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“I wanted to be proud of myself, not ashamed”:
A Qualitative Investigation of Suicide and Self-Injury Inflection Points

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Abstract

Inflection points are pivotal moments immediately preceding self-directed violence (SDV; i.e., self-injury and suicide). This study qualitatively examined factors that contributed to halting SDV during inflection points. Participants ($N=166$) completing an online survey were community-dwelling adults in the United Kingdom with some form of SDV lived experience. Thematic analysis yielded the following results. The most common themes across SDV inflection points were (in descending order): concern for the negative impact on others (e.g., fear of hurting loved ones), use of adaptive coping methods (e.g., general use of coping skills), physical deterrents (e.g., scarring, pain), social contact (sense of connection in the moment), and concern for negative consequences on oneself (e.g., fear of punishment). Healthy coping skill use contributed to halting both self-injury and suicide. Self-injury inflection points were largely characterized by intrapersonal factors, whereas suicide inflection points were highly interpersonal in nature. Implications for clinical practice, theory, and research are discussed.

Key words: Suicide; self-injury; protective factors; social contact; coping

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Introduction

Self-directed violence (SDV), comprising both suicide and self-injury, are significant public health concerns within the United Kingdom (U.K.; i.e., England, Scotland, Northern Ireland, Wales). Worldwide, over 700,000 individuals die by suicide each year (Ilic & Ilic, 2022). Across the U.K., suicide death prevalence rates remain high.. For example, in England and Wales, the suicide mortality rate was 10.7 deaths per 100,000 people in 2022 (Office for National Statistics, 2023), rising to 11.4 deaths per 100,000 in 2023 (Office for National Statistics, 2024). Further, the suicide mortality rate in Scotland was even higher at 13.9 deaths per 100,000 people as of 2022 (National Records of Scotland, 2023), rising to 14.0 deaths per 100,000 in 2023 (National Records of Scotland, 2024). Additionally, self-inflicted injury without intent to die are high in England across the past decade, with an estimated lifetime prevalence ranging between 4.9% and 6.4% (Liu, 2023; McManus et al., 2019). Rates of self-injury are again high in Scotland, with recent estimates suggesting a lifetime prevalence of 10% (Scottish Government, 2022). Beyond the loss of life, the social and economic impacts of each suicide death are widely felt, with an estimated cost to the economy of 10 billion pounds per year in the U.K.; further, suicide attempts and non-fatal self-injury often require medical care and emergency department services, producing additional economic costs (Samaritans, 2024).

Suicide and Self-Injury: Empirically supported Theory and Factors

Despite prevention and intervention efforts, suicide rates have remained steady across the U.K. in recent years (Office for National Statistics, 2023), calling attention to the need for novel approaches to suicide prevention. One such important progression in the field of suicide prevention is the development of ideation-to-action models of suicide (e.g., Interpersonal Theory of Suicide, Three Step Theory, integrated Motivational–Volitional Model) which differentiate factors contributing to suicidal ideation from those contributing to suicide attempt (Klonsky et al., 2016, 2018). Across ideation-to-action models, distinct risk factors for suicidal ideation are identified including unmet interpersonal needs (i.e., thwarted belongingness, perceived burdensomeness), hopelessness, defeat/humiliation, pain, and entrapment

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(Klonsky et al. 2018; O'Connor & Kirtley, 2018; Van Orden et al., 2010). Similarly, distinct risk factors for suicide attempt are articulated, including access to lethal means, decreased fear of death, increased pain tolerance, and prior suicide attempt history (e.g., Klonsky et al., 2018).

While ideation-to-action models have yielded extensive scientific support (e.g., Chu et al., 2017; Klonsky et al., 2021), they tend to place more emphasis on risk factors over protective factors. Prominent protective factors supported within ideation-to-action frameworks include resilience, connectedness, goals, social support, self-acceptance, and meaning in life (Klonsky et al., 2018; O'Connor & Kirtley, 2018; Teismann & Brailovskaia, 2020; Zhang et al., 2023). The extant positive psychology suicide literature also provides potential protective factors which may halt self-injury and suicide attempts. For example, self-compassion and mindfulness are negatively associated with suicidal ideation, attempt, and self-injury across samples including military veterans and clinical samples (Per et al., 2022; Suh & Jeong, 2021). Other positive psychological factors which may act in a protective manner include grit and perseverance (Anestis & Selby, 2015; Kleiman et al., 2013), gratitude (Kaniuka et al., 2021; Kleiman et al., 2013), hope (Clement et al., 2020; Huen et al., 2015), and optimism (Huffman et al., 2016). However, this growing body of literature needs further development, especially with respect to moments immediately preceding SDV.

Suicide and Self-Injury: Short-term Fluctuation and Need for Inflection Points Research

Existing research provides important information on SDV risk and protective factors. However, it fails to capture the fluidity of suicide and self-injury within short time periods (Sedano-Capdevila et al., 2021), and therefore lacks emphasis for immediate factors impacting suicide and self-injury. A recent systematic review of ecological momentary assessment (EMA) suicide research demonstrated significant fluctuations in suicidal ideation by the hour, or within-days, as well as across days (Kivelä et al., 2022). EMA findings are consistent with the fluid vulnerability theory of suicide (Rudd, 2006) which asserts that suicide risk is both a chronic (i.e., stable, or low-risk state that continues over time) and acute (i.e., dynamic, or high-risk state that fluctuates over time) process, with suicide risk erratically shifting

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depending upon a variety of environmental, cognitive, affective, and physiological factors. Although EMA research highlighted risk factors related to these short-term fluctuations (e.g., negative affect, sleep, hopelessness; Kivelä et al., 2022; Sedano-Capdevila et al., 2021), an understanding of the relevance of protective factors in stopping suicide or self-injury in the moments right before these acts occur is lacking. We define the pivotal timeframe immediately leading up to an act of self-injury or suicide attempt as “inflection points.”

Few previous suicide or self-injury investigations exist regarding the inflection point moments, or the timing immediately prior to suicidal or self-injurious behavior. Selby and Joiner (2009) proposed the Emotional Cascade model to explain the cyclic and highly reactive responses of persons with borderline personality disorder (BPD). They theorized that, after experiencing any minor situational trigger, persons with BPD experience a cascade of rumination that is only alleviated by unhealthy coping behaviors (e.g., self-injury). Applied to the present study, the intense affective-driven rumination must be halted in order to prevent self-injury. The Emotional Cascade view received recent empirical support (e.g., Selby et al., 2021). Kaniuka and colleagues (2024) conducted a qualitative study of suicide lived experiences among sexual and gender minority (SGM) adults. In the development of the SGM Suicide Risk and Protection (SuRAP) Model, Kaniuka et al. highlighted emergent themes in factors that “halted the cascade” of suicidal ideation, either in general or in the moment before an actual attempt. These themes included accessing mental health services, coping/emotion regulation, connecting to others, and identifying reasons for living. Finally, Gunn and colleagues (2024) examined themes contained in the content of suicide notes. Gunn and colleagues identified four major themes in suicide notes: (1) affect (e.g., anger, remorse), (2) relationships (e.g., negative marital experiences, separation), (3) life events (e.g., financial strain, addiction), and (4) injury and medical diagnosis (e.g., psychological diagnosis, chronic pain). The Emotional Cascade, SuRAP, and suicide note findings provide insight into what processes or factors may be at play during suicide/self-injury inflection points. However, these models are limited to specific

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populations and do not specifically query persons with lived experience about the moments immediately prior to an intended behavior.

Clinically speaking, crisis response approaches are a suicide prevention intervention aligned with the notion of inflection points. Several empirically-supported crisis management interventions exist, such as Crisis Response Planning (CRP; Bryan et al., 2017; Bryan et al., 2023), the Stanley-Brown Safety Planning Intervention (Stanley & Brown, 2012), and the Collaborative Assessment and Management of Suicidality (CAMS) Crisis Stabilization Plan (Jobes, 2012, 2023). Consistent across these crisis response approaches is a focus on warning signs, coping strategies, social support, and professional services; however, there may be other factors relevant to crisis management at the inflection points stage.

The Present Study

To extend our understanding about inflection points factors, the current study obtained qualitative information from adults with lived experiences of halted suicide and self-injury regarding their reasons for halting these behaviors. Understanding inflection points holds the potential to refine leading theories of suicide and inform strategies for short-term crisis response interventions for SDV. We explored the following research question (RQ):

RQ1: What do adults with suicide and/or self-injury lived experience identify as factors involved in halting these behaviors (i.e., inflection points)?

Materials and Methods

Participants

This study recruited community-dwelling adults residing in the United Kingdom. Participants were drawn from a larger pool of 488 participants enrolled in a study investigating lived experience of SDV (Cramer et al., 2024). Only participants providing at least one open-ended response to questions asking about inflection points for suicide attempt or self-injury were included in the present analyses. The final sample consisted of 166 community-dwelling participants, aged 16 to 60 years ($M_{\text{age}} = 26.58$, $SD = 9.0$). The sample was made up predominantly of White (91.57%), heterosexual (74.7%) women (86.74%)

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from the U.K. (96.39%). Most participants (75%) reported prior self-injury, whereas approximately 34% reported a prior suicide attempt. Similar rates were observed for lifetime aborted self-injury (77%) and aborted suicide attempt (59%). Demographic characteristics are summarized in Online Supplement Table 1.

Procedure

These data were collected as part of a large-scale online survey study (Cramer et al., in press) which examined the impact of risk and protective factors for suicidal thoughts and behaviors among adults in the U.K. Anyone aged 16 years or older and who lived in the UK was eligible to take part. There was no prerequisite to have had lived experiences of suicidal thoughts or behaviors to be able to take part. However, the present study used only those in the survey response pool who had lived experience. Potential participants accessed the survey through Qualtrics where they provided informed consent by clicking a button affirming agreement to participate, before they were able to begin the survey. The participant information sheet (PIS) explained the purpose of the study and highlighted the sensitive nature of some of the questions. In addition, the anonymous nature of the study was highlighted, and a list of available mental health resources was provided along with researcher contact information. These support mechanisms were also highlighted at the end of the study in a debriefing document. Both the PIS and the debrief were downloadable. The whole study, including this subgroup analysis, received ethical approval from the university's ethics committee (ethics #UEC20/70).

Measures

Demographics. Participants were asked for information regarding their gender, sexual orientation, age, race, birth country, and relationship status. Age (in years) and race (free text) were collected via open-ended response. All other demographic variables were collected via pre-set checklists, with a response option to indicate one's preferred response was not listed followed by the opportunity to provide a free text response.

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Inflection Points. Whilst we recognize the value and importance of theory, we wanted to ensure that our questions were not constricted by theory-based factors when exploring these pivotal life- and injury-saving moments. We therefore used open-ended survey questions which allowed individuals to use their own words to describe inflection points. Inflection points questions were developed in two steps. First, researchers reviewed existing suicide and self-injury risk assessment interviews (e.g., Lewis et al., 1992; Nock et al., 2007) to develop options of general question prompts regarding whether a person had lived experience with halted suicide and self-injury. The initial inflection points question set first included items asking whether a person had experienced (a) a suicide attempt, (b) an aborted suicide attempt (i.e., stopped by oneself), and (c) disrupted suicide attempt (i.e., halted by external intervention). All questions were phrased using a lifetime timeframe, with two response options: yes or no. Affirmative responses were followed by two different options of open-ended queries. The first asked about (a) processes and (b) factors that contributed to halting the behavior. The next set of questions addressed self-injury inflection points. We followed the exact pattern described for suicide inflection points in designing the questions about halting self-injury (i.e., merely replacing “suicide” with “self-injury”).

We then convened an expert panel of persons with suicide lived experience following guidelines in the literature (Krysinska et al., 2023). The expert panel comprising three study co-authors had the opportunity to provide feedback on: (a) the inflection point question set prior to data collection, (b) the codebook prior to qualitative analyses, (c) themes resulting from initial data interpretation, and (d) the entire manuscript. The resulting suicide inflection point questions featured two sets, one querying suicide attempt and one querying self-injury. Instructions included definitions of both suicide and self-injury. Following an affirmative response to the question concerning an aborted suicide attempt or self-injurious act, participants were asked two open-ended questions: (1) “We are interested in the factors that made you stop from making a suicide attempt/injuring yourself. Using the space below, please share with us your experience of what made you stop from attempting suicide/injuring yourself,” and (2) “We are interested in specific pivotal processes or moments that stopped you from making a suicide attempt/injuring

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yourself. Please share with us a turning point for you that impacted your decision not to attempt suicide/injure yourself." If participants did not endorse the initial questions, survey skip logic moved to the next survey. The final set of inflection points questions can be found in the study Online Supplement Appendix.

Data Analyses

Data cleaning and preparation details can be found in the study describing the full U.K. nationwide survey (Cramer et al., in press). Thematic analysis was performed by two assessors (the 4th and 5th authors) and a qualitative team lead (2nd author), each with expertise in suicide and self-injury. Following steps outlined in the literature (Boyatzis, 1998), these researchers became immersed in the data by reading all participant responses multiple times before engaging in analysis. Given that data were collected via written survey responses, we focused on analyzing semantic content (i.e., what is explicitly present and easily observable; e.g., number of instances "family" was discussed across responses) and latent content (i.e., implied deeper meaning; e.g., "The hurt my family and friends would feel" was interpreted to mean emotional rather than physical pain) insofar as coders could be confident in their interpretation of the available text. We used a coding reliability (positivist) approach to thematic analysis. As described further below, the coding team collaboratively developed and used a structured codebook, multiple coders independently coded the same data, and we calculated intercoder agreement. We calculated intercoder agreement to measure the degree to which members of our coding team were applying established codes consistently and to generate further discussions regarding the adequacy of the coding scheme.

After immersion and initial team discussions of the data, coders independently developed sets of codes, or an organizing system whereby the entire body of raw data are condensed into short descriptive labels intended to capture meaning (Saldaña, 2021). Codes are "the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon" (Boyatzis, 1998, p. 63). Individual responses to prompts were brief (ranging from a single word to a few sentences),

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yet often referenced multiple concepts; thus, phrases or sentence fragments were often coded as individual units of meaning.

We used an inductive approach to codebook construction. However, the data coding and analysis were almost undoubtedly shaped to some degree by (a) the framing of the open-ended questions (e.g., assuming persons experience “inflection points”), and (b) authors’ familiarity with relevant suicide and self-injury theory influencing how content was classified into codes and labeled (e.g., assessors’ exposure to the Interpersonal Theory of Suicide likely influenced our selection of the term “burden” in the code “Responsibility to Others/Concern About Burdening Others by Dying”). Nevertheless, steps were taken to ensure all meaningful information was abstracted and our final framework for our results represents a credible account of the data. For instance, words and phrases that could not be coded initially were reviewed multiple times to determine if they represented a new code or a subcategory of an existing code (Hsieh & Shannon, 2005). Team discussions were held to compare assessors’ codes for overlap and divergence, foster dialog about our segmentation, organization and interpretation of the data and ensure each coder’s perspectives were considered (Williamson et al., 2018). Additional codes were created as needed and a single representative label for each code was agreed upon such that we would be able to assess degree of consistency of codebook application. Our initial coding manual included 80 codes. Importantly, this coding system was developed with the aim of comprehensively *describing* our data and deepening our understanding of how participants experience inflection points. Interpretations of data from each of the coders were incorporated into the codebook. Intercoder reliability was assessed to capture the degree to which the two assessors could apply the coding system consistently post-development, and to help refine the system further (e.g., foster discussion about any concepts that may be going uncaptured at this stage in the analysis).

Before double-coding a sizable quantity of data to establish intercoder reliability, we first sought to identify and correct any easily soluble issues with the coding scheme by double-coding a small subset of data (see O’Connor & Joffe, 2020). Each of the coders independently applied this 80-code scheme to

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half of the responses from an item assessing factors that made participants stop from making a suicide attempt (approximately 45 unique responses for each coder) to determine areas for further refinement, discuss difficulties in code application, and differences in the interpretations of the codes and text. Comparison of code application at this stage was intended to reveal any clear problems with code definitions or interpretations that could be addressed (O'Connor & Joffe, 2020). An iterative approach was used where codes were scrutinized, expanded, modified, or discarded to promote the most rigorous and valid analysis (yielding 87 codes).

Next, using a positivist approach (i.e., coding reliability), assessors independently applied the coding scheme to approximately 30% of the remaining data to establish their degree of intercoder reliability. This subsample of responses spanned all four inflection point items and every participant had at least one of their responses coded to ensure representativeness of the entire dataset (consistent with recommendations by O'Connor & Joffe, 2020). Coders demonstrated an acceptable degree of intercoder reliability (80.58% agreement), particularly given the large number of codes in our scheme. The coding team discussed each incident of code discrepancy, jointly made final code selections for this portion of the data and made minor refinements to three codes before proceeding.¹ Assessors split and independently coded the remaining 70% of the data with the final 89-code scheme (see Table 1). To provide an estimate of intercoder reliability, we calculated an overall (i.e., averaged) Cohen's kappa (κ) across all responses coded by both assessors. Cohen's kappa is a commonly used metric of reliability across raters, given its ease of calculation for large coding schemes and ability to correct for chance agreement (i.e., the probability that coding agreement occurs by chance across raters; Cohen, 1960; McHugh, 2012) (see Online Supplement for further detail for choice of inter-rater agreement metrics). Intercoder reliability was strong overall ($\kappa = 0.88$, $SD = 0.21$; ranging from 0 to 1, or no agreement to perfect agreement; Cohen, 1960), especially considering the number of codes generated.

¹ Specifically, "loved ones/important others" were separated from "unspecified others," delineating "distraction" as a coping skill from "passive distraction", and rephrased a code labeled "negative affect" to "anticipated regret".

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To identify patterns in our data relevant to the research question, codes were then organized by the coding team into 17 higher-order themes and 10 subthemes by the team lead (Boyatzis, 1998). To be consistent with recent research concerning moments before SDV (e.g., Gunn et al., 2024), we allowed for as many themes and sub-themes as constructed from the data to capture the full nuance of inflection points. Feedback on theme structure was then gathered from the lived experience experts and other co-authors (Boyatzis, 1998). Themes were finalized when the qualitative analysis team could agree that textual evidence supported theme inclusion. Exemplars that best capture each theme were selected for reference (see Online Supplement Table 2). To ensure consistency, raters re-examined the established hierarchies and concluded that all relevant data had been best represented before proceeding. A collaborative and iterative approach enacted by multiple assessors enabled us to preserve the integrity of the data and reduce inaccuracies in interpretation.

Results

Finalized codes, themes, and subthemes as well as their frequency counts are reported in Table 1. Counts are provided by type of question: suicide-specific vs. non-suicidal self-injury. Seventeen major themes and their subthemes are presented below with textual examples of major themes presented in Online Supplement Table 2.

Social Contact

This theme emerged in 16.6% of participant responses. Respondents referenced social interaction(s) or interpersonal exchange(s) across both self-injury and suicide-related prompts when reflecting on their inflection points. Some participants referenced specific interactions and/or moments of interpersonal connection (see Online Supplement Table 2 for a sample quote), whereas others discussed generally increasing social activities or interpersonal engagement more broadly. Five participants (all of whom were Scottish, White and in their early-to-mid-twenties) cited interpersonal disclosure regarding their self-injury urges, behaviors, or mood-related difficulties as pivotal to their disengagement from self-injury. Subthemes emerged for both *supportive social interactions* (e.g., support seeking, feeling a

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connection to others in the moment of contemplating suicide or self-injury) and *receiving contact from others* (e.g., receiving a call or text).

Protective Relationships

This theme was observed in 6.5% of participant responses. Respondents described important relationships and social supports as contributing to halting their engagement in self-injury and suicide. Some described being reminded of a loved one as a deterrent from self-injury (e.g., seeing a photo of family or friends, hearing a roommate snoring in the next room, thinking of loved one's care for them; see Online Supplement Table 2 for a sample quote). Two participants (i.e., a White, heterosexual man and woman from Scotland) expressed that they were deterred from suicide because dying would part them from loved ones "leav[ing them] behind." Although multiple interpersonal themes emerged, codes within this theme do not refer to a specific social interaction, but rather capture that *relationships* can function to halt the process of self-injury.

Concern for Negative Impact on Others

Another relational theme emerged in more than one-third (33.7%) of responses. Respondents expressed ceasing self-injury or attempting suicide due to concerns that such behavior would negatively impact other people. Participants endorsed concerns about causing others emotional pain, that others would miss them, and that others would experience guilt or be blamed for their self-injury or death. Some respondents described having been negatively impacted by another's self-injury or suicide and wanting to avoid making a similar interpersonal impact. Several respondents discussed fears that loved ones would find their body, witness their self-injury, or be distressed by evidence of their self-injury (e.g., scars, cuts) as pivotal reasons for halting a self-injury or suicide attempt. Finally, many participants raised their responsibilities to others as a deterrent to engaging in self-injury (e.g., parental concerns about caretaking for their children if they were to die, concern for family members who rely on them, concern for pets' survival; see Online Supplement Table 2 for a sample quote) or voiced concerns that their self-injury/death would burden loved ones (e.g., financial impact on others, not wanting family to have to go

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through their personal belongings) (see Online Supplement for more details about types of familial contacts).

Concern for Negative Consequences on Oneself

This theme emerged in 16.1% of responses. Respondents also reported concern for an array of negative personal consequences when identifying pivotal processes that stopped them from engaging in self-injury/suicide. These included: fear of becoming reliant on self-injury or that self-injury would become habitual, fear of punishment for engaging in self-injury (from parents), and fear of surviving a suicide attempt and the subsequent consequences (e.g., becoming disabled, being seen as “attention seeking,” having a lower quality of life; see Online Supplement Table 2 for an example quote). Some participants reported that reflecting on their own previous consequences for self-injurious behaviors helped prevent recurrence. Two subthemes emerged within this theme. First, participants endorsed concern for *interpersonal consequences* (i.e., judgement and/or anger from others, being asked about their self-injury, or having to explain it). Second, several participants expressed concerns around *hospitalization* (either being hospitalized or reflecting on past hospitalizations as a deterrent).

Lack of Resources

This infrequent theme was observed in 3.5% of participant responses. At times, participant responses described logistical barriers that prevented engagement in self-injury (e.g., being expected somewhere, being grounded, lack of knowledge about how to self-injure “correctly”). Some described lacking access to a preferred method or reported that their means of self-injury was otherwise unsuitable (e.g., having too few doses of a medication to end [their] life, only having access to a weak rope or a blunt knife). Finally, some participants described lacking the energy to enact self-injury or suicide (see Online Supplement Table 2 for an example quote), at times, due to conditions like depression.

Physical Deterrents

This theme emerged in 18.1% of responses. Respondents discussed a number of physical deterrents associated with self-injury, yet only one response included mention of physical deterrents in

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relation to suicide (specifically regarding fear of pain). Three participants (i.e., all of whom were White women and two of whom were of sexual minority status [i.e., pansexual and bisexual]) reported finding the process of cleaning up after self-injury too aversive or too tiring. One of these participants also commented that the itching during the healing process post-injury was another deterrent. In response to the self-injury prompt, two respondents discussed concerns that they may accidentally cause themselves worse injury than intended. Two subthemes were identified in this theme. Several responses discussed concerns related to experiences of *pain/injury* (e.g., dislike of pain, aversion to blood, feeling “squeamish”), and *scarring* (e.g., feeling compelled to hide scars, fear that others will see scars, that scars may interfere with attaining/maintaining a job; see quote in Online Supplement Table 2).

Emotional Deterrents (Negative Affect Associated with Self-Injury)

Approximately one in ten (10.3%) of participants endorsed this theme. A number of affective or emotional deterrents were identified in our analysis. Participants described: anticipated regret, guilt, and embarrassment related to their self-injury/suicidal urges, as well as anticipated shame, were they to follow through (see quote in Online Supplement Table 2). *Fear* was generated as a prominent subtheme, with participants describing being afraid of the experience of death (e.g., general fear of dying, fear of the unknown or what it would be like to be dead), fearing the act of self-injury (rather than pain or the consequential injury), and unspecified fear such as generally “lacking the courage.”

Disruption

This infrequent theme emerged in 2.8% of participant responses. Some participants indicated that they did not follow through with their self-injury or suicide attempt because someone physically interrupted them (e.g., the participant’s dog approaching them, a child or romantic partner entering the room, “interference” from others; see Online Supplement Table 2 for an illustrative example). Two participants (i.e., A White, heterosexual Scottish man and woman in their twenties) indicated that they became distracted by “something else” (distinct from deliberately engaging in distraction as a coping skill).

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Self-Deterrence

This infrequent theme emerged in 1.8% of responses. This theme captures negative strategies that nevertheless reportedly facilitated disengagement from either a suicide attempt or self-injury. Participants endorsed engaging in non-lethal forms of self-injury as an alternative to suicide (see quote in Online Supplement Table 2). One 28-year-old White, heterosexual Scottish woman described taking medications slowly so that she would “[have] a panic attack where I would black out [and feel] very, very unwell before I could overdose to a fatal amount.” Four respondents (all of whom were White women in their twenties and three of whom were of sexual minority status [i.e., bisexual and lesbian]), discussed engaging in self-criticism to deter self-injurious action (e.g., “Feeling like I would be even more worthless and pathetic if I did [self-injure],” framing past self-injurious acts as “selfish”).

Use of Adaptive Coping Methods to Deter Self-Injury

This theme was observed in 22.2% of cases. Respondents also described more adaptive methods of coping with suicidal and self-injurious urges. Some referenced relying on their spirituality or religion, and a subtheme was identified for *skill use*. Participants described using general coping skills and engaging in general “self-care,” deliberately waiting for a crisis to pass, engaging in mindfulness or meditation, redirecting their attention or efforts toward something helpful or positive (see quote in Online Supplement Table 2), mental encouragement (e.g., “just keep going”), or deliberate distraction until self-injury/suicide urges lessened. The Online Supplement contains further detail regarding use of the general use of coping skills code.

Perspective Changes

This theme was observed in 15.4% of participant responses. A major theme identified changes in perspective as halting engagement with self-injury and suicide. Participants described deliberately challenging their perspective through cognitive reframing. Examples of such reframing include (1) attempting to “see the glass half full;” (2) reminding themselves that they went through these difficulties previously and the stress will pass; (3) thinking about how they were being harmful to their future self;

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realizing that negative affect is temporary; and (4) reminding themselves of the “good things in life”.

Deliberate challenging also included reflecting on the ways in which self-injury/suicide are ineffective or get in their way in both the long-term and the short-term (see an illustrative quote in Online Supplement Table 2). Some described coming to understand self-injury as “pointless,” “futile,” or that it “wasn’t going to fix the situation, only make it worse.” One 24-year-old, White, bisexual woman from England expressed her belief that death, ultimately, would not relieve her pain. Some reported beginning to think about self-injury and suicide as being “wrong” or knowing that it “was something I shouldn’t do.” Others reported simply changing their mind or “deciding not to anymore.”

Creating a Better Life

This infrequent theme emerged in 2.8% of responses. Participants frequently referenced efforts to create a worthwhile life as pivotal to their decisions to disengage from self-injury or suicide. Some referenced removing factors that made their life distressing (e.g., changing their environment, leaving an unhealthy relationship or workplace, reducing access to means or risky situations; see Online Supplement Table 2 for a quote), or adding meaningful relationships and sense of purpose to their life (e.g., increasing social activities, improving mental health). Participants also described wanting to keep valuable progress, experiences, and tangibles that might be “ruined” by self-injury. For example, some described wanting to build on a period of abstinence from self-injury, and one participant discussed wanting to preserve a tattoo that was covering scars from prior self-injuries.

Thinking About the Future

This theme was observed in 4.8% of responses. Many respondents discussed building hope for the future and cultivating a belief that things would get better as a pivotal inflection point. Some discussed reflecting on life events they were looking forward to, goals that they wanted to achieve, or activities they wanted to experience (see Online Supplement Table 2 for a sample quote), or conversely, activities and events they would miss out on if they were to die by suicide or self-injure. Participants also discussed near-term commitments they made as deterrents from self-injury or suicide, even if those events and

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activities were not presented as personally important. For example, a 21-year-old White, Scottish, woman who identified as bisexual reported “an event got moved to an easier time and when that came around I didn’t want to any more.”

Engagement with Healthcare

This theme was observed in 4.0% of cases. Participants discussed engagement with the healthcare system across both self-injury and suicide prompts. A 26-year-old, White, heterosexual woman from Scotland discussed engaging with the NHS crisis line, whereas others described seeking general resources, “getting professional help,” or counseling as pivotal to their decision to disengage with self-injury or suicide attempts (see Online Supplement Table 2). Two subthemes were constructed: type of *provider* and *treatment experiences*. Participants discussed a few specific experiences with physicians, therapists, and medication in response to the suicide specific prompts. Respondents raised positive experiences with therapy for treating self-injury only slightly more frequently.

Positive Affect

This infrequent theme emerged in 1.8% of participant responses. Some respondents referred to love for themselves or others and self-compassion as important contributors to their decision to discontinue self-injury. As reported in Online Supplement Table 2, a 38-year-old, White, heterosexual woman wrote “[I] decided I deserved better for myself.”

Ambivalence

This infrequent theme was observed in 2.3% of cases. A theme of ambivalence about death and its finality was also generated. Relevant responses conveyed uncertainty or mixed feelings about death (see Online Supplement Table 2 for an illustrative example) about the permanence of death, or “actually dying.”

No Inflection point/Not applicable

A minority (4.0%) of participant responses had no relevant themes. These respondents indicated that they did not experience a specific inflection point. Some participants highlighted that their change in

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decision was very gradual, that many factors contributed, or that no identifiable contributor was pivotal in their experience. Finally, three responses contained content that was unrelated to the prompts (e.g., complaining about therapists overall) and were coded as not applicable.

Discussion

The purpose of the study was to understand what factors were identified by adults with suicide and/or self-injury lived experience as important in halting these behaviors. We termed this pivotal timeframe "inflection points." Overall, the most common themes (with example subthemes) among inflection points (in descending order) were: concern for the negative impact on others (33.75%; e.g., fear of hurting loved ones), use of adaptive coping methods (22.17%; e.g., general use of coping skills), physical deterrents (18.14%; e.g., scarring, pain), social contact (16.62%; e.g., sense of connection in the moment), and concern for negative consequences on oneself (16.12%; e.g., fear of punishment).

In the sample, there was more self-injury focused content compared to suicide; as such, we compare codes across SDV subtypes by percentage. The most common themes for halting self-injury were (in descending order): physical deterrents (32.42%), use of adaptive coping (29.68%), perspective change (22.37%), concerns about the negative consequences for oneself (21.46%), and concerns about the negative consequences on others (20.55%). The most common themes for halting suicide were (in descending order): concerns about the negative consequences for others (50.0%), social contact (14.61%), emotional deterrents (12.92%), use of adaptive coping (12.92%), and protective relationships (10.11%). Thus, SDV subtypes share a focus on use of coping skills. However, self-injury inflection points appear to be heavily centered on intrapersonal factors/focus on the self (e.g., physical deterrents on the body/pain; perspective change/reframing one's situation; negative personal consequences such as hospitalization or perceived judgment). On the contrary, suicide inflection points appear more interpersonal in nature (e.g., negative impacts on other persons such causing them emotional pain or burden; having any or a supportive social contact; reflecting on supportive relationships). In the following sections, we place

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inflection point findings in the context of existing SDV literature, followed by review of implications for clinical practice, theory, and research.

Inflection Points: Toward an Understanding of Stopping Suicide and Self-Injury in the Moment

The overall trend of inflection points content dovetails well with existing research on drivers or buffers in the immediate moments preceding SDV. For instance, Cascade Model (Selby & Joiner, 2009; Selby et al., 2021) work implies that there is need for adaptive coping in the moments immediately preceding self-injury. Likewise, Kaniuka and colleagues (2024) identified several factors that helped limit suicidal thinking: mental health services, coping/emotion regulation, connecting to others, and identifying reasons for living. Our overall findings align well in that adaptive coping and several manifestations of social connect matter in ceasing SDV. We also identified additional themes (e.g., healthcare interactions) that align with prior work (e.g., Kaniuka et al., 2024), although these examples were quite infrequent inflection point factors. Finally, our detection of inflection point themes across SDV highlights the role of several important protective factors also present in the general suicide literature. These include, but are not limited to, hope, life meaning/meaning making (creating a better life), self-compassion (e.g., Clement et al., 2020; Kleiman & Beaver, 2013; Per et al., 2022). It appears that the some of the same factors driving or halting SDV in general may be relevant to inflection points.

At the same time, examining the nuance between suicide and self-injury, as assessment and intervention for SDV subtypes may necessitate attention to unique matters. Self-injury inflection points were highly characterized by a variety of intrapersonal themes. Physical deterrents (e.g., fear of others seeing/having to conceal scars), for instance, may be unique to the experience of self-injury. Extant literature suggests an intricate association of physical deterrents and self-injury. Scarring can stunt recovery after self-injury (Lewis, 2016), and greater concealment of scars is associated with stronger self-injurious urges (Burke et al., 2020). Also, higher pain tolerance and thresholds are associated with increased self-injury (Koenig et al., 2016). In the context of inflection points, concern about these physical deterrents appear protective. Intrapersonal focus in self-injury inflections points goes beyond the

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body. These included affect (e.g., fear of becoming reliant on self-injury), cognition (e.g., reframing self-injury as unhelpful/dysfunctional), and responses to other people (e.g., having to respond to questions about one's self-injury). The use of successful coping skills coupled with reframing of self-injury is also consistent with a functional understanding of self-injury (e.g., Klonsky, 2009), in which self-injury often serves as a maladaptive coping technique in the absence of healthy coping. Our findings suggest there is value for adaptive skills training in halting self-injurious behavior.

Suicide inflections points were largely characterized by concerns about the impact of suicide on other persons. These included general concern for loved ones, anticipation about finding the body, and inflicting emotional pain or burdensomeness. Suicide inflection points also contained a clear role for social connection in forms such as social contact, reflecting on social support, or having positive social interaction. The interpersonal pattern fits with a dense literature showing aspects such as (thwarted) belonging, social support, and burdensomeness impact suicidal thinking and behavior (e.g., Chu et al., 2017; Kleiman & Liu, 2013; Van Orden et al., 2010). Suicide inflection points appear aligned with suicide literature overall regarding interpersonal influences. The centrality of interpersonal factors in suicide inflection points is augmented by emotional deterrents. The anticipation of an array of negative emotions (e.g., fear, guilt, embarrassment) contributed to halting a suicide attempt. While presence of such negative affective states can be characteristic of someone in suicide crisis (Rudd, 2006), in inflection point moments, the anticipation of feeling this way may help cease a suicide attempt.

Implications for Clinical Practice, Theory, and Research

Inflection points results hold a number of clinical implications. Adaptive coping was a cross-cutting theme in ceasing SDV, whereas perspective changing (e.g., reframing) was prominent in self-injury inflection points. These findings substantiate therapeutic interventions designed for SDV that teach cognitive reframing, emotion regulation skills, and other behavioral coping techniques. Such approaches specific to SDV in the literature include Dialectical Behavior Therapy (DBT; Linehan, 2014) and Brief Cognitive-Behavioral Therapy for Suicide (BCBT; Bryan & Rudd, 2018). These interventions may have

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value regardless of the SDV subtype, especially for persons at-risk for acute suicide or self-injury urges. Our findings inform DBT conceptualization as well. The DBT behavior chain analysis examines consequences of behavior (Rizvi & Ritschel, 2014). While such consequences are typically emotional, social, financial, or professional, our findings suggest clinicians may address possible self-injurious behavior consequences present in themes like psychiatric hospitalization, scarring, and interpersonal strain. Inflection points can inform what content or how clinicians conduct this discussion within a DBT framework.

Equally important to long-term therapeutic approaches are short-term safety or crisis response planning interventions. These interventions (Bryan et al., 2017; Jobes, 2023; Stanley & Brown, 2012) share integration of coping skills, emergency contacts, social support, and lethal means reduction. Crisis Response Planning (CRP) within BCBT (Bryan et al., 2017; Bryan & Rudd, 2018) also integrates aspects such as reasons for living and a coping card. Inflection point findings inform content to integrate within these approaches. For instance, our findings suggest a range of coping skills such as deliberately waiting for a crisis to pass, engaging in mindfulness or meditation, redirecting their thoughts toward something positive, or deliberate distraction may help. Further, it may be helpful to incorporate further protective factors, such as an expanded conceptualization and discussion of reasons for living (e.g., future activities a person has committed to/desires to do; identifying activities that enhance life meaning).

Our findings hold additional clinical implication for the role of social interaction. We found that both general and supportive interactions can be important in suicide inflection points. Indeed, it may be that low effort, "everyday" interpersonal interactions can still be very important for helping ceasing suicide attempts. Likewise, germane to self-injury, people sometimes seemed to use interactions as a safeguard against behavior even though the function of the interaction was not explicitly described as supportive. In short, there may be importance of any connectedness for SDV inflection points. This speaks to the significance of scaling up socially-based SDV prevention efforts that enhance generally or

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intentionally supportive interactions. Examples include caring contacts (Skopp et al., 2023) and suicide awareness campaigns (Torok et al., 2017).

Inflection point themes are theoretically relevant. First, inflection point findings are consistent with premises offered by the Cascade (Selby & Joiner, 2009) and SuRAP (Kaniuka et al., 2024) Models, respectively. The Cascade view of self-injury focuses on intrapersonal processes (e.g., negative affect, emotion regulation deficits) resolved through effective coping skills (Selby et al., 2021). Self-injury inflection points largely mirror the intrapersonal and coping skill emphases. At the same time, the SuRAP observed coping/emotion regulation, connecting to others, and identifying reasons for living as halting suicidal thinking among SGM persons. Similar factors appear to function in suicide inflection, pointing to a possible widely applicable aspect of the SuRAP. Another theoretically relevant finding concerns the possible adaptive nature of fear and ambivalence. The Interpersonal Theory of Suicide (Van Orden et al., 2010) suggests fearfulness of death is a protective factor within the acquired capability for suicide. Inflection points themes showed that wide ranging fear or ambivalence may be protective across types of SDV. For example, we observed themes concerning fear of hurting others, someone witnessing the self-injury, finding the body after one's suicide death, others seeing self-injury scars, pain, death, and generalized/unspecified fear. The clear impact of fear/ambivalence in inflection points fits more broadly with recent research examining fearlessness of and anxiety about death applied to self-injury and suicide risk as well (e.g., Rogers et al., 2022; Sims et al., 2024). Moving forward, fear and ambivalence warrant more conceptual and empirical attention within suicide and self-injury theory development.

Given this is the first study on SDV inflection points, we consider it premature to offer a theory or model. With that said, findings offer a number of testable questions and future research directions. Given we observed a stark intrapersonal (self-injury) versus interpersonal (suicide) distinction in inflection points, future research should seek to replicate this trend and understand causal mechanisms underpinning this pattern. It remains an open question whether inflection point factors fluctuate in short timeframes and in a manner explicating the ceasing of SDV in the moment. Methodologically, there may be value in

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applying EMA to assess inflection points in real-time to deepen our understanding of successful halting of suicidal and self-injurious behavior. Finally, the sheer volume of themes identified in the present study depicts the nuance in inflection points. A next step toward capturing the full scope of inflection points may be development of an inflection points scale, accounting for both suicide and self-injury.

Limitations stemming from the choice of methodology must be recognized. This study asked for long-term retrospective responding, raising the possibility of recall bias or memory inaccuracy. Future inflection points research should be conducted more proximally to the halted SDV event. As the data were collected through open-ended questions as part of a survey, there were no opportunities for the research team to ask follow-up questions or to ask for elaboration. Structured or semi-structured interviews would have allowed such depth of data collection. This data collection choice limited the level of detail and depth of responses provided by the individual. An example of how these questions could have been expanded can be seen in requesting information about how long ago the behavior happened, and the severity or nature of halted suicide attempts and self-injury. Also, with such a data collection approach it is important to highlight the inability to member check. Doing so would ensure participant voices were accurately reflected in the analyses. Further, though a number of data cleaning steps were employed to ensure data quality, the original survey design largely lacked mechanisms to eliminate bots and other nefarious responding. This must be recognized within the growing concern of fraudulent participation in qualitative research (Ridge et al., 2023). While our study highlighted the multitude of reasons that might impact an individual's decision not to engage in SDV, our study was unable to examine whether some reasons might be more important than others. Understanding this issue has relevance for assessment and intervention development and should be explored further. Regarding the sample, the sample was demographically restricted (e.g., with regard to race). We also did not examine differences across groups within our sample, partially due to low cell counts in some themes/subthemes, and demographic categories. Future inflection points research should expand the cultural diversity of sampling.

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Table 1.

Finalized coding scheme and frequencies organized by theme and subtheme.

Themes and Subthemes	Codes	Total Frequency Count (%)	Number of Persons Endorsing (%)	Frequency for self-injury related Items (%)	Frequency for Suicide related Items (%)
1. Social Contact		66(16.62)		40(18.26)	26(14.61)
	Had Social Contact	26(6.55)	18(9.63)	16(7.31)	10(5.62)
	Specific Social Interaction	11(2.77)	9(4.81)	5(2.28)	6(3.37)
	General Social Contact/ General Socialization	5(1.26)	5(2.67)	4(1.83)	1(0.56)
	Initiated a Social Interaction	6(1.51)	6(3.21)	4(1.83)	2(1.12)
	Disclosure to Close Others	5(1.26)	5(2.67)	4(1.83)	1(0.56)
<i>Supportive Social Contact</i>					
	Social Support	3(0.76)	2(1.07)	2(0.91)	1(0.56)
	Sense of Connection in the Moment	8(2.02)	7(3.74)	5(2.28)	3(1.69)
<i>Receiving contact from others</i>					
	Received a Text	1(0.25)	1(0.53)	0	1(0.56)
	Received a Call	1(0.25)	1(0.53)	1(0.46)	0
2. Protective Relationships		26(6.55)		8(3.65)	18(10.11)
	Reflecting on Social Supports	20(5.04)	19(10.16)	8(3.65)	12(6.74)
	Experiencing Reminder(s) of Loved Ones/Other People	4(1.01)	4(2.14)	0	4(2.25)
	Wanting to Avoid Losing Important Relationships via Self-Injury	2(0.50)	2(1.07)	0	2(1.12)
3. Concern for Negative Impact on Others		134(33.75)		45(20.55)	89(50)
	Reflecting on Persons who Would Miss Me	5(1.26)	5(2.67)	0	5(2.81)
	Fear of Hurting Others or Causing Emotional Pain	53(13.35)	36(19.25)	19(8.68)	34(19.10)
	General Concern for Loved Ones	34(8.56)	30(16.04)	9(4.11)	25(14.04)
	Responsibility to Others/Concern About Burdening Others by Dying	16(4.03)	14(7.50)	3(1.37)	13(7.30)
	Worry that Others Would Feel Guilt or Blame for My Death/Injury	6(1.51)	2(1.07)	2(0.91)	4(2.25)
	Fear of Others Finding My Body	9(2.27)	8(4.28)	0	9(5.06)
	Fear of Others Witnessing My Self-Injury	7(1.76)	7(3.74)	7(3.20)	0

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	Lived Experience with Others' Self-injury/Suicide and the Interpersonal Impact	9(2.27)	8(4.28)	5(2.28)	4(2.25)
4. Concern for Negative Consequences on Oneself		64(16.12)		47(21.46)	17(9.55)
	General Fear of Negative Consequences	11(2.77)	11(5.88)	9(4.11)	2(1.12)
	Fear of Becoming Reliant on Self-Injury	3(0.76)	2(1.07)	3(1.37)	0
	Remembering Own Previous Consequences	8(2.02)	7(3.74)	6(2.74)	2(1.12)
	Fear of Surviving Suicide Attempt and Subsequent Consequences	5(1.26)	5(2.67)	0	5(2.81)
	Fear of Punishment	1(0.25)	1(0.53)	1(0.46)	0
<i>Interpersonal Consequences for the Respondent</i>					
	Fear of Judgement from Others	11(2.77)	11(5.88)	7(3.20)	4(2.25)
	Fear of Anger from Others	1(1.26)	1(0.53)	0	1(0.56)
	Fear of Being Asked about Self-Injury/Having to Explain	18(4.53)	17(9.09)	18(8.22)	0
<i>Hospitalization</i>					
	Reflecting on Own Previous Hospitalization	3(0.76)	3(1.07)	1(0.46)	2(1.12)
	Fear of Hospitalization	5(1.26)	4(2.14)	3(1.37)	2(1.12)
5. Lack of Resources to Self-Injure/Complete Suicide		14(3.53)		7(3.20)	7(3.93)
	Logistical Barriers	5(1.26)	4(2.14)	1(0.46)	4(2.25)
	Inadequate Access to Means	6(1.51)	6(3.21)	4(1.83)	2(1.12)
	Lack of Energy to Enact Self-Injury	6(1.51)	6(3.21)	4(1.83)	2(1.12)
6. Physical Deterrents		72(18.14)		71(32.42)	1(0.56)
	Having to Clean up	3(0.76)	3(1.07)	3(1.37)	0
	Itching Following Self-Injury	1(0.25)	1(0.53)	1(0.46)	0
	Fear of Enacting More Severe Injury than Intended	3(0.76)	3(1.07)	3(1.37)	0
<i>Pain</i>					
	Dislike of Pain/Injury	5(1.26)	5(2.67)	5(2.28)	0
	Fear of Pain	12(3.02)	7(3.74)	11(5.02)	1(0.56)
<i>Scarring</i>					
	Scarring/Having to Hide Scars	19(4.79)	16(8.65)	19(8.68)	0
	Fear of Others Seeing Scars	29(7.30)	24(12.83)	29(13.24)	0
7. Emotional Deterrents (Negative Affect Connected to Self-Injury)		41(10.33)		18(8.22)	23(12.92)
	Shame	8(2.02)	8(4.28)	6(2.74)	2(1.12)
	Guilt	6(1.51)	5(2.67)	0	6(3.37)

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	Embarrassment	6(1.51)	4(2.14)	3(1.37)	3(1.69)
	Anticipated Regret	6(1.51)	5(2.67)	5(2.28)	1(0.56)
<i>Fear</i>					
	Fear of the Experience of Death	4(1.01)	4(2.14)	0	4(2.25)
	Fear of Enacting Self-Injury	2(0.50)	2(1.07)	1(0.46)	1(0.56)
	Unspecified Fear	9(2.27)	9(4.81)	3(1.37)	6(3.37)
8. Disruption		11(2.78)		3(1.37)	8(4.49)
	Interrupted (Not via Text/Phone Call)	8(2.02)	8(4.28)	0	8(4.49)
	Become Distracted	3(0.76)	3(1.07)	3(1.37)	0
9. Self-Deterrence		7(1.76)		1(0.46)	6(3.37)
	Harm Reduction Approach (e.g., Use Less Lethal Means to Self-Injury)	1(0.25)	1(0.53)	0	1(0.56)
	General Maladaptive Coping	2(0.50)	2(1.07)	0	2(1.12)
	Engage in Self-Criticism	4(1.01)	4(2.14)	1(0.46)	3(1.69)
10. Use of Adaptive Coping Methods		88(22.17)		65(29.68)	23(12.92)
	Spirituality/Religious Faith	4(1.01)	2(1.07)	3(1.37)	1(0.56)
<i>Skill Use</i>					
	General Use of Coping Skills	49(12.34)	40(21.39)	38(17.35)	11(6.18)
	Riding Out a Crisis Passing	10(1.52)	9(4.81)	5(2.28)	5(2.81)
	Mindfulness or Meditation	6(1.51)	5(2.67)	5(2.28)	1(0.56)
	Redirecting Attention/Behavior to Something Helpful/Positive	12(3.02)	10(5.35)	7(3.20)	5(2.81)
	Deliberately Distracting Oneself	7(1.76)	6(3.21)	7(3.20)	0
	General "Self-Care"	1(0.25)	1(0.53)	1(0.46)	0
11. Perspective Changes		61(15.37)		49(22.37)	12(6.74)
	Positive Reframing	12(3.02)	11(5.88)	5(2.28)	7(3.93)
	Reflection on Self-Injury as Unhelpful/Non-Functional	35(8.82)	30(16.04)	34(15.53)	1(0.56)
	Reflection on Self-Injury as Problematic	5(1.26)	4(2.14)	4(1.83)	1(0.56)
	Changing Mind about Willingness to Engage in Self-Injury	8(2.02)	8(4.28)	5(2.28)	3(1.69)
12. Creating a Better Life		11(2.78)		8(3.65)	3(1.69)
	Removing Motivating Factors for Self-Injury	5(1.26)	5(2.67)	4(1.83)	1(0.56)
	Improving Life	2(0.50)	2(1.07)	0	2(1.12)
	Wanting to Avoid Ruining Something Valuable/Build on Progress	4(1.01)	4(2.14)	4(1.83)	0

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13. Thinking About the Future		19(4.79)		5(2.28)	14(7.87)
	Experiencing Hope for the Future	7(1.76)	6(3.21)	0	7(3.93)
	Reflecting on Upcoming Experiences/Commitments	7(1.76)	7(3.74)	5(2.28)	2(1.12)
14. Engagement with Healthcare		16(4.03)		8(3.65)	8(4.49)
	Crisis Call	2(0.50)	1(0.53)	0	2(1.12)
	Unspecified Help-Seeking or Resource Provision	4(1.01)	4(2.14)	4(1.83)	0
<i>Engagement with Provider</i>					
	Physician/Doctor	2(0.50)	2(1.07)	0	2(1.12)
	Therapist	1(0.25)	1(0.53)	0	1(0.56)
<i>Engagement with Treatment</i>					
	Taking Medication	1(0.25)	1(0.53)	1(0.46)	0
	Unspecified Treatment	1(0.25)	1(0.53)	0	1(0.56)
	Therapy	1(0.25)	1(0.53)		1(0.56)
	Positive Therapy Experience	5(1.26)	5(2.67)	3(1.37)	2(1.12)
	Negative Therapy Experience	1(0.25)	1(0.53)	0	1(0.56)
15. Positive Affect		7(1.76)		6(2.74)	1(0.56)
	Love	3(0.76)	2(1.07)	2(0.91)	1(0.56)
	Self-Compassion/Care for Oneself	4(1.01)	4(2.14)	4(1.83)	0
16. Ambivalence		11(2.28)		1(0.46)	10(5.62)
	Expressing Ambivalence Around Self-Injury/Death	4(1.01)	4(2.14)	1(0.46)	3(1.69)
	Ambivalence about Death Due to its' Finality	6(1.51)	6(3.21)	0	6(3.37)
17. No Inflection Point		16(4.03)		8(3.65)	8(4.49)
	Denying Inflection Point or Pivotal Moment	13(3.27)	11(5.88)	7(3.20)	6(3.37)
	Response was Not Applicable to Prompt	3(0.76)	3(1.07)	1(0.46)	2(1.12)

Note. Proportions (%) for code frequency counts across self-injury and suicide related items are out of 219 and 178 responses, respectively. Proportions (%) for the total code frequency counts are out of 397 responses (i.e., including both NSSI and suicide-related items).

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Online Supplement

Inter-rater agreement metric selection. Krippendorff's alpha is an increasingly favored metric of inter-rater reliability given its flexibility with multiple raters and data types (i.e., ordinal, interval, and nominal), and its conservative estimate of chance agreement (Krippendorff, 2013; Lombard, 2002). However, there are practical challenges related to calculating this coefficient with large, heterogeneous sets of codes (O'Connor & Joffe, 2020; van Oest et al., 2019). There is some debate whether Krippendorff's alpha is always the most appropriate reliability metric, particularly given that coefficient differences are modest when calculating reliability between two raters via a large number of codes (Zapf et al., 2016; Zhao et al., 2018). Although accounting for the probability of chance agreement is important and necessary, we are less concerned about this being overly inflated in the present study given the sheer number of codes generated.

Coding for multiple meanings. We coded participant responses at face value, rather than making assumptions about what an individual may have experienced (e.g., concerns about what others might think were coded as "fear of judgement from others," but were not coded as guilt or shame unless those emotions were explicitly referenced). When responses were vague or had multiple potential meanings, we were occasionally able to use information from an individual's previous responses to provide context and aid in understanding of how best to apply codes within person (e.g., The response "Distraction" was coded as referring to an intentional form of coping rather than passively becoming distracted due to a second answer reading "averting thoughts to something else"). Occasionally, participants indicated that their response to an item was "the same" as their answer to the previous question. In those cases, we applied the same set of codes across the indicated items so as to capture accurate frequencies by question type (suicide-specific vs. non-suicidal self-injury)."

Family contact frequencies and coding. Frequencies for types of relationship referenced across responses are presented in Table 1. Of note, we coded "Family" whenever expressed verbatim, and also coded it alongside "children" and "parents," to get a sense for how often family were referenced (excluding partners and pets). We applied the code "Loved Ones or Significant Others" when a response referenced an important person like a roommate or unspecified important person(s). It is likely that there may be some overlap between "significant others/loved ones" and other types of relationships (e.g., when responses reference "hurting others" participants may be referring to a combination of family and friends).

Use of general coping skills code. Assessors applied the "General Use of Coping Skills" code when responses were nonspecific (i.e., participants did not specify the type of coping strategy) and also whenever a more specific code was applied. This allowed us to derive a meaningful frequency count reflecting skills use of any kind in Table 1.

Methodological integrity. We followed guidelines provided by the American Psychological Association (Levitt et al., 2018) to ensure methodological integrity for qualitative design and analysis. The overarching goal of the present analysis was to deepen our understanding of inflection points as they are experienced by persons who have engaged with self-injury and suicide attempts. We used open-ended questions as part of an anonymous (see survey description details in primary manuscript measures section). Although responses to study questions were brief (ranging from a few words to a few sentences), meaningful information was extracted and organized into codes and broader themes that complement existing literature. Future qualitative research using an interview-based approach across more diverse samples (e.g., variation by race, country of origin, sexual orientation) would be helpful for interpretability and forming more nuanced conceptual frameworks, as resulting data would undoubtedly describe inflection points with greater depth and offer opportunities for clarification and further probing. Data

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from the present analyses are useful for guiding future questions. Researcher's perspectives were managed in multiple ways. First, survey items were developed in collaboration with community members with lived experience. Persons with lived experience were also consulted about the organization and presentation of study themes prior to and following manuscript preparation. The coding team were selected based on (1) prior experience with qualitative analysis, and (2) prior experience researching and treating suicide and self-injury. Given that the study goals were largely descriptive, a coding scheme was developed with the intention of reliable/consistent application across participant responses, such that information on the relative frequency of codes/themes across items could be gleaned. The setting of the study was intentionally non-clinical in order to capture inflection points information among persons experiencing their everyday lives. Also, no participant exclusion criteria aside from country of current residence were applied in order to draw from the most representative sample possible. However, given the U.K. context and online data collection setting, the sample has obvious limitations with regard to selection bias (e.g. needing access to technology) and demographic representation (e.g., race).

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Table 1.

Sample demographic information.

	<i>M (SD)</i>
Age	26.58 (9.0)
	<i>N (%)</i>
Gender	
Woman	144 (86.74)
Man	21(12.65)
Nonbinary/Genderfluid	1 (0.60)
Transgender	1 (0.60)
Queer	1 (0.60)
Asexual	1 (0.60)
Something not listed	7 (4.22)
Race	
White	152 (91.57)
Multiracial	1 (0.60)
Asian	1 (0.60)
Region	
United Kingdom	160 (96.39)
Europe	3 (1.81)
North America	1 (0.60)
Africa	1 (0.60)
Something not listed	1 (0.60)
Relationship Status	
Single	45 (27.11)
Casually dating	17 (10.24)
Committed relationship – one partner	104 (62.65)
Lifetime self-directed violence*	
Suicide attempt	57 (34.34)
Aborted suicide attempt	98 (59.04)
Self-injury	125 (75.30)
Aborted self-injury	129 (77.71)

Note. *M* = Mean; *SD* = Standard deviation; *A participant can have more than one type of self-directed violence; therefore, the cumulative percentage exceeds 100%.

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Table 2.

Major theme domains with sample quotes

Theme Domain	Example Quote
1. Social Contact	"I was able to connect with a person who stood with me and spoke to me."
2. Protective Relationships	"Thoughts of loved ones and how they care for me."
3. Concern for Negative Impact on Others	"I stopped myself due to the fact that it would destroy my family."
4. Concern for Negative Consequences on Oneself	"Fear that it wouldn't work and I would be left with a lower quality of life."
5. Lack of Resources	"Was going to hang myself but didn't have the energy to set it up."
6. Physical Deterrents	"Not wanting scars, fear of people seeing."
7. Emotional Deterrents	"I wanted to be proud of myself, not ashamed."
8. Disruption	"Family member interrupted the process."
9. Self-Deterrence	"Allowing myself to self harm in order to not let myself do something worse."
10. Use of Adaptive Coping Methods	"Swapping out the knife for a pen was key to bring something creative out of something negative."
11. Perspective Changes	"I stopped self-harming as much because I came to the realization after years and years of it that it only caused me and those around me pain (physically for me and emotionally for those around me), it did not help solve my problems."
12. Creating a Better Life	"Removing the negative factors from my life which acted as a trigger."
13. Thinking About the Future	"The thought of all the amazing things life still has to offer in my future is usually what stops me from doing anything."
14. Engagement with Healthcare	"seeking counselling"
15. Positive Affect	"Decided I deserved better for myself."
16. Ambivalence	"As much as I really didn't want to live anymore, I also wasn't sure that I actually wanted to die."
17. No Inflection Point	"There was no pivotal moment."

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Appendix: Suicide/Self-Injury Inflection Points Questions

Instructions: The following items address self-injurious and suicidal behaviour. Self-injury is defined as any thinking or behaviour you have engaged in with the intent of doing physical harm to yourself for any reason other than to end your life. Suicidal behavior is defined as any thinking or behaviour focused on the intent to end your life.

1. Have you made an actual attempt to kill yourself in which you had at least some intent to die?

Yes No

2. Have you been close to making a suicide attempt, but at the last minute decided not to kill yourself?

Yes No

If yes to #2:

3. We are interested in the factors that made you stop from making a suicide attempt. Using the space below, please share with us your experience of what made you stop from attempting suicide:

If yes to #2:

4. We are interested in specific pivotal processes or moments that stopped you from making a suicide attempt. Please share with us a turning point for you that impacted your decision not to attempt suicide?

5. Have you ever injured yourself in a way but not with the intention of taking your own life?

Yes No

6. Have you been close to injuring yourself without the intent to die, but at the last minute decided not to injure yourself?

Yes No

If yes to #6:

7. We are interested in the factors that made you stop from engaging in self-injury. Using the space below, please share with us your experience of what made you stop from injuring yourself.

If yes to #6:

8. We are interested in specific pivotal processes or moments that stopped you from engaging in self-injury. Please share with us a turning point for you that impacted your decision not to injure yourself?
