years of self-harm.** The majority of participants reported that their self-harming behaviours lasted for about 13 years.

During focus groups, participants expressed concern that many organisations and campaigns only focus on self-harm among young people under 25 years old. This view of self-harm as just a *"young person's issue"* can further stigmatise and isolate those who engage in self-harming behaviours, particularly since self-harm can start at any age and last a lifetime.

It is essential to acknowledge and keep in mind that self-harm is not limited to young people or a passing phase, and it is critical to consider this in future research and policy making.

Defining and talking about self-harm

For participants who have personal experience with self-harm, the emotional intent or underlying 'meaning' behind the behaviour is a crucial factor in defining it.



"I would define [self-harm] as a deliberate act on yourself that is intended to make some sort of injury... some connection to emotional difficulty, because you might do something like a tattoo but it's not with a need to release or an emotional numbness..."

Focus group participant

Self-harm, within this study and more broadly, is often viewed as a coping mechanism, but for those with lived experience it is more nuanced than that. It can be physical manifestations, with one participant describing their self-harm as *"a way of making invisible pain visible"* but the methods and reasons behind it can be complex and multifaceted.

"Self-harm is not just cutting or inducing yourself into a state or form... it can be not looking after your hygiene, not eating properly, not socialising, or thinking of ways to hurt yourself...can be various forms."

Focus group participant



"It was a coping mechanism, but it was down to a lack of empathy for myself." **Focus group participant**

The evidence from the focus groups highlights the importance of recognising self-harm as a highly personal experience, where a single definition or individual experience does not apply to everyone who engages in or has engaged in self-harm. In addressing the stigma surrounding self-harm, a holistic approach that includes the diverse voices and experiences of those affected is crucial.

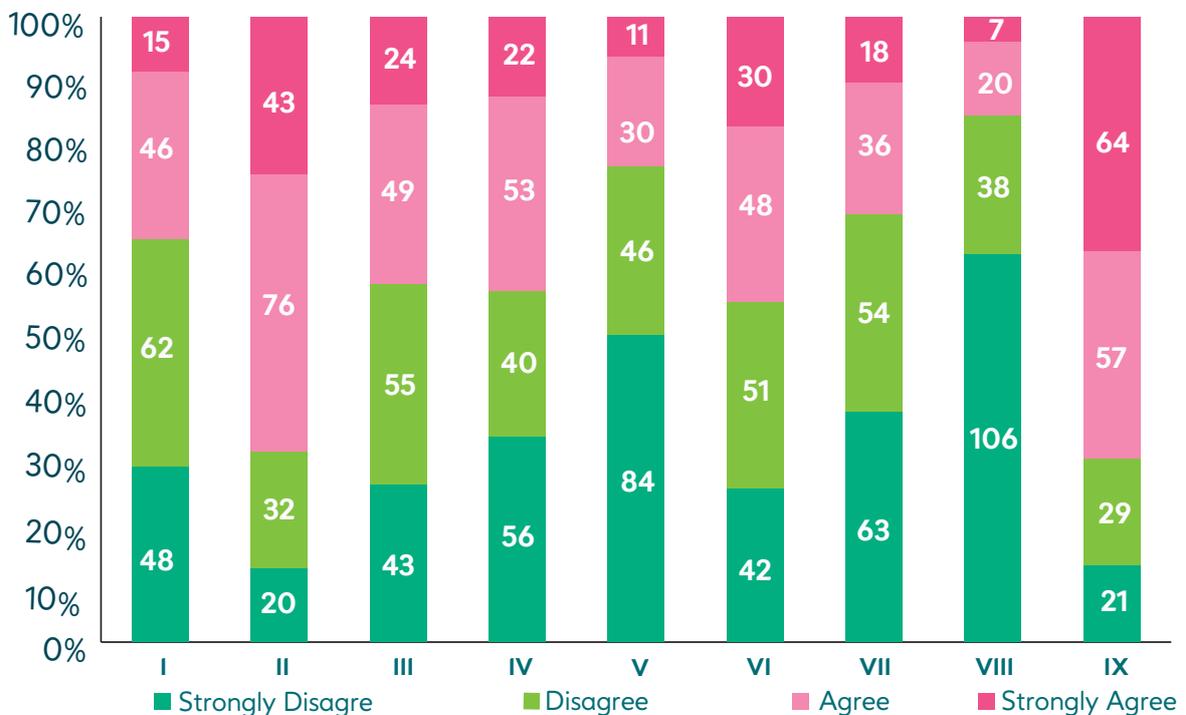
It is worth noting that, at the conclusion of each focus group, participants were asked for their thoughts on the research experience. Although this feedback was not part of the primary aim of the focus group, it became evident that these open, non-judgemental and mostly anonymous conversations can have a cathartic effect on those participating.

Internalised stigma

The purpose of **Graph F** is to assess the self-reported perception of internalised stigma related to self-harm. When interpreting the graph, it is important to note that the statements are not directly comparable as some statements are presented in the affirmative and others in the negative.

This graph does not reveal any overarching findings, as many of the responses are divided roughly 50:50 or 60:40, indicating that while there is not a high level of internalised stigma, a significant proportion of participants still report feeling this way. The graph serves as a reminder that self-harm is a personal and individual experience and can be challenging to compare across individuals.

F. Internalised Stigma of Mental Illness



I Stereotypes about people who self-harm apply to me

II In general, I am able to live life the way I want to

III Negative stereotypes about self-harm keep me isolated from the 'normal' world

IV I feel out of place in the world because I self-harm

V Being around people who don't self-harm makes me feel out of place or inadequate

VI People who don't self-harm could not possibly understand me

VII Nobody would be interested in getting close to me because I self-harm

VIII I can't contribute anything to society because I self-harm

IX I can have a good, fulfilling life, despite my self-harm

While the quantitative findings were divided, when asked to discuss experiences of self-harm, shame was felt widely.



"...I feel huge shame because of the stigma associated with self-harm."

Person with lived experience



"...disgrace, shame, don't want the neighbours talking about me, don't want to be different..." **Focus group participant**

"...embarrassed, shamed, or feel marked by your self-harming, to feel apart from others." **Person from general public**

For some participants in the focus groups, the effects of stigma operated in a cyclical manner, with the boundary between external and internal stigma becoming indistinct. Understanding the cyclical nature of stigma and its impact on individuals is crucial in developing approaches to reducing the stigma associated with self-harm.

By breaking the cycle of stigma, we can help those who engage in self-harm to feel more validated and supported in their experiences, and work towards a more compassionate and understanding society.

Case Study Aiden*

Aiden identifies as a non-binary individual in their 20s living in Ireland. They have lived experience of self-harm which began in their early childhood and has spanned across much of their life. Aiden has self-harmed through scratching and cutting, amongst other methods.

Aiden defines self-harm as actions that cause physical harm to oneself to cope with mental distress and defines stigma as negative attitudes or opinions that result from knowing certain information about someone.

"[Self-harm is] hurting oneself - physically/self-destructive behaviours/risk taking etc. to distract or counter one's mental state."

"[Stigma is] people's opinions shifting negatively after finding out something about a person/place/thing."

Aiden has experienced stigma in relation to their self-harm, which has caused them to feel less confident and has impacted their relationships with family members. They have received some supportive care from healthcare providers, but not from co-workers or supervisors. Aiden believes certain communities in Ireland and Northern Ireland are particularly affected by stigma, including the LGBTQIA+ community, people of colour, individuals who have immigrated, non-Christians, young people, and the elderly.

To reduce stigma, Aiden suggests the following top three priorities:

- Stigma training for health professionals and community workers
- More support groups and educational materials for those who self-harm
- Programmes in schools and universities

*This name has been randomly selected.

Stigmatising experiences

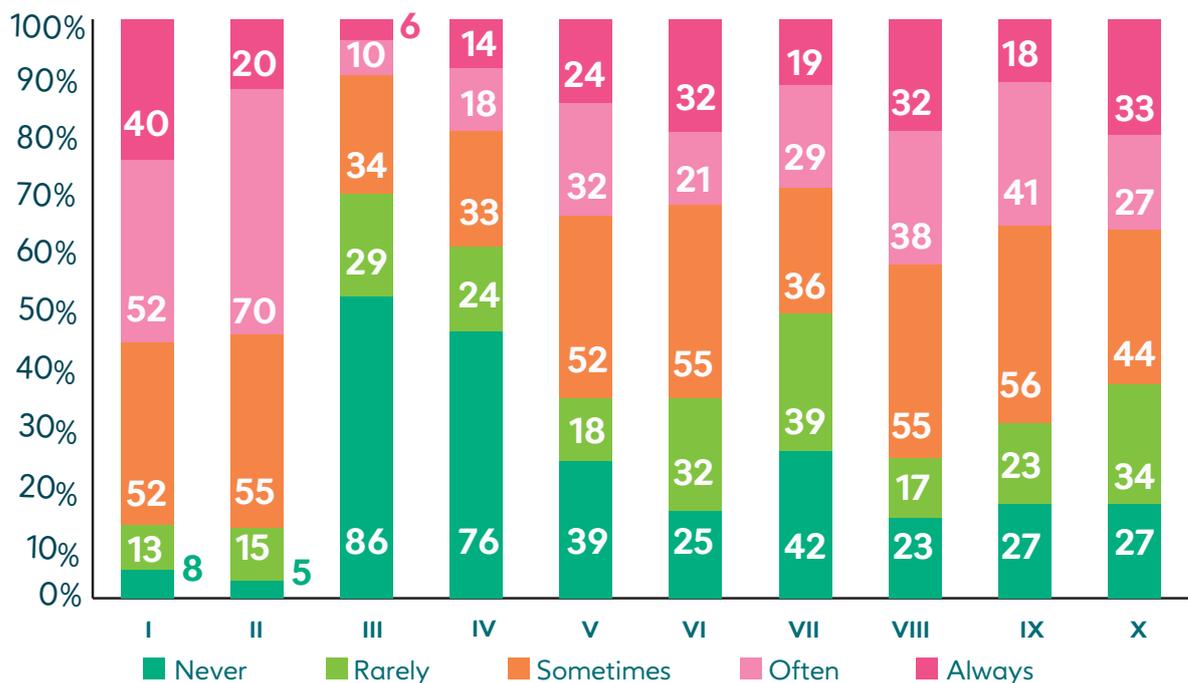
The purpose **Graph G** is to gather a comprehensive view of experiences of external stigma experiences among people with lived experience of self-harm. When reviewing the graph, keep in mind that the statements are not directly comparable as some are asked in the affirmative and others in the negative.

One of the key insights from **Graph G** is the widespread belief that self-harm can lead to being perceived as 'lesser' by others. Nearly 90% of respondents reported that they sometimes, often, or always think that others will have a lower opinion of them if it is known that they self-harm. This is corroborated by a participant's comment:

"People will see you differently and judge you, and even people who really care about you will look at you differently."

Person with lived experience

G. Inventory of Stigmatising Experiences



- I Do you think people will think less of you if they know you self-harm?
- II Do you think that the average person is afraid of someone who self-harms?
- III Have you ever been teased, bullied, or harassed because you self-harm?
- IV Have you ever felt that you have been treated unfairly or that your rights have been denied because you have self-harmed?
- V Have your experiences with stigma affected your recovery?
- VI Have your experiences with stigma caused you to think less about yourself or your abilities?
- VII Have your experiences with stigma affected your ability to make or keep friends?
- VIII Have your experiences with stigma affected your ability to interact with your family?
- IX Have your experiences with stigma affected your satisfaction with or quality of life?
- X Do you try to avoid situations that may be stigmatising to you?

Graph G also highlights the importance of compiling a wide range of perspectives, as roughly 55% of respondents felt that the average person is often or always afraid of someone who self-harms. The 'fear' category in the 'Alex' attribution questions (**Graph D**) averaged a 3.9 (out of 27), indicating very low levels of fear. This suggests that within the lived experience group, stigma may also be perceived as fear.

To counteract our own biases and stigmas, it is important to acknowledge that even if a statistic may not seem particularly high or significant within a sample, there are still individuals and their lives affected at every level of the scale.

By humanising the numbers, we can work towards a more compassionate and understanding approach to addressing the issue of stigma and self-harm in our society.

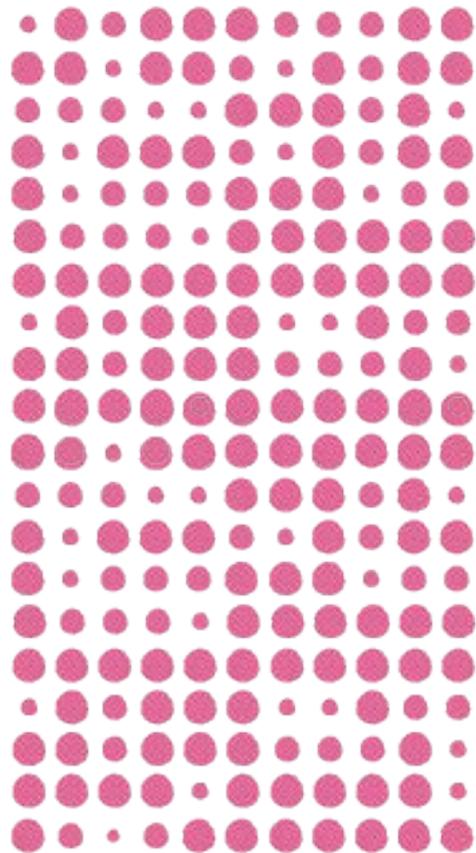
"I think there's a lot of fear around it... a lot of stuff I've been looking at is parents' response to adolescent self-harm... what does it mean... is it a mental health disorder... was it something I did...there's immediately a reaction from people... [that's the] reason people don't always say if they've self-harmed."

Focus group participant



When considering first-hand quantitative accounts of stigma and self-harm, it is important to remember that each statistic represents a person with their own unique stories and experiences.

"I hide my scars as I hate them, but it's the look on people's faces if they happen to see them..." **Person with lived experience**



Case Study Barbara*

Barbara identifies as a female in her 50s living in Northern Ireland. She has a history of self-harm including cutting and scratching amongst other methods. This began for her around the age of 12. She also reported engaging in other self-destructive behaviours such as drug use, promiscuity and risk taking.

Barbara defined self-harm as *"one way of dealing with deep emotions"*. She also had some thoughts in relation to stigma *"...people do it for attention - such a horrible way to make people feel and totally incorrect."*

Barbara reported that she has faced teasing, bullying and harassment because of her self-harm, which has at times impacted her recovery. Barbara has sometimes avoided situations where she thinks she may be stigmatised, such as seeking mental health support. However, she feels supported and understood by friends who know about her self-harm. Although she reported that these experiences of stigma have at times had an impact on her quality of life, she generally feels that she can have a good and fulfilling life, despite her self-harm.

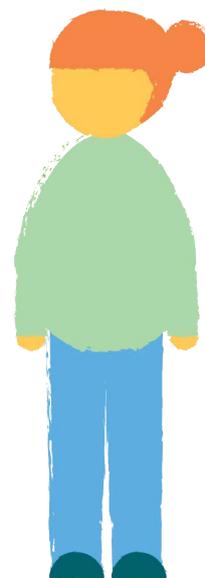
Barbara believes that groups such as people with mental health difficulties, those who use drugs or alcohol, those in recovery, women in the justice system, women who have experienced trauma and addiction, women who have involvement with social services, and refugees and asylum seekers are particularly affected by stigma in Ireland and Northern Ireland.

To reduce stigma, Barbara's top three priorities are:

- Cross-departmental government policies to reduce stigma around self-harm
- Programmes in schools and universities
- Stigma training for health professionals and community workers

She feels that awareness campaigns, support groups and support programmes for family, friends and carers are important and added: *"if our government would actually work it would be a start - everything is always left to the underfunded community and voluntary centres"*.

*This name has been randomly selected.



Lived Experience Once Removed: Family, Friends, and Carers

Self-harm can feel incredibly isolating, but it is rarely experienced in full isolation. Research is often carried out to better understand the first-person lived experience, but we wanted to have a better understanding of the impacts self-harm can have on those around the individual: first-hand experience once removed.

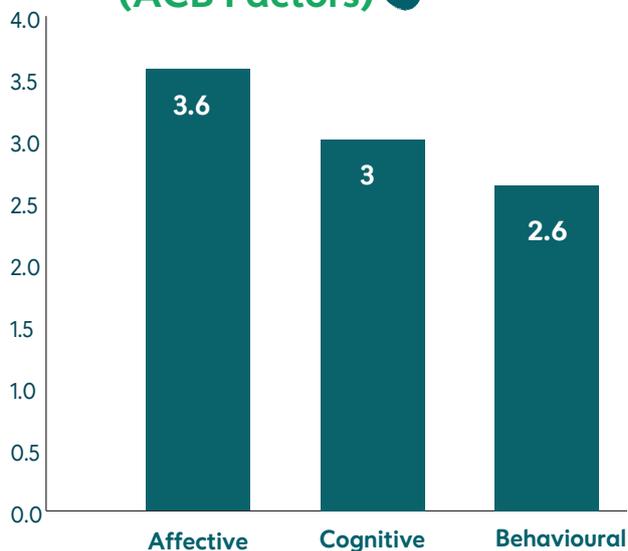
Caregivers of people with mental illness scale

The aim of **Graph K** is to understand the experiences of those who have specifically supported someone who self-harms. It focuses on the impact self-harm can have on those close to the individual, rather than just their own personal experiences. It uses a 22-question Likert Scale to determine three different types of stigma perceptions: **affective**, **cognitive**, and **behavioural**.

The score from the scale shows the level of agreement with each statement, with higher scores indicating a stronger agreement.

Participants had high scores in each category on the scale.

K. Family/Friends/Carers of People who Self-Harm (ACB Factors)



The highest score of 3.6 was found in the 'affective' category. **This shows that family, friends, and carers felt most impacted by their own thoughts and emotions related to someone they care about who self-harms.**

A score of 3 in the 'cognitive' category suggests the impact of stigma on secondary persons with loved ones feeling "stigma by association". Despite not having a first-hand lived experience with self-harm, the stigma surrounding it is so prevalent in society that it can still affect others.

Scoring 2.6 in the 'behavioural' category, participants still revealed a tendency to avoid communicating or spending time with someone who self-harms.

The other three groups did not take this study so a direct comparison cannot be made, however when looking at the 'Alex' study (**Graph D**), this family/friends/carers cohort still scored high on avoidance, indicating that even with close relationships, stigma, discomfort, or a lack of understanding can lead to avoidance.

"I worry that people will judge my daughter badly for [self-harming]."
Family/Friend/Carer



Case Study Claire*

Claire identifies as a female in her 30s from Northern Ireland who has personal experience supporting someone with a history of self-harm. She does not self-harm but lives with someone who does.

According to Claire, self-harm is a way of coping with difficult emotions or experiences, and she does not believe that it is done for attention.

"[Self-harm is] the act of inflicting pain on oneself."

"[Stigma is] something negative that sticks."

Claire recognises that caring for someone who self-harms can have a negative impact, but she does not feel helpless, sad, or under pressure. She feels comfortable talking to someone who self-harms about their difficulties and is willing to help without feeling scared or threatened.

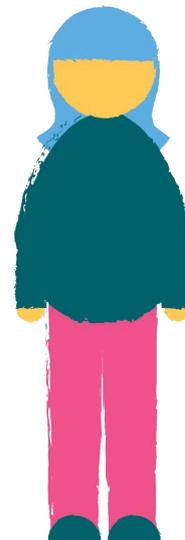
She felt she could potentially talk to her friends or healthcare provider about self-harm without fear of judgement or stigma.

Claire believes that stigma affects several groups in Ireland and Northern Ireland, including young people in care, young offenders, prisoners, people with poor mental health and people with addictions.

Her top three priorities to reduce stigma include:

- Educational and support programmes for family/friends/carers of those who self-harm
- More support groups and educational materials for those who self-harm
- Awareness campaigns highlighting stories of real people and their families.

*This name has been randomly selected.



Ears that hear, but do they listen?: Professionals

Mental health and social service professionals often face criticism for their support and interactions with those who engage in self-harm. This study aims to understand professionals' experiences working with those who self-harm, how they perceive self-harm and stigma, and how they see it impacting those they seek to treat as well as wider society. It is important to note that this section focuses on the perspectives of the professionals rather than the type of service (public, private, or voluntary) they work in.



David identifies as a male in his 50s from Northern Ireland who is a professional who supports people with current or previous experience of self-harm.

He defines self-harm as *"a person who causes harm to themselves due to the pain they are trying to deal with and manage, and feeling they have no other option at that time"*.

He defines stigma as *"how others see acts of self-harm in a negative way and look negatively at those who have been self-harming... people who are fearful and lack understanding of an issue then looking at the issues in a negative light"*.

David believes that self-harm is more common among young females but is not the same as suicide. He doesn't believe that self-harm is shameful or that people only engage in self-harm out of a desire for attention. He was unsure as to whether he would be able to talk openly with family, friends, or professionals about self-harm without fear of judgement or stigma.

He feels confident in his ability to support people who might be engaging in self-harm and finds helping self-harming individuals rewarding.

David also felt strongly that someone should have the right to self-harm, and that people should be allowed to self-harm in a safe environment.

As a professional, David felt that he was able to help people who self-harm feel more positive about themselves, and he felt strongly that people who self-harm could learn new ways of coping.

According to David, several groups in Ireland and Northern Ireland are particularly impacted by stigma, including the LGBTQIAI+ community, people with emotional health and wellbeing issues, those who feel suicidal or have attempted suicide, people who come from other countries in Eastern Europe or Africa, Irish Travellers, and people with disabilities.

To reduce stigma, David prioritises:

- Cross departmental government policies to reduce stigma around self-harm
- Programmes in schools and universities
- Awareness campaigns highlighting stories of real people and their families

*This name has been randomly selected.

Professional Antipathy Scale

The Professional Antipathy questionnaire measures the perspectives of professionals who support individuals who engage in self-harm on a Likert Scale of 1 (Strongly Disagree) to 5 (Strongly Agree). A score of 5 suggests they strongly agree with the statement.

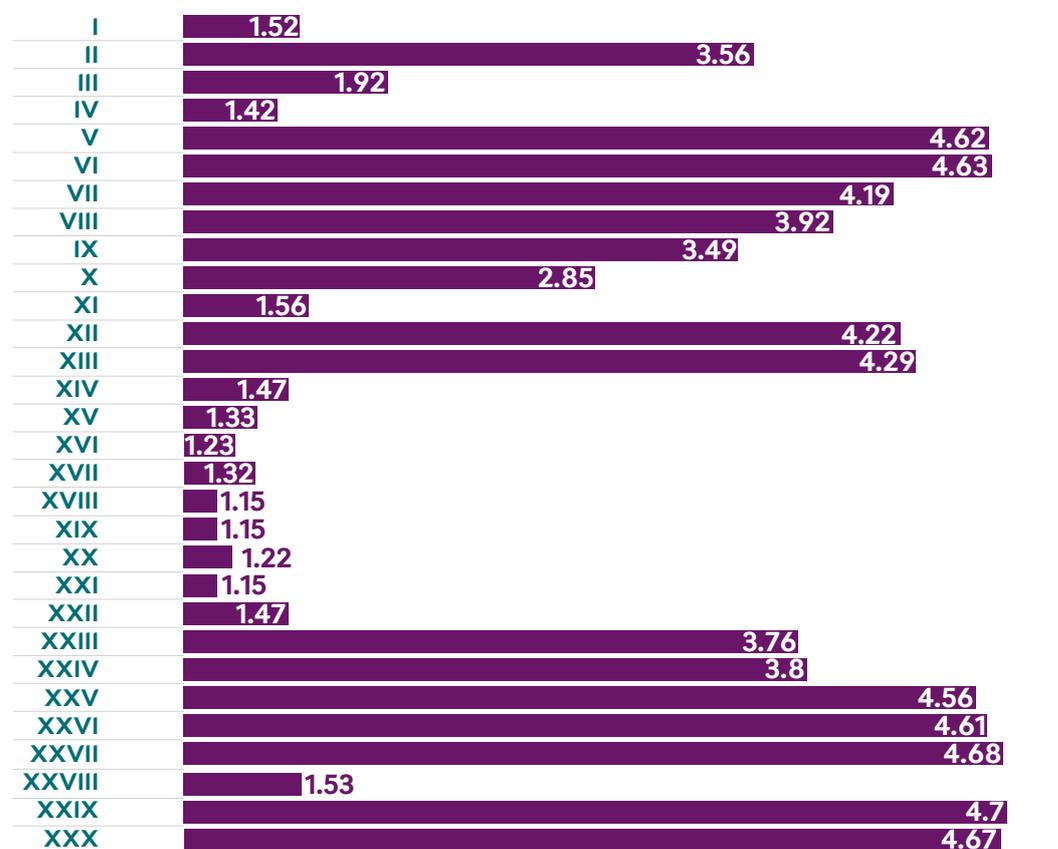
Participants answered 30 questions aimed at understanding their experiences and beliefs regarding self-harm and the support they provide. The questions included topics such as the level of empathy they show towards clients, the effectiveness of their care, and their beliefs about the motivations behind self-harm.

It is important to note some questions contained reverse scoring items, with higher scores indicating agreement. **Graph J** represents the average responses to each question.

Graph J indicates most professionals agreed that they provide warm and understanding care to clients who self-harm and listen fully to their problems and experiences. The low scores on questions that stigmatise or blame those who self-harm suggest that professionals want to help and care for those they work with.

The results should be viewed from the perspective of the individual professionals, rather than the constraints of the services in which they work.

J. Self-Harm Antipathy Scale



Graph J Questions

- I I would feel ashamed if a member of my family engaged in self-harm
- II I find it rewarding to care for self-harming clients
- III I feel to blame when my clients self-harm
- IV I feel critical towards self-harming clients
- V Self-harming clients deserve the highest standards of care on every occasion
- VI Self-harming individuals can learn new ways of coping
- VII Acts of self-harm are a form of communication to their situation
- VIII Self-harm may be a form of reassurance for the individual that they are really alive and human
- IX An individual has the right to self-harm
- X People should be allowed to self-harm in a safe environment
- XI People who self-harm lack solid religious convictions
- XII For some individuals self-harm can be a way of relieving tension
- XIII Self-harming clients have a great need for acceptance and understanding
- XIV A self-harming client is a person who is only trying to get attention
- XV When individuals self-harm, it is often to manipulate carers
- XVI People who self-harm are typically trying to get even with someone
- XVII People who self-harm are usually trying to get sympathy from others
- XVIII Self-harming clients have only themselves to blame for their situation
- XIX Self-harm is a serious moral wrongdoing
- XX Self-harming clients do not respond to care
- XXI A self-harming client is a complete waste of time
- XXII There is no way of reducing self-harm behaviours
- XXIII I help self-harming clients feel positive about themselves
- XXIV I can really help self-harming clients
- XXV I feel concern for the self-harming client
- XXVI I am highly supportive to clients who self-harm
- XXVII I acknowledge self-harming clients' qualities
- XXVIII A rational person can self-harm
- XXIX I demonstrate warmth and understanding to self-harming clients in my care
- XXX I listen fully to self-harming clients' problems and experiences

The case study of Eimear below, offers a unique insight into what it is like to work as a professional who supported individuals who have experienced self-harm.

Case study Eimear*

Eimear identifies as a female in her 30s from Ireland who previously worked as a professional supporting people who have experience of self-harm.

Eimear defined self-harm as: *"Something someone does in an effort to cope with their human experience. People in the medical world call it maladaptive coping... people who experience self-harm say they feel hopeless."*

She feels strongly about the concept of stigma in relation to self-harm and apologised for her bluntness but also stated that she wanted to be *"impolitically frank"* about it.

Eimear described stigma as: *"When people use jargon like 'poor coping' and 'maladaptive behaviour' to distance themselves from trying to understand another person's difficult human experience... it can be through jargon in psychiatry and in medical care, it can be refusing to engage in any non-positive conversation in society. It can look like telling a person what their experience is as opposed to listening. It can be dismissing someone's experience by describing a perfectly rational concern as 'catastrophising'."*

It generally looks like privilege and someone attempting to help someone by using tools in a way that shows they don't actually understand the therapy they practice."

*This name has been randomly selected.

Eimear believes self-harm and suicide are similar and that it is more common among women than men. She also feels that she would face judgement or stigma if she were to discuss self-harm with her GP or employer. Despite her confidence in supporting people who self-harm, she is unsure if she can help them feel more positive about themselves.

While she would feel comfortable if a family member or friend confided in her about self-harm, Eimear admitted that visible signs of self-harm could impact her willingness to enter a new relationship with someone.

She feels that people who self-harm need acceptance and understanding and believes they can learn new coping strategies. Eimear was undecided as to whether self-harm was a serious moral wrongdoing. She strongly disagreed that people should have the right to self-harm or that they should be allowed to self-harm safely.

When asked about groups in Ireland and Northern Ireland who are particularly impacted by stigma, Eimear said: *"People diagnosed with personality disorders get an awful rep. It's embarrassing that the psych model doesn't acknowledge the connection between childhood trauma and the causation of personality disorders. Also, definitely, those in intellectual disability professions and mental health don't have an up-to-date education on neurodivergence (i.e., autism and ADHD) - we still use terms like high functioning for people who go all day long and 'crash' and have meltdowns once home.*

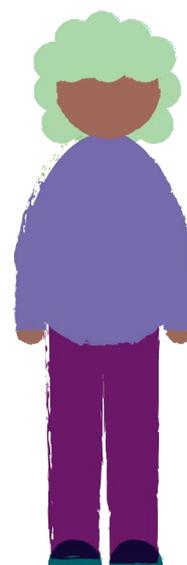
No one is more guilty of stigma than professionals because they are supposed to set the standard for these issues, and they don't. I don't think our psych services are fit for use and I say this as a retired psychiatric nurse in my 30s."

Her top three priorities for what could best reduce stigma are:

- Awareness campaigns highlighting stories of real people and their families
- Cross-departmental government policies to reduce stigma around self-harm
- Stigma training for health professionals and community workers

Eimear also suggested that training sessions should focus on the links between childhood experiences and suicide and the higher rate of suicide attempts by women using less violent methods. Eimear recommended getting rid of resilience training, describing it as condescending, and hiring more public clinical psychologists to address the long waiting lists for psychology.

She emphasised the need for a less paternal and directive system with more choices for patients. Eimear also stated that some health professionals can be bossy and rude, which may contribute to the revolving door in mental health care.



People in social and healthcare professions inevitably bring their own presumptions and tendencies (intentionally or not) into their work. These can be further shaped by their experiences with those they seek to help and can over time have an overall impact on how they view and discuss a topic, like self-harm.

Each professional is an individual and much like those with lived experience of self-harm, their experiences and opinions are often unique. This is outlined in the case study below. Grace has a different viewpoint than Eimear or David and indicates some stigmas in how she views and approaches those who self-harm.



Grace identifies as a female in her 20s from Northern Ireland who works as a professional in a role which involves supporting people with a current or previous experience of self-harm.

Grace defines self-harm as *"a deliberate act to inflict pain on self without the intention to end one's life"* and stigma as *"being treated differently/judged due to personal characteristics e.g., age, gender, ethnicity, religion, intellectual ability, mental health status"*.

Grace believes that self-harm is a coping mechanism used by people to deal with difficult emotions and experiences and that it is not the same as suicide. She thinks that young people are more likely to engage in self-harm and that people may self-harm to seek attention, but this is not the only reason. She fears that she would face judgement or stigma if she were to talk to her family or employer about self-harm.

Additionally, she feels that if she were an employer, she would be less likely to hire someone with visible signs of self-harm, and that visible signs of self-harm would also negatively impact her willingness to enter into a new relationship.

Grace has mixed feelings about the issue of self-harm and the right to self-harm in a safe environment. As a professional, she felt confident in her ability to support those who self-harm, showing warmth, understanding and genuine concern. She saw self-harm as a form of communication about what might be going on for someone.

Grace believed that certain groups across Ireland and Northern Ireland were heavily impacted by stigma, including the Travelling Community, people with severe mental health problems, people with intellectual disabilities, and children in care.

Her top three priorities to reduce stigma were:

- Programmes in schools and universities
- Stigma training for health professionals and community workers
- Educational and support programmes for family/friends/carers of those who self-harm

*This name has been randomly selected.

Participants' recommendations on reducing stigma

Samaritans Ireland believes that the best solutions to social issues come from the people who are directly impacted. To gather this information, participants were asked to rank six statements based on their perceived level of impact on society, with 1 being the most impactful and 6 being the least impactful.

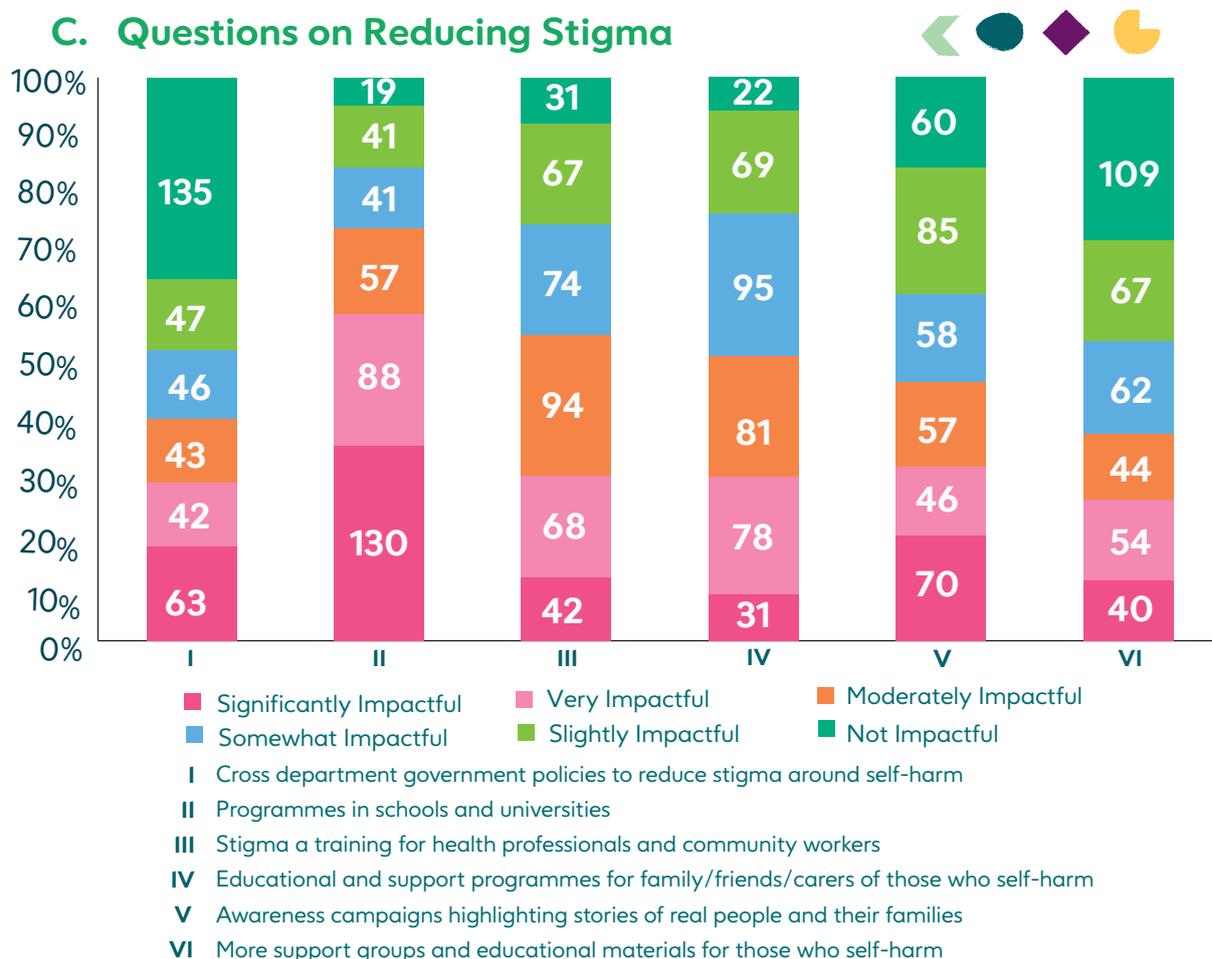
Over 70% of participants believed programmes aimed at reducing self-harm and stigma in schools and universities would have the most impact.

These results showed people have a clear preference for recommendations that take a targeted approach towards key groups, rather than broader solutions.

This was followed by stigma training for health professionals and community workers, and educational and support programmes for the family, friends, and carers of those who self-harm. There was little support for government policies or additional support groups and educational materials for individuals who engage in self-harm.

The emphasis on reducing self-harm and stigma in schools and universities and providing training for health professionals and community workers highlights the importance of educating and supporting those who are in direct contact with individuals who engage in self-harm.

C. Questions on Reducing Stigma



Conclusion and Key Findings

The findings of this report serve as a stark reminder of the impact of stigma on individuals who self-harm. Despite progress in the mental health field, it is clear stigma continues to affect those struggling with self-harm, often exacerbating their pain and isolation. The survey responses highlighted the deeply personal and nuanced nature of self-harm experiences, underscoring the importance of taking a collaborative and inclusive approach to addressing this issue.

Conclusion

Moving forward, this report emphasises the need for expanded research into self-harm and stigma, particularly from a qualitative perspective. It also underscores the critical role of media and entertainment industries in shaping public perceptions and reducing stigma surrounding mental health and self-harm. The recommendation to follow Samaritans' media guidelines when developing plotlines related to self-harm is a crucial step in this direction.

Perhaps most importantly, this report calls upon each of us to acknowledge our own responsibility to combat stigma and support those who are struggling with self-harm. By sharing our personal experiences and advocating for greater acceptance and support, we can help build a more compassionate and understanding society. Ultimately, it is only through collective action and a deep commitment to understanding and acceptance that we can hope to address the complex issues surrounding self-harm and mental health.



"...it feels great to be a part of something like this and I'm really grateful to have been part of this and part of a group that wants to really work on this and develop the understanding..."

Focus group participant

Key Findings

Our research has uncovered several significant findings that shed light on self-harm and stigma:

- **Self-harm is not an issue that only affects young people, nor is it a passing phase that one can simply grow out of.** This behaviour can manifest at any age and persist throughout one's lifetime. Therefore, it is crucial to remain mindful of this fact when conducting research and developing policies related to self-harm. It is imperative that we take a holistic, whole-life approach to understanding and addressing self-harm. This involves acknowledging the complex and multi-faceted nature of self-harm and recognising that effective intervention must extend beyond the moment of crisis. By adopting a comprehensive approach that considers the individual's entire life experience, we can better understand the root causes of self-harm and develop effective strategies to prevent further stigma and isolation for those who engage in self-harming behaviours.

➤ **Theoretical willingness to support those who self-harm is high. However, when confronted with real-life scenarios, such as carpooling or renting out an apartment, the majority of respondents reported that they would not offer support.** This clear disconnect between hypothetical willingness and actual practical support for individuals who self-harm warrants further investigation in future research. It raises important questions about the motivations and actions that contribute to this discrepancy, such as fear, stigma, or lack of understanding.

By exploring these factors, we may be able to better understand how to bridge the gap between theoretical willingness and practical support, and ultimately improve outcomes for those who engage in self-harm.

➤ **The exact prevalence of self-harm remains a challenge to determine due to limitations in reporting methods and available data.** This research has shed light on the issue by revealing that a significant number of individuals have encountered someone they suspect may be engaging in self-harm. This observation, while likely limited to physical self-harm that is visible on body areas, suggests that self-harm may be more prevalent than previously thought.

Unfortunately, individuals who engage in self-harm often experience further stigmatisation and dismissiveness when seeking help, particularly from healthcare professionals. This perceived stigmatisation can lead to those in need of care not receiving the support they deserve.

➤ **The way in which self-harm is portrayed in the media has a significant impact on how it is perceived and understood by the public.** Our data has revealed that a high number of people base their understanding of self-harm solely on what they have seen depicted in movies or TV shows.

This media portrayal can directly shape the stigmas and biases that individuals carry with them into the real world, which can have negative consequences for those who engage in self-harming behaviours.

Misunderstandings and negative stereotypes perpetuated by the media can lead to further stigmatisation and isolation for individuals who engage in self-harm, making it more difficult for them to seek the help and support they need.

➤ **Participants clearly expressed their preference for targeted solutions to reduce the stigma surrounding self-harm, rather than broad, generalised approaches.** The recommended targeted interventions included: programmes aimed at reducing self-harm and stigma in schools and universities, training for healthcare professionals and community workers, and education and support for loved ones who are in direct contact with individuals who engage in self-harm.

These targeted interventions reflect a deeper understanding of the root causes of self-harm and the unique needs of those who engage in these behaviours.

➤ **Lack of awareness and knowledge of self-harm leads to the development of stigma.** Stigma can arise from the acceptance and dissemination of incomplete or inaccurate information, leading to biased judgements.

Such stigmatisation can be extremely harmful to those who are vulnerable, and it is critical for society, especially those in positions of authority such as government, workplace managers, or health and social care professionals, to actively combat it.

➤ **The workplace is not viewed as a safe or accepting environment for individuals who engage in self-harm.** The study revealed that there is a significant amount of stigma and discrimination within the hiring process, as visible signs of self-harm could potentially impact an employer's willingness to hire.

The study found that there is a lack of support and acceptance within the workplace, with 80% of respondents stating that they would not feel comfortable disclosing their self-harm to their employer.

Given that many adults spend the majority of their lives in the workplace, it is crucial to take steps to ensure that there is equity and acceptance for individuals who engage in self-harm.

➤ **Self-harm is a highly individualised, and so is the definition of it.** This study found a significant degree of dissonance among participants when defining or describing self-harm.

There was disagreement over what exactly constitutes self-harm, with some participants suggesting that the definition was too broad while others felt it was not inclusive enough.

Given the highly personal nature of self-harm, it is important to recognise that the definition can vary significantly from person to person.

Ultimately, it is up to individuals with lived experience to define self-harm with as many or few specificities as they need to fully capture their own experiences.



Recommendations and Areas for Future Research

This research has uncovered a range of issues and challenges that individuals who self-harm face, including stigma and discrimination in various areas of life. Based on the findings, below are several recommendations which aim to address the root causes of stigma and create a more inclusive and compassionate society for those who self-harm.

Ireland

◆ **It's never too early to start talking about mental health and wellbeing:**

Self-harm can begin at a very early age, so it is vital that education about mental health and wellbeing start as young as possible. Mandatory wellbeing programmes should be developed for pupils as young as junior infants, focusing on feelings, openness and inclusivity. Age-appropriate lessons should include healthy coping mechanisms and how to reach out for support.

A strong foundational understanding of general mental wellbeing will the transition to programmes for older students which cover more in-depth topics like self-harm or suicide prevention, easier.

◆ **Clear pathways to report stigma:**

Healthcare settings and workplaces should be stigma free areas. Anyone who reaches out for help or support should be met with compassion. There should be clear pathways to report feeling stigmatised or shamed when presenting for help at hospitals or GP offices. Workplaces should also develop clear policies outlining zero-tolerance for stigma and a process for employees to report any issues.

◆ **Mandatory workforce training:**

Health and social care professionals:

All health and social care professionals should undergo mandatory training focusing on stigma associated with mental health and self-harm. While training courses are currently available to frontline health and other key staff, there is a stark disconnect between how professionals think they are responding and the feelings/experiences of those with lived experiences. These mandatory trainings should be developed with those with lived experience and involve mental health ambassadors and advocates.

General workforce:

Mental health and stigma training should be required by all employers during inductions and as part of ongoing training to ensure workplaces are safe and accepting places. It is important that staff at all levels – especially in human resources - understand the dangers of stigma and how best to have conversations around self-harm and mental health difficulties. Developed with those with lived experience, the training should empower staff to engage in supportive, non-judgemental conversations around self-harm and mental health difficulties and also ensure widespread education about where and how to seek help.

◆ **Compliance with Samaritans' Media Guidelines:**

All media, film and TV production companies should adhere to Samaritans' media guidelines when reporting on self-harm or developing plot lines related to self-harm. These guidelines provide valuable insight into how to approach the subject matter sensitively and accurately, without perpetuating harmful stereotypes or contributing to stigma. By following these guidelines, producers can help to ensure their depictions of self-harm are responsible and informed, and do not contribute to the misinformation that can lead to stigma and bias in the general population.

◆ **Keep those with lived experience of self-harm, as well as their carers, family and friends at the core of all research:**

Engaging with individuals who self-harm and their broader support networks is a critical step in creating policies and services that are more responsive, effective, and inclusive. Research on self-harm and stigma within Ireland needs to continue as our understanding evolves and policies need to stay current. By prioritising the voices and experiences of those with lived experience of self-harm in research, policymakers and service providers can help to create a mental health system that is more supportive, empathetic, and effective for all.

◆ **Collect timely and accurate data:**

Accurate and reliable data needs to be available in order to inform policy decisions and resource allocation. The National Suicide Research Foundation should be supported to ensure all hospitals are collecting and sharing data in a consistent and timely manner. All data should be standardised, validated and collected consistently to ensure transparency across the region.

◆ **Increase political and public awareness to reduce stigma:**

Led by the Department of Health, a whole-government approach should be taken to reduce stigma including Samaritans media training to all public officials to ensure appropriate language is always being used when speaking about self-harm or suicide. A cross-departmental responsibility should be adopted with a public education campaign to raise awareness to reduce the associated stigma of self-harm by promoting positive messages about mental health and providing accurate information about the causes and effects of self-harm as well as encouraging help-seeking behaviours.

◆ **Fulfil recommendations made in national strategies and policies:**

Continued support and focus are required on self-harm within the national suicide prevention strategy, *Connecting for Life*, and key prioritisation of recommendations 22, 23, and 91 from the national Mental Health Policy, *Sharing the Vision*. It is important that those seeking help can access help whenever and wherever they need it without fear of stigmatisation or shame. Professional staff within these environments must also be adequately trained and supported to ensure they are able to provide the best care to those who need it most.

Northern Ireland

◆ **Increase public awareness and reduce stigma:**

The Department of Health and the Public Health Agency should undertake a public education campaign to raise awareness to reduce the associated stigma of self-harm by promoting positive messages about mental health and providing accurate information about the causes and effects of self-harm as well as encouraging help-seeking behaviours.

- ◆ **Address root causes of self-harm:**
The Protect Life 2 and Mental Health Strategies should be prioritised and fully funded to ensure that services are available and enhanced for those who self-harm including, counselling, therapy, and other evidence-informed interventions for individuals who engage in self-harm. This will ensure individuals have access to the appropriate treatment and support at the right time.
- ◆ **Foster a positive school and university environment:**
Schools and universities should be equipped with the resources and knowledge to identify and address self-harm. There should be a well-being programme developed and taught in schools with a focus on openness and inclusivity, with age-appropriate lessons to ensure young people are provided with accurate and comprehensive information about self-harm.
- ◆ **Develop workforce training:**
To support individuals who engage in self-harm, mandatory training should be developed and delivered to all healthcare professionals, teaching staff and community workers. Including specific policies on how to respond to self-harm, and empower staff to engage in supportive, non-judgemental conversations.
- ◆ **Collect timely and accurate data:**
It is important to collect accurate and reliable data to inform policy decisions and resource allocation. All data should be standardised, validated and collected consistently. Data should also be made available in a timely manner to ensure transparency across the region.
- ◆ **Improve co-operation and cross-departmental working:**
Government departments, the statutory sector, and the voluntary and community sector must work together to address issues around self-harm. Self-harm is a complex issue that intersects with many areas across many departments and services. The Department of Health should take a co-ordinating role to ensure relevant and timely information is shared on evidence-informed interventions in relation to self-harm with all government departments, including the statutory and voluntary and community sector.
- ◆ **Engaging with those with lived experience of self-harm, as well as their carers, family and friends:**
Engaging with individuals who self-harm and their broader support networks is a critical step in creating policies and services that are more responsive, effective, and inclusive. By prioritising the voices and experiences of those with lived experience of self-harm, policymakers and service providers can help to create a mental health system that is more supportive, empathetic and effective for all.
- ◆ **All media, film and TV production companies use Samaritans' media guidelines when reporting on self-harm or developing plot lines related to self-harm:**
These guidelines provide valuable insight into how to approach the subject matter sensitively and accurately, without perpetuating harmful stereotypes or contributing to stigma. By following these guidelines, producers can help to ensure their depictions of self-harm are responsible and informed, and do not contribute to the misinformation that can lead to stigma and bias in the general population.

Further Resources

Future areas of research

The main findings of this research are expected to guide future studies that involve samples from both Ireland and Northern Ireland. The study has revealed while people generally express a willingness to help those who self-harm, they tend to avoid real-life scenarios such as renting an apartment or carpooling with someone who self-harms. Further qualitative studies are recommended to understand the discrepancy between self-perceptions of helpfulness and acceptance and actual avoidance behaviours. Many participants also had a broader definition of self-harm beyond physical injuries, highlighting the need for further research on the experiences and stigmas associated with both visible and hidden self-harm.

This study suggests the need to explore the intersection of stigmas, including the impact of pre-existing stigmas and demographics such as age, gender identity, migrant status, and economic status. While sexuality was not included in this work, future research could explore the impact of sexuality on self-harm and stigma in Ireland and Northern Ireland.

An open-ended question on stigma was added to the survey and participants frequently identified particular groups that are impacted by stigma. These included women, ethnic minorities, Travellers, young people, people of colour, individuals with low incomes, those with experience in the criminal justice system, and people from different religious or faith communities. Further research to engage with these communities and explore the correlation between overall stigma and stigma specific to self-harm/mental health difficulties should be conducted. This would facilitate discussion around self-harm and mental health and help in identifying potential solutions to tackle stigmas in communities.

If you found this report triggering, Samaritans is available 24/7 on freephone 116 123 or by email jo@samaritans.ie (Irl) or jo@samaritans.org (NI)

The following organisations are also available for support.

Ireland

Aware	T: 1800 80 48 48 Text 50808: Text HELLO to 50808
Jigsaw	T: 01 472 7010
BodyWhys	T: 01 210 7906 E: alex@bodywhys.ie
LGBT Ireland	T: 1800 929 539
Pieta	T: 1800 247 247
ChildLine	T: 1800 666 666 (Under 18's only) T: 01 676 7960 (Parents can ring) Text: 50101 (free text)

Northern Ireland

Zest	T: 02871 266 999
Aware	E: info@aware-ni.org
Childline	T: 0800 1111
Cara Friend	T: 028 9089 0202
The Rainbow Project	T: 028 9031 9030
SAIL: Support, Acceptance, Information, Learning	T: 07443 611317

For more information on self-harm and suicide statistics and research, please contact the following agencies:

Ireland:

National Self-Harm Registry – www.nsrif.ie
Suicide Statistics – www.cso.ie
National Office Suicide Prevention: www.nosp.ie

Northern Ireland:

Suicide Statistics – www.nisra.gov.uk
Self-Harm Statistics - www.publichealth.hscni.net

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Samaritans Ireland is a charity registered in Ireland (20033668) and incorporated as a company limited by guarantee (450409). Samaritans Ireland's registered office is located at 4-5 Usher's Court, Usher's Quay, Dublin 8, D08Y223. CHY number: CHY11880. The directors/trustees of Samaritans Ireland are as follows: E. Farrell, G. Danton, A. Heron, C. Skelly, É. Ní Mhuircheartaigh, A. Mc Murray, M. Horgan, A. Deane, W. Wilson, C. Culliton, and C. Feehley.