Chracteristics of included studies

Table 4.1 Studies analysed with quantitative methods.

Author Year Ref no Country	Study design	Number Gender	Patient characte-ristics	Assessments	Results	Study quality Comments
Borschmann et al 2013 [129] United Kingdom	A parallel group, single blind, treatment as usual (TAU) RCT to test feasibility of JCP for patients with BPD **Final sample** n=88 n=46 TAU n=42 JCP + TAU	**Inclusion criteria** 1. ≥18 years 2. Meeting diagnostic criteria for BPD 3. Have self-harmed in the previous 12 months 4. Under the ongoing care of CAMT 5. Able to provide written consent Power-calculation done 17% male	**Baseline characteristics** Total: n=88 Mean age: 35.8 SD=11.6 Majority of participants were female British caucasians, aged in their 30's, single and unemployed Meeting diagnostic criteria of BPD according to DSM-5 and having self-harmed in the previous 12 months with the intention of causing harm to themselves	10 self-reporting questionnaires, among them CSQ, Perceived Coercion with TES and WAI, at baseline and at 6 month follow-up **Primary outcome measure** Occurrence of self-harming behaviour over the 6-month period following randomisation **Secondary outcome measures** Depression, anxiety, engagement and satisfaction with services, quality of life, well-being and cost-effectiveness	In the two groups (JCP + TAU and TAU), 13 participants (14.7%) dropped out prior to follow-up In addition two participants died during the follow-up period It is feasible to recruit and retain people with BPD to a clinical trial of JCPs. The intervention appeared to have high face validity with the trial participants The JCPs were used both during (73.5%) and between (44.1%) crises and were viewed favourable by participants Almost half (47.1%) reported a greater sense of control over their problems and an improved relationship with their mental health team The large majority of participants would recommend JCP to other service users An underpowered trial due to a higher drop-out-rate than the estimated 10% No evidence of clinical efficacy in this feasibility trial but as the trial was underpowered it remains possible that JCP is effective for people with BPD	Moderate The study is somewhat under-powered as a consequence of fewer included and a higher drop-out rate than expected. Otherwise, properly conducted study of good design Ethical approval

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Table 4.1 continued

Author Year Ref no Country	Study design	Number Gender	Patient characte-ristics	Assessments	Results	Study quality Comments
Warm et al 2002 [128] United Kingdom	Internet-based survey of who they had consulted for help in the past and their level of satisfaction with these various sources of professional help	243 valid respondents Females: 205 Males: 34 4 respondents did not specify gender	Female mean age: 21 Male mean age: 23 **Country of origin** USA (133), UK (50), Australia (20) Canada (16), Germany (4), New Zealand, Sweden, Ireland, Finland (2 each), Japan, Singapore, Belgium, Israel, Dominican Republic, Denmark, and Norway (1 each) NR=5 A variety of self-harming behaviour reported	**On-line questionnaire with 12 sections about** 1. Personal information (eg age, gender) 2. Education and employment 3. Details of the respondent's family (eg number of siblings) 4. Relationship with others 5. Types of self-harm 6. Background information (ie behavioural histories associated with self-harm) 7. Romantic relationships 8. Circumstances surrounding self-harm 9. Emotions in relation to self-harm 10. Life events (ie those that have triggered self-harm) 11. Consultations with others 12. Understanding of self-harm	Of 243 respondents, 178 (73.3%) reported that they had sought help in the past. Psychiatrists, counsellors and psychologists were consulted most frequently but the satisfaction was lower for psychiatrists (27%) and nurses (23.1%) than for psychologists (35.6%) and counsellors (34.2%) Dissatisfaction was generally higher for psychiatrists (51.3%), nurses (49.2%) and doctors (48.9%) compared to other sources of help. Voluntary organisations received most favourable ratings Respondents were most likely to self-harm at night, and the act of self-harm reduced anxiety, depression and confusion	Moderate Very little description of represen-tativeness with using an Internet survey and its' limitations. The authors' precon-ceptions are not described No note of ethical approval. The first author claimes (in written communi-cation), that the study was approved by the ethics committee of the university

BPD = *Borderline personality disorder;* **CAMT** = *Community mental health team;* **CSQ** = *Client satisfaction questionnaire;* **DSM** = *Diagnostic and statistical manual of mental disorders;* **JCP** = *Joint crisis plan;* **NR** = *Not reported;* **RCT** = *Randomised controlled trial;* **SD** = *Standard deviation;* **TAU** = *Treatment as usual;* **TES** = *Treatment experience scale;* **WAI** = *Working alliance inventory*

Table 4.2 Studies analysed with mixed methods (qualitative and quantitative).

Author Year Ref no Country	Study design	Number Gender	Patient characte-ristics	Assessments	Results	Study quality Comments
Fortune et al 2008 [126] United Kingdom	School-based survey conducted in a representative sample of 41 secondary schools in Oxfordshire, Northamptonshire and Birmingham Questionnaire including open-ended question about help seeking and barriers to help seeking Qualitative research methods (not specified) were used to identify themes occurring in response to the open-ended questions	Total: 5 293 pupils 593 had life time history of DSH Females: 421* Males: 137* Not reported: 35	5 293 pupils Age: 15–16 years (mainly) 593 (10.3%) had a life time history of DSH	Self-reporting questionnaire including demographic information (age, gender and ethnicity) and questions about lifestyle, life events, problems, thoughts of self-harm, DSH, and coping Scales to measure depression, anxiety, impulsivity and self-esteem Respondents who acknow-ledged a history of DSH were asked to mark potential sources of help from a list of nine suggested sources of help. Those who had not sought help were asked about barriers to help seeking	The most common source of help was friends, followed by family members. Telephone help-lines and teachers were mentioned by a smaller number of adolescents. Formal sources of help were mentioned by many fewer respondents **A model of help-seeking behaviour described in five stages is presented** a. Perceptions of DSH b. Perception that something can be done c. Motivation to seek help d. Barriers to help-seeking e. Choosing sources of help **Motivation to act was** a. I will hurt or worry people who I care about b. It could create more trouble c. Emotional states d. Being labelled as an "attention-seeker" **Barriers to seek help were** a. Finding it hard to talk b. Did not know what to do	Moderate Ethical issues not problematised. Researcher's preconception not described Ethical approval

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Table 4.2 continued

Author Year Ref no Country	Study design	Number Gender	Patient characte-ristics	Assessments	Results	Study quality Comments
Davies et al 2011 [130] United Kingdom	Pilot study, mixed methods. 6 week intervention of self-administered acupuncture as an alternative coping skill for emotional distress Purposive sampling **Baseline measures** Interview to confirm the clinical diagnosis of emotionally unstable personality (ICD-10 criteria) **During intervention and providing qualitative data** Space for free text in the diary **6 weeks follow-up** Semi-structured face to face interview, framework analysis	10 participants: Females: 8 Males: 2	Age between 24 and 56 years (mean 38.5) Had used DSH between 10 and 40 years (mean 23.1 years, SD 9.8), multiple methods All subjects took prescribed psychotropic medications One participant (male) dropped out of the study after the first week and declined the use of acupuncture. No outcome data beyond baseline, apart from follow-up BDI, was available for that participant	**Baseline measures** DSHI = Measuring, nature, severity, and frequency of DSH Baseline depressive symptoms using BDI **During intervention and providing quantitative data** A diary containing weekly self-report cards on levels of emotional distress, DSH and use of acupuncture. Further use of coping mechanisms such as prescribed and non-prescribed drugs, and alcohol **6-weeks follow-up** BDI	The qualitative findings concerned the process of acupuncture identified important categories: triggers for acupuncture, practical issues with self-acupuncture, the technique employed, the timing of the procedure and obstacles to self-acupuncture The effects of acupuncture were categorised into psychological, physical and social effects	Moderate (both quanti-tative and qualitative parts) Unclear description of the selection process of participants. Saturation is not mentioned Ethical approval

** Varies due to missing data.*

BDI = *Becks depression inventory;* **DSH** = *Deliberate self-harm;* **DSHI** = *Deliberate self-harm inventory;* **ICD** = *International classification of diseases;* **NR** = *Not reported;* **SD** = *Standard deviation*

Table 4.3 Studies analysed with qualitative methods.

Author Year Reference Country	Material method Analysis method	Informants	Summary of results	Study quality Comments
Cooper et al 2011 [119] United Kingdom	Purposive sampling Semi-structured individual interviews with service users regarding contact-based interventions (eg letters, telephone calls or crisis cards*) following self-harm Thematic analysis	n=11 Service users who had recently attended the emergency department (ED) of 3 hospitals in a city in the Northwest of England Females: 6 Males: 5 Age: 18–50 years (median 34) **Staff** NR in this report 16 invited staff and 10 agreed to participate, 8 in a focus group and 2 individual interviews Age and gender=NR	Need for tailored support and encouragement from service providers following discharge from ED Early interventions, proactive contact and a genuineness of the service were important. Letters and crisis cards were not viewed as a genuine attempt to help. A contact-based intervention (eg phone calls) was described as a gesture of caring and contained being looked after and for some prevented self-harm. Practical issues and problems with proposed interventions concerned design and delivery, immediacy of mode of contact, frequency of contact, delivery by mental health specialists, relationship to existing services, barriers to uptake, anonymity of contact, means of contact and reaction to contact The authors point out the need for encouragement and support soon after discharge which should proactively engage service users and provide a genuine response	Moderate Unclear description of the selection of participants as well as of the data analysis process. Saturation is not mentioned nor the authors' preunder-standing Ethical approval
Huband et al 2004 [125] United Kingdom	Phenomenological study with semi-structured interviews about experiences of cutting and the helpfulness of specific interventions Grounded theory approach	10 women who subsequently volunteered were recruited from a county in central England Age: 21–48 years (mean 35.1) All participants had self-injured multiple times, mainly cutting and burns DES showed that dissociative experience was common in the sample PBI scores indicated low perceptions of parental care and overprotection scores was considerably higher than the mean for normal subjects	10 key experimental themes in relation to participants' experiences before cutting themselves (which then were put together in two distinct pathways to self-wounding). The *spring* is associated with a feeling of becoming increasingly 'wound up'. The other, called the *switch* is associated with a sudden and often overwhelming desire to cut, once a switch had been thrown, some women described a craving to cut while others just went ahead and did it The participants rated how helpful different management styles were towards self-wounding behaviour. Having a long-term relationship with one key-worker and expressing feelings about the past were rated overall as the most helpful methods of managing their self-wounding Attempting to practice relaxation techniques during internal conflicts – (wounding or not wounding) was reported as particularly unhelpful	Moderate The method section is clear but confusing regarding the two different methodological approaches. Further there is unnecessary quantification of qualitative findings Ethical approval

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Table 4.3 continued

Author Year Reference Country	Material method Analysis method	Informants	Summary of results	Study quality Comments
Hunter et al 2013 [120] United Kingdom	A longitudinal qualitative design with semi-structured interviews aiming to investigate short and long term meanings of psychosocial assessment, and how service users' interpretations of the assessment and hospital experience (due to self-harm) affect future help-seeking intentions 13 initial interviews after hospital attendance, 7 follow-up interviews conducted 3 months later **Analysis** IPA	13 participants Females: 6 Males: 7 **Follow-up interview** Females: 3 Males: 4 **Age** Early 20's–early 60's 5 participants self-cut 5 self-poisoned 1 did both of the above 1 scratched 1 reported suicidal ideation only 4 males reported no previous self-harm 2 females and 1 male reported infrequent episodes of previous self-harm 2 males and 4 females reported multiple episodes of previous self-harm	The participants reported the function of psychosocial assessment as unclear, and just as a routine aspect of hospital care Positive value of assessment was legitimation of distress, having someone to talk to, and inspiring hope for change Negative aspects were feelings of shame and being judged by staff, cycle of referral to same/similar services increased hopelessness, and struggling to be heard and believed Outcomes of hospital attendance was about unclear arrangements for follow-up care, stagnation (little or no change in their circumstances), interactions with staff shape future help-seeking intentions, and the need for contextualised and personalised follow-up care Psychosocial assessment can be of therapeutic benefit when it encourages a sense of legitimation and hope. This benefit is conveyed through interactions with staff An initial step would be to ensure that service users understand the function and potential outcomes of assessment Timely follow-up, consistent with psychosocial assessment is needed to maintain hope and engagement with services	Moderate Vagueness in description of inclusion (not clear distinction between self-harm and suicide attempt) and therefore unclear selection of participants. Saturation is not mentioned, nor the authors' preunder-standing Ethical approval

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Table 4.3 continued

Author Year Reference Country	Material method Analysis method	Informants	Summary of results	Study quality Comments
Kool et al 2009 [121] The Netherlands	Grounded theory Semi-structured interviews about the process of how to reduce or stop severe self-injury, and what factors play a role in that process	**Females** 12 **Age** 26–60 years (average 39) **History of self-harm** 6–46 years (average 22) All of them used multiple types of self-injury methods 6 were diagnosed with DID 3 were diagnosed with DID and a personality disorder (2 BPD, and 1 not otherwise specified with borderline traits)	Key triggers of self-injury appeared to be the nature and sense of connection **The process of stopping self-injury** 1. Connecting and setting limits 2. Increased self-esteem with a further deepening of contact with the self 3. Learning to understand oneself 4. Autonomy-make active choices to increase control 5. Learning other strategies to cope with unbearable feelings 6. Maintenance – focusing on preventing a relapse into self-injurious behaviour **Negative factors for reducing self-injury** 1. Use of medication 2. Nurses being very caring when attending to injuries fed the need for love and care, previously withheld from them 3. Strict rules and high expectations 4. Connection is the key strand running through the entire process. Nurses should create conditions for restoring a sense of connection to the patient. It can be done by letting patients know, in words and attitude, that they regard them as an important and full person, regardless of their behaviour. By working with patients in examining the reasons for and meaning of self-injury, nurses can convey to the patients that they have a deeper understanding of the patient as a human being that goes beyond the self-injurious behaviour	Moderate Participants were, according to the authors, a highly selected group of, probably not comparable with the majority of people who self-harm Description of the data collection procedure is unclear and saturation is not mentioned, nor the authors' preunder-standing No note of ethical approval, but the study was discussed with the medical ethics committee of the hospital where the study took place. The committee decided that as long as the patients were informed in writing and verbally, gave written informed consent, and were guaranteed anonymity and confidentiality, no ethical approval was necessary

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Table 4.3 continued

Author Year Reference Country	Material method Analysis method	Informants	Summary of results	Study quality Comments
Lindgren et al 2011 [118] Sweden	Focused ethnography Participant observations and informal interviews about the interaction between women who self-harm and their professional caregivers, over a period of 6 months at two psychiatric inpatient wards A total of approximately 150 h of descriptive observations with about 40 h of focused observations and informal interviews In this study data comes from the focused observations and informal interviews Social constructionism Analysis using the concept of interpretative repertoires from discursive psychology	**Females** 6 (3 at each ward) **Age** 21–37 years (median 23.5) 3 were admitted to involuntary care 3 were admitted to voluntary care **Self-reported diagnoses** One woman had not been diagnosed, the other five reported 1–3 diagnoses each, including personality disorder, depression, eating disorder and Asperger syndrome **Medication** Antidepressants, clozapine, benzodiazepines, hypnotics, painkillers, and acid-reducing medicines	The professional caregivers used a "fostering repertoire" and a "supportive repertoire" and the women who self-harmed used a "victim repertoire" and an "expert repertoire" The women and the caregivers were positioned, and positioned themselves and people around them, within and among these interpretative repertoires to make sense of their experiences of the interaction The interactions between a "fostering repertoire" and an "expert repertoire" and between a "fostering repertoire" and a "victim repertoire" were described as largely unsatisfying by the participants Inflexible ward rules, disrespect for one another, and a non-listening approach contributed to the unsatisfying experiences among the participants The interactions between a "supportive repertoire" and a "victim repertoire" strengthened the underdog position taken on by the women, which allowed both the women and the caregivers to "hide" behind rules and restrictions Interactions between a "supportive repertoire" and an "expert repertoire" were described as more "equal" and included satisfying experiences	High Well performed and presented study No discussion of the study's limitations Ethical approval

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Table 4.3 continued

Author Year Reference Country	Material method Analysis method	Informants	Summary of results	Study quality Comments
Lindgren et al 2015 [117] Sweden Based on the same data collection as in Lindgren et al 2011 [118]	Focused ethnography Participant observations and informal interviews about the interaction between women who self-harm and their professional caregivers, over a period of 6 month at two psychiatric inpatient wards A total of approximately 150 h of descriptive observations with about 40 h of focused observations and informal interviews Data from descriptive observations Qualitative content analysis	**Females** 6 (3 at each ward) **Age** 21–37 years (median 23.5) 3 were admitted to involuntary care 3 were admitted to voluntary care **Self-reported diagnoses** One woman had not been diagnosed, the other five reported 1–3 diagnoses each, including personality disorder, depression, eating disorder and Asperger syndrome **Medication** Antidepressants, clozapine, benzodiazepines, hypnotics, painkillers, and acid-reducing medicines	The main feature of everyday life in psychiatric inpatient care for women who self-harm was interpreted as *being surrounded by disorder*, which consisted of being in a *confusing environment*, subjected to *routines and rules that offer safety but lack consistency, and waiting both in loneliness and in togetherness* The confusing environment was described as a very important impediment to the women's progress towards health. The wards were a non-soothing place with little space to rest and relax and the women could not depend upon having a permanent room during their stay. They were not able to protect themselves from hearing and observing unpleasant events, and were not able to escape because the doors were locked Waiting in loneliness and waiting in togetherness were closely connected and had common features experienced by the women in the ward. These features were described as both positive and negative, eg when nursing staff was unavailable, the women turned to each other for support Routines and rules offered safety but also frustration and insecurity. When routines and rules were understandable, adapted to individual needs, and used consistently and equally among patients and when appropriate also among staff, they offered safety	High Well performed and presented study. Unclear what ruled the length of the participant observations Ethical approval
Long et al 2014 [122] Ireland	Qualitative study Individual semi-structured interviews about help seeking process among people with a history of self-injury Grounded theory approach	Females: 8 Males: 2 **Age** 19–42 years (mean 31) **Inclusion criteria** **18 years** • Living in Northern Ireland • A history of self-injury • No longer engaging in self-injury • Access to counselling at the time of research participation	Two categories and their associated sub-categories and concepts are presented **The process of help-seeking** 1. "Involution of feeling" as barriers to help-seeking included *stigma, judgement and misunderstanding, fear and confusion, coping, control*, and *never wanted support* 2. "To be treated like a person" illustrates experiences of help-seeking and included *stopping the fall, suicidal crisis, selectively choosing who you tell, out into nowhere*, and *just enough to move on*	Moderate Procedure for data collection not clearly described The findings represent only two categories (but more findings seems to be presented in forthcoming articles) The authors' preunder-standing is not mentioned Ethical approval

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Table 4.3 continued

Author Year Reference Country	Material method Analysis method	Informants	Summary of results	Study quality Comments
Looi et al 2015 [123] Sweden	Qualitative approach Individually written self-reports, using an electronic form, on how people who self-harm perceive alternatives to coercive measures in relation to actual experiences of psychiatric care Data was subjected to qualitative content analysis	19 self-reports were included **Gender** NR Sometimes the participants signed with their names suggesting that the study included both males and females The report was anonymous. No information about the participant was required **Inclusion criteria** **18 years** • Experience of self-harm • Treated in psychiatric inpatient care • Ability to write in Swedish or English Information provided spontaneously gave some insights regarding participants' characteristics Several participants indicated that they had extensive experience of psychiatric inpatient care All reports were written in Swedish	**The results revealed three content areas** 1. *Encounters* including the category *'a wish for understanding instead of neglect'* 2. *Relation* including the category *'a wish for mutual relation instead of distrust'* 3. *Care* including the category *'a wish for professionalism instead of a counterproductive care'* There is a considerable gap between participants' wishes for and their actual experiences of psychiatric care Patients not asking for 'miracle treatment' but to be listened to, understood and met in a mutual relation with professional caregivers in an adapted environment **Persons who self-harm are caught in a catch-22 situation** If the patients do not say what they need they will not get it – but if they say what they need they are denied it. The authors claim that it is due to caregivers believing that patients who self-harm are manipulative. On the contrary the results of this study suggest that patients are forced to behave in a 'manipulative' way as a response to caregivers' disbelief	Moderate Unclear selection process might be due to recruiting participants through social media Saturation in both data collection and data analysis is not mentioned Ethical considerations are limited to reporting ethical approval

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Table 4.3 continued

Author Year Reference Country	Material method Analysis method	Informants	Summary of results	Study quality Comments
Perseius et al 2003 [124] Sweden	Qualitative study Individual-focused interviews about patients' and therapists' perceptions of receiving and giving DBT treatment Patients filled in a semi-structured questionnaire with background data concerning socio-demographic variables and symptoms Therapists filled in a free format questionnaire focusing on areas corresponding to the patient group The therapists took part in a group interview Data was subjected to qualitative content analysis	**Females** 10 **DBT therapists** Female: 2 Male: 2 NR in this study **Age** 22–49 years (median 27) In DBT treatment for ≥12 months All participants reported between 100–500 DSH acts All diagnosed with BPD according to DSM-IV **Other self-reported diagnoses** Depression (9) Anxiety disorder (9) Eating disorder (3) Social phobia (2) All participants (except one) reported previous suicide attempts	**Three categories were found regarding patients' perceptions** 1. The therapy effect a. is life saving b. provides skills to help conquer suicidal and self-harm impulses c. helps in accepting your feelings and not condemning 2. The effective components of the therapy a. respect and confirmation is the foundation b. brings understanding and focus on the problems c. is your own responsibility and the stubborn struggle with yourself d. contract brings support and challenge e. group therapy is hard but necessary f. telephone coaching is important in crisis support 3. Psychiatric care before DBT a. not being understood and disrespectful attitudes b. discontinuity and betrayal c. poorly adapted tools	Moderate Saturation is not mentioned, nor the authors' preunder-standing The qualitative study is entirely descriptive without any formulation of neither hypothesis or model for future studies Ethical approval

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Table 4.3 continued

Author Year Reference Country	Material method Analysis method	Informants	Summary of results	Study quality Comments
Rissanen et al 2009 [127] Finland	Qualitative descriptive approach Methodological triangulation in data collection: written descriptions and individual interviews about help and helping factors regarding self-mutilation Inductive content analysis	n=72 adolescents **Written descriptions** 62 (gender: NR) **Age** 12–21 years from all over Finland **Interview** 10 (females) Age 13–17 years from eastern Finland 7 of them had received professional care (3 had not)	**Three groups of people that could help were identified** 1. Age-mates including peers and fellow self-mutilating adolescents 2. Loved ones 3. Adults, including unknown adults, health and social care professionals, teachers and school counselors, and parents **Factors contributing to help were divided into two sub-categories** 1. Factors that enable help-seeking 2. Helpful factors Help-hindering factors as well as unhelpful factors are also described Any person who knows about an adolescent's self-mutilation can be a helper, and an adult who is aware is duty-bound to intervene Nurses have an opportunity to understand the care needs of self-mutilating adolescents by seeing, listening to, and by really contacting them Factors contributing to help need to be taken into consideration in caring encounters and if possible they should be increased, whereas factors hindering help should be reduced	Moderate Vague description of study context. Saturation is not mentioned, nor the authors' preunderstanding. The result appears to be under processed Ethical approval

** Crisis cards are small cards on which the participants have written what they should do when having a crisis with risk for self-harm actions.*

BPD = *Borderline personality disorder;* **DBT** = *Dialectical behavioural therapy;* **DES** = *Dissociative experiences scale;* **DID** = *Dissociative identity disorder;* **DSH** = *Deliberate self-harm;* **DSM** = *Diagnostic and statistical manual of mental disorders;* **IPA** = *Interpretative phenomenological analysis;* **NR** = *Not reported;* **PBI** = *Parental bonding index*