Wording the pain:
An exploration of meaning-makings around emotions and self-injury

Daphne Josselin

Portfolio submitted in fulfilment of the
Professional Doctorate in Counselling Psychology (DPsych)

Department of Psychology, City University

October 2013

Table of contents

List of tables and figures

Acknowledgments

I would like to thank my supervisor, Professor Carla Willig, for inspiring the idea behind this project and for providing rigorous guidance and warm encouragement throughout. Huge thanks are also due to my research participant, Tina, who volunteered to share her experience and did so bravely, richly and repeatedly.

My family endured months of distraction and snappiness as I was plodding away, yet kept me fed, warm and (mostly) sane. Guys: you're the best.

Last, I owe my amazing cohort much of the learning I gained through this long training, and lots of fun besides. I felt supported online and off, and sharing my enthusiasm for this weird profession was empowering. So, to every single one of my 'shrink' friends: thank you.

Declaration

The author grants powers of discretion to the City University Librarian to allow this thesis to be copied in whole or in part without further reference to her. This permission, however, covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

Preface

This doctoral portfolio is about meanings: how we, as scientists and practitioners, try to make sense of psychological and behavioural phenomena. Each piece was completed during my training at City University, and provides evidence of the knowledge and skills I gained during that time. As will be further described below, each of the three components making up this thesis also represents one approach to sense-making around emotions and self-injury. Although their purpose and epistemological position differ, taken together they offer a rich picture of what counselling psychologists must engage with in their research and clinical work.

The first section presents a critical appraisal of the literature on emotion regulation skills training, and queries the way in which cognitive-behavioural therapists have embraced recent research on emotion dysregulation and developed new approaches to psychological disorders. The meaning-making process this review exemplifies is of the sort many would regard as 'scientific'. The literature being scrutinized is concerned with arriving at a consensual definition of emotions and emotion regulation; developing models and measurement tools to study them empirically; and eschewing individual understandings and social context to test hypotheses and produce generalizable results. These are then used to underpin therapeutic approaches aimed at addressing maladaptive deficits in emotion regulation, deficits presented as central to a wide range of psychological and behavioural difficulties, including self-injury. The review concludes that while treatments like dialectical behaviour therapy or mindfulness-based approaches are widely seen as beneficial to those receiving them, evidence that they actually improve emotion regulation remains sparse, and research in the field rife with methodological shortcomings. However the critique itself subscribes to a realist epistemology, since it rests on the assumption that the 'truth' of emotions awaits full discovery. It thus mirrors the approach to meaning-making around emotions adopted by quantitative researchers and CBT practitioners, one in which emotions can be labelled and quantified, and behaviours such as self-injury eliminated through manualised interventions.

The original piece of research presented in the second section stands in sharp contrast to this view, with its refusal to portray individual experience - very much including emotions - as made up of measurable phenomena. Here the idea is to explore the meaning-making process around self-injury by using an ideographic and pluralistic qualitative approach. One participant's account of her experience of self-injury and attending emotions is repeatedly analysed, each time using a different interpretative lens so as to avoid 'shoehorning' the behaviour into a particular theoretical frame. The text is visited first from a phenomenological perspective, using interpretative phenomenological analysis; then from a narrative perspective, drawing on linguistics and story-telling; and finally from a psychosocial perspective, combining discursive and psychoanalytical readings. The result is a multi-layered picture, one which emphasizes the highly individual nature of self-injury and of the emotional experiencing underlying it; and which acknowledges the role played by unconscious, linguistic, relational and social factors in any attempt at elucidating the behaviour. The work also points to the contribution of the researcher to the meaning-making process: not as neutral scribe or analyst, but as fully involved creator of meaning alongside the participant. Though rigorous it thus embodies a tentative and reflexive approach to scientific sense-making around self-harm and emotions, one that may hold particular relevance for counselling psychologists given its respect for individual experience and its pluralist ethos.

The third and final section of this portfolio, a client study, engages with therapeutic meaning-making: the attempt by client and clinician to explore, understand and work with difficult emotions and behaviours. It illustrates a piece of therapeutic work carried out with a young woman presenting with low mood, severe anxiety and a range of maladaptive coping behaviours including self-injury. The approach chosen was schema-focused cognitive-behavioural therapy, which works explicitly with emotions through the use of experiential techniques, and with the client's unmet emotional needs through 'limited reparenting' by the therapist. The study shows how, as the work unfolded over the first nine sessions of a yearlong intervention, therapist and client tried to construct meaning around the latter's overwhelming emotions and self-destructive behaviour. This third section thus points to the openness, complexity and value of therapeutic meaning-making. It also considers how the practitioner herself makes sense of her emotions in the counselling room, both in the moment and retrospectively.

Taken together, these three pieces reflect different ways of 'making meaning' around emotions and self-injury. But they also document my own journey through the training, from positivist academic eager to engage with the quantitative literature on emotions to inform a CBT practice, to counselling psychologist seeking to explore the unique reality of her client's emotional landscape and self-injuring. My doctoral research forms an important bridge between the two: an intensive foray into qualitative research and an exercise in reflexive curiosity around the experience of one individual. The three components of my portfolio thus express different aspects of the learning I hope to take forward in my counselling psychology practice: the ability to engage critically with the psychological literature regardless of methodology and theoretical orientation; an awareness of epistemological stances and how they inform the construction of meaning in and out of the therapy room; a pluralistic approach to therapeutic work, guided by an ongoing exploration of my client's world; and a constant reflection on my own input into research and therapy.

Part 1 – Critical literature review

Improving emotion regulation through cognitive-behavioural interventions: A review of the evidence so far

1. Introduction

Problems with emotions or emotion regulation characterise the vast majority of the diagnostic categories of psychopathology in the DSM-5 (American Psychiatric Association, 2013). In some cases (e.g., mood and anxiety disorders), emotional dysregulation is so prominent that it forms the definitional basis of the disorder; in others (e.g., borderline personality disorder, posttraumatic stress disorder or substance abuse), emotional difficulties are 'merely' seen as pervasive.

Yet, while counsellors and psychotherapists of different persuasions have long recognised the role of emotions in psychological well-being and psychopathology, it is only recently that emotional processes have become a clear focus for clinical work. At the time of writing, emotion regulation skills training had been incorporated in cognitive-behavioural interventions for a growing range of disorders, from depression and anxiety to borderline personality disorder, substance abuse disorder, and eating disorders. One American healthcare provider had even launched a Women's Emotion Regulation Program, aimed broadly at 'helping women better manage feelings' (Free Press Release, 2010).

The present work looks at recent efforts by cognitive-behavioural therapists to directly address impaired emotion regulation in a range of psychological disorders. More specifically, it asks two closely related questions: how much do we know about the relationship between emotion regulation and psychological health? And how much support is there for emotion regulation skills training as a means of addressing psychological disorders? In the process, the potential contribution of emotion regulation skills training to the practice of counselling psychology is tentatively outlined. Given the breadth of the subject, this review will not aim at being exhaustive; instead, it will provide an overview of the field with particular attention to work carried out with

adults, as well as a more rigorous evaluation of those pieces of research deemed especially relevant.[1]

2. Emotion regulation and psychological health

2.1 Defining emotion regulation

Defining emotions is no easy task. According to the Paperback Oxford English Dictionary, the term emotion refers to 'a strong feeling, such as joy or anger', and to an 'instinctive feeling as distinguished from logic or reasoning' (Soanes, 2006). This broad definition can of course refer to an unmanageable array of experiences as regards intensity, length, complexity etc. One way to address this issue is to focus on the role of emotions: from a functional standpoint, emotions can be defined as 'adaptive, goal-defining aspects of experience that help aid in decision making concerning movement towards or away from particular actions or plans' (Mennin, 2006, p.95). However emotions can also be maladaptive and hurtful, something a functional approach struggles to accommodate.

In the modal model of emotions, this pitfall is avoided by concentrating instead on the core features of emotions, namely: the way they arise in situations seen by the individual as relevant to a goal, and possessing meaning; their multifaceted aspect, as emotions are typically accompanied by physiological and behavioural changes; and finally their malleability (Gross & Thompson, 2007). This approach goes a long way toward providing an encompassing conceptual framework for the study of emotions; it also brings out their multiple manifestations and determinants, which make the empirical study of emotions especially challenging (Mauss & Robinson, 2009).

While the topic of emotion regulation has been attracting academic interest since the early 1990s, it is only in the past ten year that it has become a major focus of attention for researchers and practitioners. This, together with the aforementioned complexity of emotions themselves, may account for the lack of a single, consensual definition of emotion regulation in the literature (Bloch, Moran, & Kring, 2010). Still, recent years

[1] Campos and his colleagues (2011) report 564 peer-reviewed empirical articles on emotion regulation in adults and adolescents since 2001.

have been marked by considerable efforts to clarify the construct, and by a relative convergence on certain definitional features.

Gross and Thompson (2007) thus identify three core features of emotion regulation, acceptance of which has become widely shared: first, emotion regulation may entail the maintenance, enhancement or downward regulation of both positive and negative emotions; second, emotion regulation encompasses both conscious, effortful, and controlled regulation and unconscious, effortless, and automatic regulation; and third, emotion regulation processes can be adaptive or maladaptive according to context.[2] This last aspect is worth emphasizing here, since it calls for attention to potential dispositional factors or situational characteristics alongside regulatory processes (Bonanno, Papa, Lalande, Westphal, & Coifman, 2004).

The differences between emotion regulation and related constructs also appear to have been tentatively clarified: coping is thus distinguished from emotion regulation by its dominant focus on decreasing negative affect, and this over relatively long periods of time; defences tend to be unconscious, automatic, and concerned with the regulation of sexual or aggressive impulses, and of attendant emotional states such as anxiety (Gross & Thompson, 2007).

Last, and of particular relevance to clinical work, efforts have been made to delineate the nature of *adaptive* emotion regulation, recently described as involving 'choosing and implementing regulation strategies that are appropriate for the context, appropriate for how controllable the internal and external events are, and are in accordance with one's long term goals' (Werner & Gross, 2010, p.20). These strategies can be many: perspiration and a more rapid breathing may be physiological ways to regulate emotional arousal; screaming, laughing and crying can all be behavioural responses to unwanted emotional states. Researchers must therefore make a choice between focusing on one strategy or a limited set thereof (e.g., Garnefski, Kraaij, & Spinhoven, 2001), with the attendant risk of partiality; or adopting a more holistic approach.

[2] The distinction between intrinsic and extrinsic emotion regulation (emotions regulated by self or others), highly significant in developmental psychology, has so far not been a salient feature of work on adult processes.

In line with the latter, full-fledged models of emotion regulation have been developed to map emotion regulation processes. The dual memory model thus views emotion regulation as akin to schema activation, with regulation taking place in three different ways: the regulation of peripheral feedback (e.g. manipulating facial expression or modifying body posture to modulate the body state generated by the schema); the re-direction of attention away from elements activated by the schema; and the elaboration of emotional information so as to focus on all aspects of the situation (Philippot & Feldman, 2004).

In another approach, Gross and Thompson (2007) build on their process model of emotion regulation to array different families of emotion regulation strategies along different points of the emotion generative process: (1) selection of the situation (e.g., avoidance of situations expected to give rise to negative emotions); (2) modification of the situation (e.g., seeking support); (3) deployment of attention (e.g., distraction); (4) change of cognitions (e.g., reappraisal); and (5) modulation of experiential, behavioural, or physiological responses. As will be shown below this approach, with its distinction between antecedent- and response-focused emotion regulation strategies, seems to hold particular appeal for cognitive-behavioural therapists intent on developing targeted interventions.

2.2 Studying emotion regulation

With research in the field taking off, different tools and methods have been used to measure emotion regulation and study emotion regulation strategies. Among the former figure the Cognitive Emotion Regulation Questionnaire (Garnefski, Kraaij, & Spinhoven, 2001), the Difficulties in Emotion Regulation (Gratz & Roemer, 2004), and the Emotion Regulation Skills Questionnaire (Berking et al., 2008), all of which were found to have good reliability and have been used in several studies. However it is worth noting that some of the strategies included in these questionnaires, such as self-blame and rumination, do not constitute emotion regulation strategies as defined by Gross and Thompson (2007). Nor are self-reports an unbiased source of evidence. In that respect, efforts to include peer reports in assessments of emotion regulation seem worth pursuing (e.g., Gross & John, 2003).

More recently, research on unconscious or automatic emotion regulation has used computer-based experimental tasks (e.g., Hopp, Troy, & Mauss, 2011), while functional magnetic resonance imaging (fMRI) studies of cognitive reappraisal have yielded valuable light onto the neural processes involved (e.g., Ochner & Gross, 2004). In laboratory studies, expressive behaviour and physiological change have also been used as indicators of emotion regulation (e.g., Goldin, McRae, Ramel, & Gross, 2008). Thanks to this growing range of methods and instruments, understanding of individual differences in emotion regulation and how they may relate to psychological health has grown considerably.

Still, this proliferation of instruments also carries with it significant issues: for instance, the use of different scales to measure emotion regulation skills or difficulties limits the comparability of the resulting findings. As for experimental designs, they may miss important contextual or relational factors only observable in naturalistic settings. There is also a need for research into the individual goal conflicts that underpin the choice of one emotion regulation strategy over another (Campos, Walle, Dahl, & Main, 2011). In that respect qualitative work may be regarded as a valuable addition to a field so far marked by the heavy (indeed, quasi exclusive) use of quantitative approaches, despite early calls for a greater use of narrative and ethnographic methods (Campos, Frankel, & Camras, 2004).[3]

In the end, even if one rejects the view that emotion generation and emotion regulation are concurrent, coterminous processes, making it impossible to study 'pure' emotion regulation (ibid.), the study of emotion regulation appears riddled with methodological challenges, some of which may impede the establishment of a solid evidence base for targeted treatments.

2.3. Implications for psychological health

One can think of various ways in which ineffective emotion regulation may underlie psychopathology: emotions may be too intense for the appropriate strategy to kick in; or the strategy itself may have been lost (e.g., in Alzheimer's dementia) or not developed;

[3] See Eatough and Smith (2006) for a significant exception.

or emotion regulation strategies may be intact, but poorly implemented in inflexible, context-insensitive ways (Werner & Gross, 2010). Still, if emotion regulation is to represent a target for treatment, the link between impaired or maladaptive emotion regulation and psychological health must be rigorously documented. Here again, research work has significantly increased in recent years.

Looking first at general emotion regulation skills, a study using self-reports of emotion regulation skills in a sample of 289 inpatients diagnosed with a range of mental disorders found that these patients reported fewer skills than non-clinical controls (Berking et al., 2008). Moreover, pre-treatment emotion regulation skills appeared to be significantly related to measures of mental health and well-being in the clinical sample, even after controlling for the intensity of negative affect. Despite the limitations introduced by the sole use of self-reports, and by the fact that clinical and non-clinical samples were not matched, this study lends credence to the idea of a relationship between general emotion regulation skills and mental health.

Work has also been carried out on the relationship between specific emotion regulation strategies and various indicators of psychological functioning. For instance cognitive reappraisal has been associated with positive affect, better interpersonal functioning, and well-being (Gross & John, 2003). In another study, this time with schizophrenic participants, greater use of reappraisal was associated with reduced depression (Henry, Rendell, Green, McDonald, & O'Donnell, 2008). By the same token, work on suppression has shown it to be used more in clinical populations than healthy controls, and this for a range of disorders including anxiety and mood disorders (Campbell-Sills, Barlow, Brown, & Hofmann, 2006); panic disorder (Baker, Holloway, Thomas, Thomas, & Owens, 2004); and posttraumatic stress disorder (Roemer, Litz, Orsillo, & Wagner, 2001). At the same time there is some evidence that suppression can be a successful way of downregulating distressing emotions in healthy subjects (Dunn, Billotti, Murphy, & Dalgleish, 2009); and of reducing sadness in depressed individuals, at least in the short term (Liverant, Brown, Barlow, & Roemer, 2008).

Still, a meta-analysis of the relationships between six emotion-regulation strategies (acceptance, avoidance, problem solving, reappraisal, rumination, and suppression) and symptoms of anxiety, depression, eating disorders and substance related disorders found

that ‘despite all the interest that emotion regulation and strategies have received in the last decade, the number of effect sizes for some combinations was, indeed, small’, and this especially for acceptance and reappraisal (Aldao, Nolen-Hoeksema, & Schweizer, 2010, p.233). It also pointed to the paucity of work exploring the flexible use of different emotion regulation strategies depending on context. Overall, while findings to date are encouraging, there seems to be a need for further emotion- and context-specific work if the processes at play are to be more precisely delineated.

Future research should also factor in age and gender-related differences. That age has an impact on the forms of emotion regulation used (e.g. from extrinsic to intrinsic, from behavioural to mentalistic, increasingly reflective of cultural norms etc.), and on manifestations of emotional dysregulation, is well known (Holodynski & Friedlmeier, 2006; Thompson & Goodman, 2010). Indeed, developmental psychologists have been among the first to take an active interest in the topic, in line with their attention to emotional development generally.[4] However research suggests that age may continue to impact emotion regulation strategies over the life cycle (Garnefski & Kraaj, 2006).

Somewhat surprisingly given the fact that women are diagnosed with affective disorders up to twice as frequently as men (Gater et al., 1998), gender differences in emotion regulation and dysregulation have only recently become a focus of attention. One study using fMRI to explore possible gender differences in emotional reactivity and emotion regulation found no behavioural difference in men and women’s emotional responses, but significant neural differences surrounding the use of cognitive reappraisal (McRae, Ochsner, Mauss, Gabrieli, & Gross, 2008). Two non-competing explanations were tentatively outlined: that men may make greater use of automatic emotion regulation than women; and that women may use positive emotions in the service of reappraisal to a greater degree than men. The latter hypothesis received some support in another study, this time using self-reports, which found that women tended to use positive refocusing as a cognitive emotion regulation strategy more often than men (Garnefski, Teerds, Kraaij, Legerstree, & van den Kommer, 2004). While these findings suggest that gender may affect emotion regulation, they will need replicating in clinical settings before the

[4] See notably the special issue of *Child Development* dated March/April 2004.

potential role of gender as a moderator of the relationship between emotion regulation and psychopathology can be fully ascertained, and its therapeutic implications explored.

To conclude, while work is still on-going to clarify the processes involved, the bulk of evidence so far points to a relationship between maladaptive emotion regulation strategies and psychological ill-health. This has been used to justify new treatment approaches targeting emotion regulation.

3. Working with emotion regulation therapeutically: CBT approaches

The idea that emotion work has therapeutic value has long been embraced in a range of approaches, especially within the psychodynamic and experiential modalities (Greenberg & Safran, 1987). However, as recently as thirteen years ago it could still be claimed that 'Although CBT clearly addresses "emotional" problems, the role of in-session emotional arousal in CBT, with few exceptions, remains terra incognita in both research and clinical practice' (Samoilov & Goldfried, 2000, p.373). This is not to say that cognitive-behavioural therapy (CBT) had no impact on the emotional awareness or states of the client: mood rating for instance was used widely to develop the former, while practicing cognitive restructuring offered to many a novel, adaptive form of emotion regulation. However primacy was given to thoughts and behaviour, with the reduction of negative emotions arguably representing a (significant) by-product. Since then however, emotion and emotion regulation have become a key focus for therapeutic work for a growing number of cognitive-behavioural therapists; indeed, addressing emotional dysregulation could be seen as a cornerstone of the much vaulted 'third wave' of behavioural therapies (Hayes, 2004).

At the same time it is important to acknowledge that cognitive-behavioural approaches are not the only ones to incorporate emotion regulation training. For instance, in the experiential emotion-focused therapy (EFT) emotions are seen as fundamental to the construction of the self, and a key determinant of self-organisation (Greenberg, 2006). The role of the therapist is therefore to help people become aware of, accept, and make sense of their emotional experience. Therapy involves both altering emotional experience, and changing the narratives in which emotional experience is embedded (Greenberg & Pascual-Leone, 2006). Like their CBT counterparts, EFT practitioners

use methods such as identifying and labelling emotions, developing meditative practice, relaxation and self-talk.

Still, for reasons of space this review is primarily concerned with efforts by cognitive-behavioural therapists to design new modes of interventions that are explicitly geared towards helping clients improve their emotion regulation skills, and will therefore concentrate on these, starting with three forms of cognitive-behavioural therapy that specifically target emotion regulation through dedicated skills training: dialectical behaviour therapy; emotion regulation therapy; and the unified protocol for the treatment of emotional disorders. A last sub-section will consider the contribution of more indirect forms of emotion regulation 'training': those based on mindfulness and acceptance approaches. Taken together these represent the most prominent examples of CBT interventions on emotion regulation to date, and as such worthy foci for the present review.

3.1 Dialectical behaviour therapy for borderline personality disorder

According to the DSM-5, diagnostic criteria for borderline personality disorder (BPD) notably include: affective instability due to a marked reactivity of mood; chronic feelings of emptiness; and inappropriate, intense anger or difficulty controlling anger (American Psychiatric Association, 2013). Whereas Beckian formulations of the disorder focus on key assumptions and beliefs, and Young's more recent schema mode model on child-like regressive states or modes, Marsha Linehan's dialectical behaviour therapy places the emphasis firmly on emotional dysregulation (Beck et al., 2004). Correspondingly, hers is the only approach to go beyond general work on experiencing and expressing emotions to include emotion regulation skills training.

According to Linehan's biosocial theory, BPD is primarily a disorder of the emotion regulation system. Borderline individuals are both emotionally vulnerable and lacking in emotion regulation skills, something that she assigns to the interplay between biological predispositions and environmental experiences, more specifically a lack of validation by others when experiencing painful emotions (Linehan, 1993a). Treatment should therefore focus on 'the twin tasks of teaching the borderline patient (1) to modulate extreme emotionality and reduce maladaptive mood-dependent behaviors, and

(2) to trust and validate her own emotions, thoughts, and activities' (ibid., p.62). Teaching emotion regulation skills mostly addresses the first of these two tasks.

Learning to modulate emotions requires first of all the application of mindfulness skills. A central assumption of DBT is that much of the distress experienced by borderline individuals is the result of their secondary responses to primary emotions. Reducing shame, anger or anxiety therefore requires accepting those primary emotions that are adaptive and appropriate to the context, i.e. experiencing them in a supportive, non-invalidating environment. This emphasis on acceptance is common to other recent approaches in cognitive-behavioural therapy (see below).

However Linehan's approach also specifies a range of specific DBT emotion regulation skills taught weekly, in a group format, over a period of one year (Linehan, 1993b). These include: identifying and labelling affect; identifying obstacles to changing emotions, i.e. helping the individual to identify the functions and reinforcers for particular emotional behaviours; reducing vulnerability to 'emotion mind', with advice on nutrition, exercise, general health and the use of non-prescribed mood altering drugs; increasing positive emotional events, both short and long term; increasing mindfulness to current emotions; taking opposite action, i.e. altering emotional states by changing facial and postural expression (e.g., adopting a relaxed stance when feeling anxiety or anger), or taking a different action (e.g., sitting down instead of leaving the room). Finally, work is done on applying distress tolerance techniques so as to be able to tolerate negative emotions without resorting to impulsive, and possibly harmful, actions.

In addition to a number of uncontrolled trials, at the time of writing several published randomized controlled trials (RCTs) appeared to support DBT's efficacy in addressing suicide attempts and self-harm in patients with BPD, with and without comorbid substance abuse (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Armstrong, 1993; Linehan et al., 1999; Koons et al., 2001; Linehan et al. 2002; Verheul et al., 2003; van den Bosch, Koeter, Stijnen, Verheul, & van den Brink, 2005; Linehan et al., 2006; McMain et al., 2009; Feigenbaum, 2012; Priebe et al., 2012). Further RCTs supported the use of DBT in the treatment of eating disorders (Safer, Telch, & Agras, 2001; Telch, Agras, & Linehan, 2001); and two more offered

preliminary confirmation of the efficacy of DBT in older patients with depression (Lynch, Morse, Mendelson, & Robins, 2003; Lynch et al., 2007).

However these RCTs suffered from a number of methodological shortcomings, including one or several of the following: small sample size; variable length of both DBT treatment and treatment as usual (TAU); use of multiple therapists; superior experience, training and supervision of the DBT therapists compared with those in the TAU condition; lack of treatment specificity in the TAU condition; and absence of follow-up (Robins & Chapman, 2004; Öst, 2008).

One RCT seemed to avoid most of these pitfalls (Linehan et al., 2006). In the study, 101 women aged between 18 and 45 years who met the criteria for BPD and for current and past suicidal behaviour were randomized to two treatment groups: DBT or community treatment by experts (CBTE). The CBTE therapists were nominated by community mental health leaders for their expertise working with difficult clients. Treatment was offered over a one year trial, with a one year post-treatment follow-up. Despite a high drop-out rate among CBTE clients, which was factored into the statistical analyses, the study provided convincing evidence of the efficacy of DBT in preventing suicide attempts, reducing the frequency of emergency department visits and inpatient psychiatric care for suicidal ideation, and keeping subjects in treatment (though not in reducing the frequency of non-suicidal self-injury). Subjects receiving DBT were also less likely to continue taking psychotropic medication, including anti-depressants, during the treatment year.

However there was no description of the treatment received under the CBTE condition, a potentially significant methodological flaw. Further, in common with previous RCTs the study did not attempt to tease out the effects of different components of DBT, making it impossible to assess the relative efficacy of the emotion regulation skills training component (as opposed to that of cognitive restructuring, behavioural skills training, or emotional validation more generally), or whether improved emotion regulation mediated the positive treatment outcomes. The same critique could be levelled at another study, this time looking at DBT skills use as an outcome and mediator for treatment in women with borderline personality disorder (Neacsiu, Rizvi & Linehan, 2010). While the authors found that the self-reported use of DBT skills had

significantly improved over time, and that it fully mediated both the decrease in suicide attempts and depression and the increase in control of anger observed (but not the drop in non-suicidal self-injury), they did not distinguish between emotion regulation skills and others.

This last shortcoming Nadja Slee and her associates (2008) partially addressed. They conducted mediation analyses as part of a RCT of CBT for young people engaging in deliberate self-harm (DSH). The 90 participants, aged between 15 and 35 years, were randomly assigned to CBT including emotion regulation skills training in addition to treatment as usual, or to treatment as usual only. Findings showed that changes in DSH were partially mediated by changes in emotion regulation difficulties, and in particular difficulties with impulse control and goal-directed behaviours when experiencing negative emotions. But these effects were small. Moreover, other emotion regulation skills such as awareness, clarity, and acceptance of emotional response, as well as full access to emotion regulation strategies perceived as effective, were not found to have a mediating effect.

Two recent RCTs also deserve attention here. The first one used emotion regulation group therapy in addition to ongoing treatment for deliberate self-harm among women diagnosed with borderline personality disorder, and found significant effects on self-harm and other self-destructive behaviours, as well as on emotion dysregulation, depression, BPD symptoms and quality of life (Gratz, Tull, & Levy, 2013). The second tested whether adding an intensive emotion regulation skills training component to inpatient CBT for major depressive disorder would improve its efficacy; results suggested that it did, participants reporting decreased negative affect, improved well-being and improved emotion regulation (Berking, Ebert, Cuijpers, & Hofman, 2013). However the mechanisms of change remained unclear, including the possible mediating effect of emotion regulation.

Looking at the research conducted on what is probably the best known and best supported CBT intervention targeting emotion dysregulation through emotion regulation skills training, one can only be struck by the paucity of outcome studies using an additive design, such that the distinct contribution of emotion regulation training to treatment outcome could be ascertained. Recent studies seem to be addressing this issue

at last, but their small number, variable treatment protocols, and different therapeutic foci mean that conclusive cumulative findings remain a long way off.

3.2 Emotion regulation therapy for generalised anxiety disorder

According to David Barlow (1988), anxiety disorders are essentially disorders of emotion. Despite having different phenotypes, they all involve negative affect, typically in the form of fear and anxiety, the timing and intensity of which appear to be problematic. Hence a growing interest in possible relationships between anxiety symptoms and a range of emotion regulation strategies (Campbell-Sills, Barlow, Brown, & Hofmann, 2006; Amstadter, 2008; Hofmann, Heering, Sawyer, & Asnaani, 2009).

Among anxiety disorders, general anxiety disorder (GAD) has attracted particular attention as a syndrome involving emotional regulation deficits and an overuse of cognitive strategies. According to the DSM-5, one essential feature of GAD is excessive worry occurring over a period of more than six months (American Psychiatric Association, 2013). While some of the more recent theoretical models of the disorder tend to emphasize cognitive avoidance and faulty metacognitions in accounting for this excessive pattern of worrying, others focus on deficiencies in emotional awareness and processing (Behar, Dobrow Di Marco, Hekler, Mohlman, & Staples, 2009; Cooper, Miranda & Mennin, 2013).

The emotion dysregulation model (EDM) of GAD developed by Douglas Mennin and his colleagues falls in the latter category (Mennin, 2004). The EDM is articulated around four main propositions: first, individuals with GAD experience more intense emotions than do other people, especially when it comes to negative emotional states; second, these individuals have a poorer understanding of their emotions than do most individuals; third, they tend to perceive their emotions as more threatening; and fourth, they possess maladaptive emotion regulation strategies that potentially leave them in a worse emotional state than that which they initially set out to regulate.

The corresponding treatment, emotion regulation therapy (ERT) for GAD, incorporates components of emotion focused treatments into a cognitive-behavioural framework, and is delivered in individual work over 20 sessions. In its original formulation, ERT was

delivered over a 16-week period, and included four distinct phases: the first four weekly sessions focused on psychoeducation about the disorder (Phase I); the following four aimed at developing somatic awareness and emotion regulations skills (Phase II). These skills were then practiced intensively over a four week period, with twice-weekly sessions during which the client was exposed to emotionally evocative themes (Phase III); during Phase IV the final, weekly sessions focused on termination and relapse prevention (Mennin, 2006).

Of particular interest here is the emotion regulation skills training component. In Phase II, it first concentrated on the acquisition of somatic awareness skills, in order to increase flexible awareness of bodily reactions to emotions; this was done largely through the use of progressive muscle relaxation. It then focused on increasing understanding of emotional experience and regulation, especially when confronted with intense emotional experiences. Clients were given lists of emotions and their corresponding motivational information, and learned to identify, label and differentiate between different emotional states, with particular attention to primary emotional experiences. Finally, work was done on contextual skills, involving strategies for getting needs met and regulating emotions as appropriate in different life domains. These comprised skills for increasing client understanding of how needs become salient through different emotional experiences; skills for facilitating emotional expression in an interpersonal context; and skills to manage intense emotional states, including self-soothing and learning about contextual clues.

These emotion regulation skills were then practiced and deepened in Phase III through thematic experiential exposure, which could include techniques such as the two-chair dialogue, the use of a derivative of Beck's downward arrow technique to explore the worry and attendant emotional arousal, imagery work and role-play.

A recent overview of ERT suggests a significant modification of the approach, which seems to have become suffused with ACT interventions (Mennin & Fresco, 2010), thus bringing it much closer to Roemer and Orsillo's acceptance-based behavioral therapy for GAD (Roemer & Orsillo, 2007). Whether this merely reflects the growing popularity of acceptance-based therapy or is indicative of shortcomings in the early version of ERT is unclear.

More problematic is the fact that while the emotional dysregulation model of GAD has received some support (Mennin, Heimberg, Turk, & Fresco, 2005; Mennin, Holaway, Fresco, Moore, & Heimberg, 2007), the evidence supporting ERT is only emerging. At the time of writing it included a NIHM-funded open trial (N=19) and a RCT (N=60), both of which reported considerable reductions in GAD and depression symptoms, with gains maintained at the 9-month follow-up (Fresco, Mennin, Heimberg & Ritter, 2013). While these results are encouraging, once again the empirical evidence supporting the role of emotion regulation training in addressing psychological disorders seems sparse.

3.3 The unified protocol for the treatment of emotional disorders

One potential benefit of using an emotion regulation framework in psychopathology is to better delineate the mechanisms that are common across psychological disorders, and to design interventions with broad applicability and effectiveness. It is on this premise that the unified protocol for the treatment of emotional disorders was developed (Moses & Barlow, 2006; Barlow et al., 2011).

The treatment itself maps onto the model proposed by Gross (Gross, 1998; Gross & Thompson, 2007): each of the five families of emotion regulation is directly targeted, with a total of seven different modules. This modular approach, and the possibility to extend the treatment from nine to 18 sessions, is meant to ensure flexibility, maybe even full tailoring to the individual client. In each module assessment measures (mostly nomothetic self-report scales) are used to track progress and help guide intervention.

Briefly summarized, the modules address maladaptive situation selection through emotion exposure; situation modification through preventing emotional avoidance; attentional deployment through training in present-focused non-judgmental awareness (using mindfulness of the breath); maladaptive cognitive change through cognitive reappraisal; and maladaptive emotion-driven behaviour through opposite action-tendencies.

The approach has been supported by case studies (e.g., Allen, McHugh, & Barlow, 2008), and by an encouraging series of open trials (Ellard, Fairholme, Boisseau, Farchione, & Barlow, 2010). A RCT was also recently completed, which found

significant reductions in symptoms across a range of anxiety disorders as well as treatment effects on measures of temperamental affectivity, suggesting that emotional processing was being altered (Farchione et al., 2012). However the sample size remained small (N=37), the control group was not in active treatment, and mediation effects were not documented, thus preventing a fuller understanding of emotion regulation processes therein. A larger clinical trial is now under way, which should shed further light on the efficacy of this modular form of emotion regulation training. Should it prove successful, it would further establish the centrality of emotion dysregulation in a range of emotional disorders, and the value of using targeted approaches to emotion regulation. For the time being however, the evidence base remains thin.

3.4 Mindfulness-based approaches to emotion regulation

No review of emotion regulation interventions would be complete without taking a closer look at the role of mindfulness-based work in the so-called 'third wave' of behaviour therapies, a term originally seen as encompassing mindfulness-based cognitive therapy (Segal, Wiliams, & Teasdale, 2002), acceptance and commitment therapy or ACT (Hayes, Strosahl, & Wilson, 1999) and DBT, among others (Hayes, 2004).[5] With the exception of DBT, reviewed above, these approaches do not comprise specific modules on emotion regulation skills training. However they claim to improve emotion regulation indirectly, by enabling individuals to achieve healthier emotional awareness and acceptance. As such, they also form the backdrop of the three treatments reviewed so far (indeed, in the case of ERT and the unified protocol, increasingly so).

According to the proponents of mindfulness-based therapies, the practice or process of mindfulness (e.g., through meditation or, in both DBT and ACT, through work on cognitions and behaviours) can produce a decrease in negative emotional arousal, facilitate increased engagement with positive emotional states, generate greater metacognitive insight, and promote acceptance of emotional experiences (Chambers, Gullone, & Allen, 2009). This last aspect is central in ACT, a major goal of which is to help individuals get rid of cognitive fusion and experiential avoidance, two rigid forms of emotion regulation which interfere with normal adjustment to ever changing life

[5] Marsha Linehan reportedly regards DBT as a form of CBT, not as part of a 'third wave' (Hofmann & Asmundson, 2008).

conditions (Hayes, Strosahl, & Wilson, 1999). It is also claimed that mindfulness training can reduce reliance on strategies such as rumination and over-engagement with thought (Corcoran, Farb, Anderson, & Segal, 2010). It would thus counter maladaptive response-focused emotion regulation strategies, and as such could potentially complement traditional CBT, with its emphasis on antecedent-focused strategies (Hofman & Asmundson, 2008).

There is already some evidence that mindfulness-based approaches may indeed promote adaptive emotion regulation. One study found significant correlations between self-reports of mindfulness and self-reported use of a range of adaptive emotion regulation strategies in a sample of 212 college students (Feldman, Hayes, Kumar, Greeson, & Laurenceau, 2007). Another study comparing emotional responses to affectively valenced picture slides in two groups, one of which had received a 15mn recorded focused breathing induction, concluded that receiving such mindfulness-based interventions might produce more adaptive emotional responding to negative stimuli (Arch & Craske, 2006).

A third, more recent piece of work used multimodal assessment to examine the effects of a brief mindfulness-based intervention in a laboratory setting on emotional experiences and regulation in response to three film clips: one distressing, one positive, and one affectively mixed (Erisman & Roemer, 2010). While no significant differences between mindfulness and control groups were found on physiological measures, significance differences emerged for self-reported scores on the Difficulties in Emotion Regulation Scale, with participants in the mindfulness condition reporting more adaptive regulation in response to the affectively mixed clip, and less negative affect immediately following this clip, though not after a 3mn recovery period.

Still, in the last two studies the sample used was small and made up of college students rather than reflecting a clinical population, while the brief mindfulness intervention used may not have reproduced the full experience of mindfulness among the participants.

The study conducted by Berking and his associates (2008) therefore provides interesting insights. In their survey of 289 inpatients treated for a variety of mental disorders, the addition of a specific training in emotion regulation skills to a 6-week CBT-based

treatment produced a greater reduction in depression and negative affect, and a greater increase in positive affect, compared with a control group receiving only the CBT intervention. Importantly, the emotion regulation subscales most strongly and consistently related to mental health outcomes were modification, resilience and acceptance of negative emotions, thus lending some support to acceptance-based approaches. However the assessment of emotion regulation skills and mental health outcomes was solely based on self-reports and patients were not randomized to conditions. Nor was there a follow-up confirming the durability of the gains achieved.

As for the studies that have been recently conducted to assess the impact of mindfulness and acceptance interventions on both emotion regulation and symptomatology for specific disorders (e.g., Kumar, Feldman, & Hayes, 2008; Treanor, Erisman, Salters-Pedneault, Roemer, & Orsillo, 2011), they tend to use small samples, self-reports and different intervention packages, three methodological shortcomings present in most empirical studies on mindfulness (Chiesa & Malinowski, 2011).

Additional work using complementary measures and a true experimental design, and assessing longer term effects, is therefore warranted. As already asserted above, the conduct of rigorous mediation analyses will also be critical in teasing out the distinct impact of improved emotion regulation skills, both general and disorder-specific, on treatment outcomes.

4. Summary and conclusion

Emotion has long been recognised as central in psychotherapy, in a tradition going back to Freud himself. However the study of emotional processes in psychological disorders is relatively new, driven partly by more sophisticated research techniques (e.g., the use of fMRI) and the attendant progress in understanding normative emotional functioning.

Emotion regulation is exemplar in that respect: it is only recently that consensus began to emerge on how it could be conceptualised, and even though there seems to be general agreement regarding its importance for psychological health, more work needs to be done on how different emotions and emotion regulation strategies may affect psychopathology, and this across age and gender groups. This in turn requires the

development of well-validated instruments: while the proliferation of scales may be unavoidable in a young field of study, a degree of integration is required if research findings are to be consolidated. Progress may also require a greater degree of methodological eclecticism, so as to get a better understanding of emotion regulation as it unfolds in its social and cultural context, and in response to personally relevant goals and emotional experiences.

By the same token, treatments focusing on emotion dysregulation have produced encouraging results; some, like DBT, already have demonstrated value in improving psychological functioning. However it is not enough to show that such treatments improve psychological well-being: given that the treatments are specifically directed at improving emotion regulation, it is also important to demonstrate that clients do develop more adaptive emotion regulation skills in the process. On this last point however the evidence remains sparse, with the majority of outcome studies failing to adequately measure improvements (or otherwise) in emotion regulation as opposed to symptomatology.

As this review hopefully showed, the field of emotion regulation is an exciting one. Research in the field is expanding, and has the potential for valuable clinical applications (both disorder-specific and transdiagnostic) which may usefully complement the toolkit of counselling psychologists. There is also scope for further exploration. For instance, research devoted to the role of emotion dysregulation in addiction, and to ways in which emotion regulation training might be usefully combined with CBT protocols in that area, is still in its infancy (Cheetham, Allen, Yücel, & Lubman, 2010; Kassel, 2010). This is intriguing considering the oft-encountered claim that mindfulness should become a standard component of interventions in the field.

However future outcome studies will require a more rigorous design, with larger clinical samples, standardized measures and protocols, a greater attention to therapist effects, adequate follow up and, critically, a greater focus on the specific contribution of improved emotion regulation skills, whether imparted directly or, in the case of mindfulness-based approaches, indirectly. Only then will emotion regulation training stop being a promising intervention and become a proven, maybe even indispensable, component of CBT work.

References

Aldao, A., Nolen-Hoeksema, S., & Schweizer, S. (2010). Emotion-regulation strategies across psychopathology: A meta-analytic review. *Clinical Psychology Review, 30,* 217-237.

Allen, L.B., McHugh, R.K., & Barlow, D.H. (2008). Emotional disorders: A unified protocol. In D.H. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (4th ed.) (pp.216-249). New York: Guilford Press.

American Psychiatric Association (APA) (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Publishing.

Amstadter, A.B. (2008). Emotion regulation and anxiety disorders. *Journal of Anxiety Disorders*, *22*, 211-221.

Arch, J.J., & Craske, M.G. (2006). Mechanisms of mindfulness: Emotion regulation following a focused breathing induction. *Behaviour Research and Therapy, 44*(12), 1849-1858.

Baker, R., Holloway, J., Thomas, P.W., Thomas, S., & Owens, M. (2004). Emotional processing and panic. *Behaviour Research and Therapy, 42*, 1271-1287.

Barlow, D.H. (1988). *Anxiety and its disorders: The nature and treatment of anxiety and panic*. New York: Guilford Press.

Barlow, D.H., Farchione, T.J., Fairholme, C.P., Ellard, K.K., Boisseau, C.L., Allen, L.B., Ehrenreich-May, J. (2011). *Unified protocol for transdiagnostic treatment of emotional disorders: Therapist guide*. New York: Oxford University Press.

Beck, A.T., Freeman, A., Davis, D.D. and associates (2004). *Cognitive therapy of personality disorders* (2nd ed.). New York: Guilford Press.

Behar, E., Dobrow Di Marco, I., Hekler, E.B., Mohlman, J., & Staples, A.M. (2009). Current theoretical models of generalized anxiety disorder (GAD): Conceptual review and treatment implications. *Journal of Anxiety Disorders, 23*, 1011-1023.

Berking, M., Ebert, D., Cuijpers, P., & Hofman, S.G. (2013**).** Emotion regulation skills training enhances the efficacy of inpatient Cognitive Behavioral Therapy for major depressive disorder: A randomized controlled trial. *Psychotherapy and Psychosomatics, 82,* 234-245.

Berking, M., Wupperman, P., Reichardt, A., Pejic, T., Dippet, A., & Znoj, H. (2008). Emotion-regulation skills as a treatment target in psychotherapy. *Behaviour Research and Therapy, 46*(11), 1230-1237.

Bloch, L., Moran, E.K., & Kring, A.M. (2010). On the need for conceptual and definitional clarity in emotion regulation research on psychopathology. In A.N. Kring & D.M. Sloan (Eds.), *Emotion regulation and psychopathology. A transdiagnostic approach to etiology and treatment* (pp.88-104). New York: Guilford Press.

Bonanno, G.A., Papa, A., Lalande, K., Westphal, M., & Coifman, K. (2004). The importance of being flexible: The ability to both enhance and suppress emotional expression predicts long-term adjustment. *Psychological Science, 15*, 482-487.

Campbell-Sills, L., Barlow, D.H., Brown, T.A., & Hofmann, S.G. (2006). Effects of suppression and acceptance in emotional responses of individuals with anxiety and mood disorders. *Behaviour Research and Therapy, 44*, 1251-1263.

Campos, J.J., Frankel, C.B., & Camras, L. (2004). On the nature of emotion regulation. *Child Development, 75*(2), 377-394.

Campos, J.J., Walle, E.A., Dahl, A., & Main, A. (2011). Reconceptualizing emotion regulation. *Emotion Review, 2*(1), 26-35.

Chambers, R., Gullone, E., & Allen, N.B. (2009). Mindful emotion regulation: An integrative review. *Clinical Psychology Review, 29*, 560-572.

Cheetham, A., Allen, N.B., Yücel, M., & Lubman, D.I. (2010). The role of affective dysregulation in drug addiction. *Clinical Psychology Review, 30,* 621-634.

Chiesa, A., & Malinowski, P. (2011). Mindfulness-based approaches: Are they all the same? *Journal of Clinical Psychology, 67*(4), 404-424.

Cooper, S.E., Miranda, R., & Mennin, D.D. (2013). Behavioral indicators of emotional avoidance and subsequent worry in generalized anxiety disorder and depression. *Journal of Experimental Psychopathology*, JEP in Press, 1-18. Accessed on 16 October 2013 at http://www.researchgate.net.

Corcoran, K.M., Farb, N., Anderson, A., & Segal, Z.V. (2010). Mindfulness and emotion regulation: Outcomes and possible mediating mechanisms. In A.N. Kring & D.M. Sloan (Eds.), *Emotion regulation and psychopathology. A transdiagnostic approach to etiology and treatment* (pp.339-355). New York: Guilford Press.

Dunn, B.D., Billotti, D., Murphy, V., & Dalgleish, T. (2009). The consequences of effortful emotion regulation when processing distressing material: A comparison of suppression and acceptance. *Behaviour Research and Therapy, 47,* 761-773.

Eatough, V., & Smith, J. (2006). 'I was like a wild wild person': Understanding feelings of anger using interpretative phenomenological analysis. *British Journal of Psychology 97,* 483-498.

Ellard, K.K., Fairholme, C.P., Boisseau, C.L., Farchione, T.J, & Barlow, D.H. (2010). Unified protocol for transdiagnostic treatment of emotional disorders: Protocol development and initial outcome data. *Cognitive and Behavioral Practice, 17,* 8-101.

Erisman, S.M., & Roemer, L. (2010). A preliminary investigation of the effects of experimentally induced mindfulness on emotional responding to film clips. *Emotion, 10*(1), 72-82.

Farchione, T.J., Fairholme, C.P, Ellard, K.K., Boisseau, C.L., Thompson-Hollands, J., Carl, J.R., Gallagher, M.W., & Barlow, D.H. (2012). Unified protocol for transdiagnostic treatment of emotional disorders: A randomized controlled trial. *Behavior Therapy, 43,* 666-678.

Feigenbaum, J.D., Fonagy, P., Pilling, S., Jones, A., Wildgoose, A., Bebbington, P.E. (2012). A real-world study of the effectiveness of DBT in the UK National Health Service. *British Journal of Clinical Psychology, 51,* 121-141.

Feldman, G.C., Hayes, A.M., Kumar, S., Greeson, J., & Laurenceau, J.-P. (2007). Development, factor structure, and initial validation of the Cognitive and Affective Mindfulness Scale. *Journal of Psychopathology and Behavioral Assessment, 29*, 177-190.

Free Press Release (2010). Princeton House Behavioral Health Begins Emotion Regulation Program for Women. Accessed on 23 March 2011 at http://www.free-press-release.com/news-princeton-house-behavioral-health-begins-emotion-regulation-program-for-women.

Fresco, D.M., Mennin, D.S., Heimberg, R.G., & Ritter, M. (2013). Emotion regulation therapy for generalized anxiety disorder. *Cognitive and Behavioral Practice, 20*, 282-300.

Garnefski, N., & Kraaij., V. (2006). Relationships between cognitive emotion regulation strategies and depressive symptoms: A comparative study of five specific samples. *Personality and Individual Differences, 40*, 1659-1669.

Garnefski, N., Kraaij, V., & Spinhoven, P. (2001). Negative life events, cognitive emotion regulation and emotional problems. *Personality and Individual Differences*, *30*, 1311-1327.

Garnefski, N., Teerds, J., Kraaij, V., Legerstree, J., & van den Kommer, T. (2004). Cognitive emotion regulation strategies and depressive symptoms: Differences between males and females. *Personality and Individual Differences*, *36*, 267-276.

Gater, R., Tansella, M., Korten, A., Tiemens, B.G., Mavreas, V.G., & Olatawura, M.O. (1998). Sex differences in the prevalence and detection of depressive and anxiety disorders in general health care settings: Report from the World Health Organization collaborative study on psychological problems in general health care. *Archives of General Psychiatry, 55*, 405-413.

Goldin, P.R., McRae, K., Ramel, W., & Gross, J.J. (2008). The neural bases of emotion regulation: reappraisal and suppression of negative emotion. *Biological Psychiatry, 63*, 577-586.

Gratz, K.L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment, 26*, 41-54.

Gratz, K.L., Tull, M.T., & Levy, R. (2013). Randomized controlled trial and uncontrolled 9-month follow-up of an adjunctive emotion regulation group therapy for deliberate self-harm among women with borderline personality disorder. *Psychological Medicine, FirstView Article (October 2013)*, 1-14.

Greenberg, L.S. (2006). Emotion-focused therapy: A synopsis. *Journal of Contemporary Psychotherapy, 36*, 87-93.

Greenberg, L.S., & Pascual-Leone, A. (2006). Emotion in psychotherapy: A practice-friendly research review, *Journal of Clinical Psychology: In Session*, *62*(5), 611-630.

Greenberg, L.S., & Safran, J.D. (1987). *Emotion in psychotherapy: Affect, cognition and the process of change.* New York: Guilford Press.

Gross, J.J. (1998). The emerging field of emotion regulation: An integrative review. *Review of General Psychology, 2*(3), 271-299.

Gross, J.J., & John, O.P. (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology, 85*(2), 348-362.

Gross, J.J., & Thompson, R.A. (2007). Emotion regulation: Conceptual foundations. In J.J. Gross (Ed.) (2007). *Handbook of emotion regulation* (pp.3-24). New York: Guilford Press.

Hayes, S.C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior Therapy, 35*(4), 639-665.

Hayes, S.C., Strosahl, K.D., & Wilson, K.G. (1999). *Acceptance and Commitment Therapy: An Experiential Approach to Behavior Change*. New York: Guilford Press.

Henry, J.D., Rendell, P.G., Green, M.J., McDonald, S., & O'Donnell, M. (2008). Emotion regulation in schizophrenia: Affective, social, and clinical correlates of suppression and reappraisal. *Journal of Abnormal Psychology, 117*, 473-478.

Hofmann, S.G., & Asmundson, G.J.G. (2008). Acceptance and mindfulness-based therapy: New wave or old hat? *Clinical Psychology Review, 28*, 1-16.

Hofmann, S.G., Heering, S., Sawyer, A.T., & Asnaani, A. (2009). How to handle anxiety: The effects of reappraisal, acceptance, and suppression strategies on anxious arousal. *Behaviour Research and Therapy, 47*, 389-394.

Holodynski, M., & Friedlmeier, W. (2006). *Development of emotions and emotion regulation*. New York: Springer.

Hopp, H., Troy, A.S., & Mauss, I.B. (2011). The unconscious pursuit of emotion regulation: Implications for psychological health. *Cognition and Emotion*, 25, 532-545.

Kassel, J.D. (Ed.) (2010). *Substance abuse and emotion*. Washington: APA.

Koons, C.R., Robins, C.J., Reed, J.L., Lynch, T.R., Gonzalez, A.M., Morse, J.Q., Butterfield, M.I., & Bastian, L.A. (2001). Efficacy of dialectical behavior therapy in women veterans with borderline personality disorder. *Behavior Therapy, 3*, 371-390.

Kumar, S., Feldman, G., Hayes, A. (2008). Changes in mindfulness and emotion regulation in an exposure-based cognitive therapy for depression. *Cognitive Therapy and Research, 32*, 734-744.

Linehan, M.M. (1993a). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Linehan, M.M. (1993b). *Skills training manual for treating borderline personality disorder*. New York: Guilford Press.

Linehan, M.M., Armstrong, H.E., Suarez, A., Allmon, D., & Heard, H. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48*, 1060-1064.

Linehan, M.M., Comtois, K.A., Murray, A.M., Brown, M.Z., Gallop, R.J., et al. (2006). Two-year randomized controlled trial and follow-up of dialectical behaviour therapy versus therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry*, 63, 757-766.

Linehan, M.M., Dimeff, L.A., Reynolds, S.K., Comtois, K., Shaw-Welch, S., Heagerly, P., Kivlahan, D.R. (2002). Dialectical behavior therapy versus comprehensive validation plus 12-step for the treatment of opoid dependent women meeting criteria for borderline personality disorder. *Drug and Alcohol Dependence, 67,* 13-26.

Linehan, MM., Heard, H.L., & Armstrong, H.E. (1993). Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48,* 1060-1064.

Linehan, M.M., Schmidt III, H., Dimeff, L.A., Craft, J.C., Kanter, J., & Comtois, K.A. (1999). Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. *The American Journal on Addictions, 8,* 279-292.

Liverant, G.I., Brown, T.A., Barlow, D.H., & Roemer, L. (2008). Emotion regulation in unipolar depression: The effects of acceptance and suppression of subjective emotional experience on the intensity and duration of sadness and negative affect. *Behaviour Research and Therapy, 46,* 1201-1209.

Lynch, T.R., Cheavens, J.S., Cukrowics, K.C., Thorp, S.R., Bronner, L., & Beyer, J. (2007). Treatment of older-adults with co-morbid personality disorder and depression: A dialectical behavior therapy approach. *International Journal of Geriatric Psychiatry, 22,* 131-143.

Lynch, T.R., Morse, J.Q., Mendelson, T., & Robins, C.J. (2003). Dialectical behaviour therapy for depressed older adults: A randomized pilot study. *American Journal of Geriatric Psychiatry, 11*(1), 33-45.

Mauss, I. B, & Robinson, M.D. (2009). Measures of emotion: A review. *Cognition and Emotion, 23,* 209-237.

McMain, S.F, Links, P.S., Gnam, W.H., Guimond, T., Cardish, R.J., Korman, L., Streiner, D.L. (2009). A randomized trial of dialectical behaviour therapy versus general psychiatric management for borderline personality disorder. *American Journal of Psychiatry, 166,* 1365-1374.

McRae, K., Ochsner, K.N., Mauss, I.B., Gabrieli, J.J., & Gross, J.J. (2008). Gender differences in emotion regulation: An fMRI study of cognitive reappraisal. *Group Processes & Intergroup Relations, 11,* 143-162.

Mennin, D.S. (2004). Emotion regulation therapy for generalized anxiety disorder. *Clinical Psychology and Psychotherapy, 11*, 17-29.

Mennin, D.S. (2006). Emotion regulation therapy: An integrative approach to treatment-resistant anxiety disorders. *Journal of Contemporary Psychotherapy, 36*, 95-105.

Mennin, D.S., & Fresco, D.M. (2010). Emotion regulation as an integrative framework for understanding and treating psychopathology. In A.N. Kring & D.M. Sloan (Eds.), *Emotion regulation and psychopathology. A transdiagnostic approach to etiology and treatment* (pp.356-379). New York: Guilford Press.

Mennin, D.S., Heimberg, R.G., Turk, C.L., & Fresco, D.M. (2005). Preliminary evidence for an emotion dysregulation model of generalized anxiety disorder. *Behaviour Research and Therapy, 43,* 1281-1310.

Mennin, D.S., Holaway, R.M., Fresco, D.M., Moore, M.T., & Heimberg, R.G. (2007). Delineating components of emotion and its dysregulation in anxiety and mood psychopathology. *Behavior Research, 38*, 284-302.

Moses, E.B., & Barlow, D.H. (2006). A new unified treatment approach for emotional disorders based on emotion science. *Current Directions in Psychological Science, 15*(3), 146-150.

Neacsiu, A.D., Rizvi, S.H., & Linehan, M.M. (2010). Dialectical behavior therapy as a mediator and outcome of treatment for borderline personality disorder. *Behaviour Research and Therapy, 48*(9), 832-839.

Ochsner, K.N., & Gross, J.J. (2004). Thinking makes it so: A social cognitive neuroscience approach to emotion regulation. In K. Vohs & R. Baumesiter (Eds.), *Handbook of self-regulation: Research, Theory and Applications* (pp.229-258). New York: Guilford Press.

Öst, L.-G. (2008). Efficacy of the third wave of behavioral therapies: A systematic review and meta-analysis. *Behaviour Research and Therapy, 46*, 296-321.

Philippot, P., & Feldman, R.S. (Eds.) (2004). *The regulation of emotion*. New York: Laurence Erlbaum Associates.

Priebe, S., Bhatti, N., Barnicot, K., Bremner, S., Gaglia, A., Katsakou, C., Molosankwe, I., McCrone, P., & Zinkler, M. (2012). Effectiveness and cost-effectiveness of dialectical behaviour therapy for self-harming patients with personality disorder: A pragmatic randomised controlled trial. *Psychotherapy and Psychosomatics, 81*, 356-365.

Robins, C.J., & Chapman, A.L. (2004). Dialectical behaviour therapy: Current status, recent developments, and future directions. *Journal of Personality Disorders, 18*(1), 73-89.

Roemer, L., Litz, B.T., Orsillo, S.M., & Wagner, A.W. (2001). A preliminary investigation of the role of strategic withholding of emotions in PTSD. *Journal of Traumatic Stress, 14*, 149-156.

Roemer, L., Orsillo, S.M. (2007). An open trial of an acceptance-based behavior therapy for generalised anxiety disorder. *Behavior Therapy, 38*, 72-85.

Safer, D.L., Telch, C.F., & Agras, W.S. (2001). Dialectical behavior therapy for bulimia nervosa. *American Journal of Psychiatry, 158*, 632-634.

Samoilov, A., & Goldfried, M.R. (2000). Role of emotion in cognitive-behavior therapy, *Clinical Psychology: Science and Practice, 7*(4), 373-385.

Segal, Z.V., Wiliams, J.M.G., & Teasdale, J.D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York: Guilford Press.

Slee, N., Spinhoven, P., Garnefski, N., & Arensman, E. (2008). Emotion regulation as mediator of treatment outcome in therapy for deliberate self-harm. *Clinical Psychology and Psychotherapy, 15*, 205-216.

Soanes, C. (Ed.). (2006). *Paperback Oxford English dictionary* (6th ed.). Oxford: Oxford University Press.

Telch, C.F., Agras, W.S., & Linehan, M.M. (2001). Dialectical behavior therapy for binge eating disorder. *Journal of Consulting and Clinical Psychology, 69*, 1061-1065.

Thompson, R.A., & Goodman, M. (2010). Development of emotion regulation: More than meets the eye. In A.N. Kring & D.M. Sloan (Eds.), *Emotion regulation and psychopathology. A transdiagnostic approach to etiology and treatment* (pp.38-58). New York: Guilford Press.

Treanor, M., Erisman, S.M., Salters-Pedneault, K., Roemer, L., Orsillo, S.M. (2011). Acceptance-based behavioral therapy for GAD: Effects on outcomes from three theoretical models. *Depression and Anxiety, 28*(2), 127-136.

van den Bosh, L.M.C., Koeter, M.W.J., Stijnen, T., Verheul, R., & van den Brink, W. (2005). Sustained efficacy of dialectical behaviour therapy for borderline personality disorder. *Behaviour Research and Therapy, 43*, 1231-1241.

Verheul, R., van den Bosch, L.M.C., Koeter, M.W.J., de Ridder, M.A.J., Stijnen, T., van den Brink, W. (2003). Dialectical behaviour therapy for women with borderline personality disorder: 12-month, randomized clinical trial in the Netherlands. *British Journal of Psychiatry, 182*, 135-140.

Werner, K., & Gross, J.J. (2010) Emotion regulation and psychopathology: A conceptual framework. In A.N. Kring & D.M. Sloan (Eds.), *Emotion regulation and psychopathology. A transdiagnostic approach to etiology and treatment* (pp.13-37). New York: Guilford Press.

Part 2 – Doctoral research

Making sense of self-injury: A pluralistic qualitative approach

Abstract

Non-suicidal self-injury is a complex behaviour influenced by a wide range of biological, psychological, social and cultural factors. In an attempt to inform counselling psychology practice and research, this piece of work focuses on the individual meanings attached to self-harming, and more precisely on the ways in which someone engaging in repetitive self-injury may construct and convey her unique experience. A set of three interviews conducted with the same participant is analysed using three different interpretative lenses: interpretative phenomenological analysis, narrative analysis and a psychosocial approach. The result is a rich, multi-layered understanding of one individual's experience of the behaviour, a reading that privileges complexity, intersubjectivity and openness over theoretical parsimony. The thesis also shows how the adoption of a reflexive stance, continuous engagement with the text, and close attention to the participant's well-being can be used to tackle the significant epistemological, methodological and ethical challenges raised by a pluralist approach. Overall this doctoral research illustrates the value of qualitative pluralism as a mixed methods approach enabling researchers and scientist-practitioners to engage more deeply with the subjective meanings attached to severe emotional and behavioural difficulties, something of obvious relevance to counselling psychology.

1. Introduction

Self-injurious behaviour has a long recorded history, going back to biblical times (Favazza, 1996). But the past twenty years have seen a rise in interest in the phenomenon from both researchers and practitioners, to the extent that non-suicidal self-injury was considered for inclusion as a distinct syndrome in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2011).[6] This first chapter surveys the rapidly growing literature on self-injury, paying particular attention to the difficulties encountered in defining and measuring the phenomenon; the broad range of predisposing factors and possible functions already identified; and the way theoretical models have been developed to account for the behaviour and guide the treatment of self-injury. It then introduces the question guiding the research project presented in this portfolio, and shows how it fits with existing work on the perspective of the self-injuring individual. A brief reflexive section concludes.

1.1 Describing self-injury: definition and epidemiology

1.1.1 Definition

There is no clear and consensual definition of self-injury. In part, this is due to disagreement regarding its key features, such as the absence or presence of suicidal intent. While American researchers have sometimes applied the label - or the equivalent 'self-injurious behaviours' - to both suicidal and non-suicidal experiences, they have lately focused much of their attention on non-suicidal self-injury, defined as the 'direct and deliberate destruction of body tissue in the absence of any observable intent to die' (Nock, 2010, p.342). By contrast, in the UK the term 'self-injury' tends to refer to a sub-type of self-harm methods, to be distinguished from self-poisoning, and this regardless of the motivations behind the act (Royal College of Psychiatrists, 2010; NICE, 2004).

[6] Non-suicidal self-injury was eventually classified as a 'condition for further study', i.e. 'a condition that may be the focus of clinical attention, or that may otherwise affect the diagnosis, course, prognosis or treatment of a patient's mental disorder' (American Psychiatric Association, 2013).

The use of the term 'deliberate', prevalent in the American literature, has also attracted criticism, self-injuring individuals pointing to the blame attached to the notion of wilfulness, and to wide variation both in the manner in which the behaviour is carried out and in the level of awareness accompanying it (Pembroke, 2004).[7] Such is the confusion that authors have sometimes chosen to eschew definition altogether, alluding instead to 'a complex set of behaviours, with different meanings in different contexts' (Motz, 2001, p.152).

Still, adopting a definition of self-injury, however tentative, seemed useful in order to develop a better conceptual, epidemiological and theoretical handle on this complex phenomenon. For the purpose of the present work, self-injury was therefore defined as an act involving the infliction of pain and/or injury to one's own body, either deliberately or impulsively, without suicidal intent. Importantly, because of its simplicity this definition opened up space for individual meaning(s) to be attached to the act. However, as should be clear from the above discussion, it was also informed by current debates over terminology and therefore not 'neutral'.

1.1.2 Prevalence and forms of self-injury

Efforts to collect clear statistics on the incidence and prevalence of self-injury are complicated both by the lack of a clear definition and by the overlapping use of terms such as self-mutilation, self-injurious behaviour, deliberate self-harm, self-cutting, self-inflicted violence, and parasuicide.[8] Researchers must also contend with the social taboo attached to the behaviour: some incidents are misreported as accidental; many others are treated in private and never reach the attention of health services or professionals. One large-scale community survey of adolescents thus found that only 6.3% of those engaging in self-cutting (with or without suicidal intent) reported presenting to a hospital (Hawton, Harriss, Simkin, Bale, & Bond, 2004). Data collected in clinical settings must therefore be approached with some caution.

[7] These critiques have been endorsed by British clinicians (NICE, 2004).

[8] While this study privileged the use of the narrower term 'self-injury', 'self-harm' was also employed as synonymous, partly to avoid undue repetition and partly to reflect the participant's usage of the term.

Bearing this caveat in mind, self-injury is thought to affect around 4% of the general population, with up to 1% reporting a severe history (Klonsky & Muelenkamp, 2007). Higher rates of self-injury have been found in adolescents and young adults, with a reported average age of onset of between 12 and 14 years; and in psychiatric patients more generally, with estimates of up to 20% for adult psychiatric inpatients and 40% for adolescent inpatients (Rodham & Hawton, 2009; Briere & Gil, 1998; Hurry, 2000). Further, there is some evidence that the occurrence of self-injury in the general population may be increasing, especially among adolescents and college students (Muehlenkamp, 2005).

Regarding the methods used, skin-cutting appears to be the most prevalent form of self-injury in clinical samples, followed by banging, hitting and burning. However scratching was found to be the most common form in a large non-clinical sample (Whitlock, Eckenrode, & Silverman, 2006). Other methods include picking, biting, scraping, inserting sharp objects under the skin or in bodily orifices, tying ligatures, pulling out hair and eyelashes, scrubbing, and swallowing sharp objects or harmful substances. Importantly, in most individuals self-injurious behaviour tends to combine different methods, and to vary greatly in terms of frequency, severity, and resulting impairment, both over time and between individuals (Gratz, 2001; Sutton, 2007). There is also considerable variation when it comes to the visibility and social acceptability of the behaviour (Turp, 2002).

Self-injury is often seen as affecting females more than males, and several community-based studies have found the behaviour to be more common among adolescent girls and women (Hawton, Rodham, Evans, & Weatherhall, 2002; Suyemoto, 1998). However studies of adults in clinical settings have reported inconsistent results (Muehlenkamp, 2005). For instance, a study of adult presentations in Leeds A&E departments found that 54.4% of those attending for self-injury were men, and that the nature of the acts was broadly similar for males and females (Horrocks, Price, House, & Owens, 2003). Self-injury among men may therefore be more common than generally thought.[9] Indeed, a recent survey using a random-digit dialing sample of 439 US adults found no association between self-injury and gender (Klonsky, 2011). Interestingly no association

[9] For a discussion of the gender stereotype commonly associated with self-harm, see Millard (2013).

was found with ethnicity, educational history or household income either, thus contradicting earlier findings based on young people presenting in casualty departments, which suggested a strong relationship between various forms of self-harm and socio-economic deprivation (Ayton, Rasool, & Cottrell, 2003).

It is also worth mentioning that psychiatric patients are not the only minority group to be affected disproportionately by self-injury. There is evidence that self-injury is rife in forensic settings (HM Prison Service, 2011). It is also common among people with various kinds of learning disabilities, albeit in a more stereotypical form (Luiselli, 2009). A higher incidence of self-harming behaviour, including self-injury, has been reported among young Asian women (Cooper et al., 2006); and gay men and lesbians are thought to be at greater risk of self-injury (Davies & Neal, 1996; Whitlock, Eckenrode, & Silverman, 2006).

1.2 Explaining self-injury: aetiology and theoretical models

1.2.1 Diagnosis and co-morbid disorders

Research has shown that self-injuring individuals are also a heterogeneous population when it comes to diagnosis and aetiology. Among clinical patients self-injury is most commonly associated with borderline personality disorder (BPD), of which it is currently seen as a symptom (DSM-5; American Psychiatric Association, 2013). Yet the strength of the association between the two has been questioned. For instance, Herpetz, Sass and Favazza (1997) found that if diagnostic criterion 5 (which includes self-mutilation) was not included, only 28% of the self-mutilating individuals in their sample would meet the diagnostic criteria for BPD, leaving a large percentage without a primary diagnosis.

Self-injury has also been linked with depressive and anxiety disorders, eating disorders, post-traumatic stress disorder (PTSD) and substance abuse disorders. A recent literature search thus found that between 25.4% and 55.2% of eating disorder patients also presented self-injurious behaviour, while between 54% and 61% of self-injuring patients also had an eating disorder (Svirko & Hawton, 2007). Another study reported lifetime rates of deliberate self-harm greater than 50% among samples with PTSD

(Cloitre, Koenen, Cohen, & Han, 2002). But there is some evidence that maturity alone can lead to the cessation of self-injury, something which is not true of many of the disorders with which it has been linked (Walsh & Rosen, 1988).

Such discrepancies led to calls for the classification of non-suicidal self-injury as a separate clinical syndrome in the DSM-5, calls which were eventually not heeded. While the recognition that self-injury is more than the 'symptom' of an associated disorder may have been a positive step, this move towards a pathologisation of a behaviour seen by many self-injuring individuals as adaptive, even life-affirming, would have carried serious implications.

1.2.2 Predisposing factors

Associations between self-injury and a wide range of predisposing factors have been found, the latter notably including: opioid deficiency (Sher & Stanley, 2009); childhood abuse (e.g., Klonsky & Moyer, 2008; Muelhenkamp, Kerr, Bradley, & Larsen, 2010); interpersonal difficulties (e.g., Adrian, Zeman, Erdley, Lisa, & Sim, 2011); suicidal intent (e.g., Muelhenkamp & Guttierrez, 2004); and exposure to media representations (Whitlock, Purington, & Gershkovich, 2009). However these associations are neither simple nor straightforward.

The link with childhood abuse is a case in point. Self-injury is often reported by individuals having experienced abuse in childhood, especially sexual abuse (Briere & Gill, 1998; Yates, 2009). However Klonsky and Moyer's meta-analysis (2008) found that childhood sexual abuse explained little or no unique variance in self-injurious behaviour, while Nock and Kessler (2006) found that sexual abuse was associated with an increased risk for suicide attempt but not self-injurious behaviour. This suggests a complex association between childhood abuse and self-injury, probably mediated by psychopathological factors such as alexithymia, dissociation or emotion dysregulation (Muehlenkamp, Kerr, Bradley, & Larsen, 2010; Rallis, Deming, Glenn, & Nock, 2012).

Equifinality thus seems to be a defining characteristic of self-injury: one behaviour, several causal factors. But how these factors interact over time, and with cultural and social norms more generally, remains unclear; and the role of proximal factors such as

daily hassles, stress or conflicts, or that of protective factors, has yet to be adequately understood (Fliege, Lee, Grimm, & Klapp, 2009).

1.2.3 The functions of self-injury

Focusing on the possible aims or functions of self-injury raises additional questions. In his 2007 review of the evidence, including both self-reports and laboratory studies, David Klonsky identified such diverse items as: emotion regulation, with self-injury helping to alleviate overwhelming negative emotions such as anger, anxiety or frustration; self-punishment, the second most often cited function of self-injury after affect regulation; interpersonal influence, self-injury here serving as a means to communicate feelings, elicit attention or affection, or bond with others; the generation of feeling to combat dissociation, a phenomenon often experienced by those with severe self-injury (and a history of trauma); suicide prevention; sensation seeking; and the affirmation of personal boundaries or control. A more recent study, using a phenomenological approach on a sample of 154 participants, similarly listed emotional release, the reduction of dissociation or numbness, gaining control, self-punishment, suicide prevention and distraction from pain or flashbacks (Polk & Liss, 2009).

Importantly however these functions are not mutually exclusive; they can and do co-occur. While a consensus seems to have emerged regarding the basic functions of and motivations behind self-injury, how these may apply to individuals, or even to the same individual at different points in time, thus remains an open question, and one arguably best tackled by the clinician through phenomenological enquiry as the answer may have considerable implications for treatment (Babiker & Arnold, 1997; Walsh, 2007).

It is also worth noting that most of these functions can be fulfilled through a wider range of behaviours potentially harmful to the body: tattoos or piercings for instance can be seen as ways to affirm personal boundaries; extreme sports offer strong sensations; and factitious disorders such as Munchausen syndrome can be directed at others, in an attempt to communicate feelings. Nor is it uncommon for an individual to combine several forms of potentially harmful practices, some of which are culturally

sanctioned.[10] All this should be borne in mind when attempting to understand the personal meaning of self-injury.

1.2.4 Theoretical models and clinical implications

As was made clear in the preceding review, theoretical models of self-injury must contend with a highly variable, complex and overdetermined behaviour. Several have nevertheless been developed, each with distinct clinical implications. While the purpose of this research is not to evaluate their usefulness, a look at their assumptions and limitations provides important background.

Neurobiological theories

A first set of theories emphasize the neurobiological underpinnings of self-injury. One hypothesis links self-injury with a deficit in endogenous opioids, itself associated with chronic and severe childhood trauma and stress. Engaging in self-injury would enhance opioids production, creating a 'rush'. Evidence for this hypothesis is based on reports of diminished pain sensitivity during episodes of self-injury; findings of altered endogenous opioids levels in self-injuring individuals; and the partial success of opioid antagonist treatments such as naltrexone (Sher & Stanley, 2009).

However not all individuals treated with naltrexone respond positively; some may even increase their self-injury. Further, while the evidence suggests that endogenous opioids may be implicated in self-injury, notably in the context of BPD, the relevance of this explanation for self-injuring individuals with less severe presentations remains unclear. Other hypotheses, supporting a role for the serotonergic and dopaminergic systems, have yet to be confirmed (e.g., Herpetz, Sass, & Favazza, 1997; Coccaro et al., 1989). While genetics and neurobiology may play a role in the pathophysiology of self-injury, possibly in interplay with childhood abuse, more research is required before firm and generalizable conclusions can be drawn.

[10] On the notion of culturally accepted self-harming acts/activities, or CASHAS, see Turp (2002).

Linehan's biosocial approach to BPD

Marsha Linehan's biosocial emotional regulation model holds a particular place here, the therapeutic approach it underpins, dialectical behaviour therapy, having developed a strong evidence base for the treatment of BPD, including a reduction in self-injurious behaviours.[11] According to Linehan, BPD is primarily a disorder of the emotion regulation system. Borderline individuals are both emotionally vulnerable and lacking in emotion regulation skills, something that she assigns to the interplay between biological predispositions and environmental experiences, more specifically a lack of validation by others when experiencing painful emotions (Linehan, 1993a). Self-injury then becomes a way to regulate emotional arousal at times when the individual is flooded by distressing feelings.

Treatment should therefore focus on 'the twin tasks of teaching the borderline patient (1) to modulate extreme emotionality and reduce maladaptive mood-dependent behaviors, and (2) to trust and validate her own emotions, thoughts, and activities' (ibid., p.62). This is achieved using a wide range of cognitive and behavioural techniques, with particular emphasis on developing mindfulness and distress tolerance (Linehan, 1993b). The therapist further has to strike a balance between encouraging the client to change, and simultaneously accepting her.[12]

Linehan's approach has been widely embraced in the treatment of BPD, including in the United Kingdom. However to the extent that self-injury is seen as a symptom of an underlying personality disorder, her biosocial model can be said to participate in the pathologisation of the behaviour.

[11] Several randomized controlled trials (RCTs) appear to support DBT's efficacy in addressing self-injury in patients with BPD (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Verheul et al., 2003; van den Bosch, Koeter, Stijnen, Verheul, & van den Brink, 2005; Priebe et al., 2012). However five RCTs found no significant effect of DBT on the frequency of self-harm (Linehan et al., 1999; Koons et al., 2001; Linehan et al., 2006; McMain et al., 2009; Feigenbaum et al., 2012).

[12] Throughout the thesis, 'he' and 'she' can stand for either client or therapist.

Other cognitive and behavioural approaches

While cognitive-behavioural (CBT) therapists often combine cognitive and behavioural interventions when working with self-injuring individuals, different models have been proposed for the behaviour, placing the emphasis either on cognitions or on behavioural responses.

Kennerley's theoretical conceptualisation of self-injury focuses on four types of cognitions thought to drive and facilitate the behaviour: fundamental beliefs (e.g., 'I'm bad and I deserve to get hurt'); facilitating beliefs (e.g., 'This is the only way to show how I really feel'); reactions to self-injury (e.g., 'This is the only way that I can cope'); and flashbacks and other intrusive recollections of traumatic and/or painful events, which may trigger self-injury as a means to distract or dissociate (Kennerley, 2004). Therapeutic work aims at challenging the first three categories of cognitions, notably through the use of behavioural experiments. While this approach has the merit of being free from any associated diagnostic classification, it is arguable whether it can adequately address the multiple difficulties and maladaptive schemas presented by some self-injuring individuals, at least on its own.

Behavioural accounts of self-injury emphasize the role of reinforcement in shaping and maintaining the behaviour. For instance attention linked to the practice may act as a form of positive reinforcement (Walsh & Rosen, 1988). So might the 'high' reported by a number of self-injuring individuals. The four-function model developed by Matthew Nock and Mitchell Prinstein thus conceptualizes self-injurious behaviours as resulting from the interaction of positive or negative reinforcement with intrapersonal or social contingencies (Nock & Prinstein, 2004).

Though based on similar premises, the experiential avoidance model presents a more complex picture. Like Linehan's biosocial model - but meant to apply to a broad population (rather than only individuals with a diagnosis of BPD), the model sees self-injury as a negatively reinforced strategy for reducing or terminating unwanted emotional arousal (Chapman, Gratz, & Brown, 2006). Its authors hypothesise a range of potential underlying characteristics in self-injuring individuals, such as higher impulsivity or emotional intensity. Once established, the use of self-injury as an

experiential avoidance behaviour is maintained by rebound effects (heightened negative emotions following self-injury trigger another round of self-injuring); failure of emotional processing (the individual is never given a change to 'survive' her emotions); rule-governed behaviour ("If I cut, I'll feel better"); and habituation to the negative consequences of self-injury.

While the model clearly fits accounts of emotional release during or following self-injury, and may account for the maintenance of the behaviour, it cannot adequately explain the development of self-injury when other forms of experiential avoidance could be used (e.g., thought suppression or substance use).[13] To be fair, their inability to account for the onset and termination of self-injurious behaviour is a problem common to all cognitive and behavioural approaches. Here social learning theory may have something to contribute, and two hypotheses have indeed been proposed: that self-injuring youths may initially have emulated the behaviour of peers, or media-based representations of peers; and that self-punishment may have become a substitute for family punishment, itself associated with relief from guilt or shame (Jarvi, Jackson, Swenson & Crawford, 2013; Nock & Cha, 2009).

Like DBT, treatments based on an experiential avoidance model focus on the acquisition of distress tolerance and emotion regulation skills, greater exposure to emotional arousal, and response prevention (e.g., Gratz, 2007; van Vliet & Kalnins, 2011; Razzaque, 2012). However their efficacy remains largely untested.

Psychodynamic approaches

In psychodynamic approaches self-injury is seen as reflecting unconscious conflicts and dynamics. Freud (1917) first identified a tendency in his melancholic patients to launch violent verbal attacks upon themselves, attacks which could have equally been directed at significant others; it was as if rather than directly attacking the object, their loved one, his patients had first internalised it. This idea was further developed by object relations theorists. Looking at young infants, Klein (1933) identified an internal struggle between a destructive self and a life-enhancing self, a struggle in which the primary caretaker

[13] As was already mentioned in section 1.2.1, other types of experiential avoidance behaviours can be used alongside self-injury. Associations between self-injury and thought suppression have also been recorded (Najmi, Wegner, & Nock, 2007).

played a key role. Thus, if the mother received the good and bad parts of the infant's self and offered love and nurturance in return, then this experience would be 'reintrojected' by the infant and would strengthen his life-affirming self. However if the infant experienced rejection, neglect or abuse, then a 'dependency-hating' object would be internalised, which would in turn attack the needy, infantile self.

In self-injuring individuals, one therefore sees two processes at play: on a conscious level, the individual is trying to protect the body by getting rid of 'bad' feelings; however on an unconscious level the internalised, destructive self is launching an attack on the object itself and/or on the needy, dependent self (Nathan, 2004). Interestingly this makes the psychodynamics of self-injury radically different from those of suicide: in the latter, a conscious wish to self-destruct appears to combine with an unconscious desire to save the loved object or good part of the self.

Bion's concept of containment sheds further light on the behaviour. For Bion (1967), the capacity to process experience in non-harmful ways depends on a capacity for containment, including the ability to think in the face of distress rather than acting out painful feelings. This capacity normally develops in the presence of a maternal figure able to 'contain' the infant's feelings, so that the infant gradually internalizes it. Self-injury then reflects an absence of containment, both psychologically and metaphorically, the flow of blood from self-cutting serving to 'eloquently express a spilling over of that which cannot be contained' (Turp, 1999, p.314). It is worth noting that psychodynamic approaches place a significant emphasis on the symbolic significance of self-injury.

They also emphasize the importance of control and mastery. In Fiona Gardner's 'encaptive conflict', relationship with the internalised object involves both possession and the wish to get away, so that 'Cutting unconsciously serves to attack the inner mother who crosses all boundaries, and who is both needed and reviled' (Gardner, 2001, p.15). Though developed in infancy, the encaptive conflict can be compounded or triggered by later abuse, in which similar dynamics with an all-powerful abuser are at play. Self-injury can then be seen as an unconscious attempt to repeat and re-enact the trauma, this time under the victim's own control. The fact that self-injury often develops in adolescence, a time not only of separation but also of rapid bodily changes, is also

given attention. As these changes take place, self-cutting can become a way to control the estranged body, which now provides 'both the target and receptacle for unmanageable feelings and uncontrollable instinctual impulses' (ibid., p.61).

For the psychodynamic therapist working with self-injuring individuals, the therapeutic task is to provide containment through the transference. The therapist tries to contain his client's intolerable feelings of pain, anger and hatred, and to return them to her in a form that can be assimilated, as interpretations, so they no longer need to be directed at her own body. As she develops insight into the origins and needs behind her self-injuring, the client also develops more autonomy; fantasies of omnipotence exerted through destructive control over the body are progressively replaced by a new sense of self-worth (Gardner, 2001).

The mentalisation-based approach to BPD

The idea of maternal responsiveness so central to object relations theory is also at the heart of the more recent mentalisation-based approach to BPD. Mentalisation or mentalising is the process whereby we make sense of self and others in terms of subjective states and mental processes. The development of mentalising capacities is predicated on the presence of caring, attentive caregivers, capable of understanding and mirroring the infant's mental states. According to Bateman and Fonagy (2006), the absence of a robust mentalising capacity mediates the relationship between disorganised early attachment and poor affect regulation, attention and self-control in borderline patients. Whenever their attachment system is triggered, their failure to mentalise and consequent use of 'prementalistic' modes of thinking will result in a distorted perception of the relationship between outer and mental worlds, making these patients more likely to self-injure. For instance, seeing mental and outer realities as one and the same (*psychic equivalence*) may result in unbearable feelings of badness; seeing them as disconnected (*pretend mode*) may lead to dissociative states; and seeing them as linked in terms restricted to the physical world (*teleological stance*) may encourage 'manipulative' behaviours such as self-cutting, since only actions with a physical impact are seen as capable of altering the mental state of self and others.

The aim of therapy is therefore to restore the client's mentalising capacity by focusing on his moment-to-moment state of mind, and in particular by: 'mentalising the transference', i.e. validating and exploring the client's transference feelings; recognising the contribution of the therapist to enactments of the transference; developing collaborative interpretations; and presenting an alternative perspective. This approach has had encouraging results in alleviating symptoms of BPD, including self-injury (Bateman & Fonagy, 2008; Bateman & Fonagy, 2009).

Psychosocial approaches

While recognising the importance of personal factors and histories in driving self-injury, psychosocial approaches point to the importance of context. For these authors, self-injury 'speaks of an individual's pain and struggle. It also tells of the social, cultural, and political circumstances in which they and we find ourselves' (Babiker & Arnold, 1997, p.144).

Anna Motz (2001) points to the impact of institutional dynamics, and the way in which incarceration, whether in a prison or on a psychiatric ward, may act as a trigger for repeated self-injury by replicating earlier conditions of humiliation and powerlessness. Rather than accept the language of psychopathology and see self-injury as indicative of an underlying disorder, as is often the case in the so-called medical model, we should recognise the deeper meaning and communicative function of self-injury, and the social and cultural context in which it takes place.

Feminist approaches to self-injury represent another significant contribution. Pointing to the recorded prevalence of the behaviour among women, feminist authors propose that 'self-injury reflects girls' and women's experiences of relational and cultural violations, silencing, and objectification' (Shaw, 2002, p.192). Reduced to silence by the surrounding social and cultural norms, women can only express their psychological distress through bodily enactment. Yet instead of acknowledging and engaging with the meaning thus inscribed, professionals too often ignore or distort it, for instance diagnosing a personality disorder, thus replicating the very conditions that gave birth to the behaviour. This is hardly surprising since conceptualisations of mental illness and ideas about women's place in society are products of the same cultural milieu.

Feminist therapists therefore reject the pathologisation of self-injury, preferring to see it as a coping strategy, a means of self-expression, and in some cases a form of self-empowerment, the meaning of which must be explored and understood. Crucially, given that self-injury often develops against a background of coercion and interpersonal violence, the therapist will avoid imposing her own agenda and will not make eliminating the behaviour a goal of therapy unless the client specifically wishes it to be so (Brown & Bryan, 2007).

Recent work on the sociology of self-injury further challenges the medical, pathological model, claiming that thanks to sub-cultural and interactional venues (e.g., online support groups), a growing number of self-injuring individuals has come to regard the behaviour as an acceptable - albeit deviant- coping strategy and means of expression, even a lifestyle choice (Adler & Adler, 2007).

There is thus no 'model' of self-injury but a wide array of approaches placing varying emphasis on biological, functional, cognitive, unconscious, social and cultural factors, and in the process painting the picture of a complex, multi-layered behaviour.

1.3 Understanding self-injury: towards an exploration of individual meanings

> 'self-injury is a language which we as helpers are called upon to comprehend in all its meanings' (Babiker & Arnold, 1997, p.144)

1.3.1 From function to meaning: the perspective of the self-injuring individual

One point on which most if not all of those working on and with self-injury seem to agree, is the need to engage with the behaviour at the phenomenological level in order to gain greater understanding of the way it presents in the therapy room. Following in the footsteps of psychoanalytic writers, whose case-studies from Freud onwards documented the outer and inner worlds of their self-injuring analysands, qualitative researchers have therefore sought to provide a more intimate picture of self-injury, one in which meanings rather than prevalence, functions or aetiology would form the focal point. To do so, they have employed a wide variety of methods (Table 1.1).

Table 1.1: Qualitative research into the meaning of self-injury for the individual engaging in the behaviour: examples

Study	***Method***	***Data***	***Participants***
Schoppmann et al. (2007)	hermeneutic phenomenological	observations, interviews, emails	5 female interviewees aged 18 to 35
Russell, Moss & Miller (2010)	hermeneutic phenomenological	repeat interviews	4 men aged 37 to 58
Rao (2006)	phenomenological	interviews	6 women
Crouch & Wright (2004)	IPA	interviews	6 male and female in-patients aged 12 to 16
Adams, Rodham & Gavin. (2005)	IPA	interviews, online focus groups, emails	22 men and women, aged 16 to 26
Alexander & Clare (2004)	IPA	interviews	16 lesbian or bisexual women aged 18 to 50
Sinclair & Green (2005)	narrative	interviews	12 women and 8 men, aged 16 to 48
Walker (2009)	narrative	interviews	4 women
Huband & Tantam (2004)	grounded theory	interviews	10 women aged 21 to 48
Reece (2005)	grounded theory	interviews	9 women
Harris (2000)	content analysis	letters	6 women aged 20 to 45
Rissanen, Kylmä & Laukkanen (2008)	content analysis	written self-descriptions	69 female and one male, aged 12 to 21

These studies have further illustrated the multifunctional nature of self-injury, and its individual variability. The phenomenological exploration of the meaning of self-injury also revealed previously overlooked aspects of the behaviour, for instance the role of social identity in accounting for the spread and maintenance of self-injury on an adolescent unit (Crouch & Wright, 2004); the way external signs of self-injury can take over one's sense of self (Walker, 2009); the existence of different experiential pathways to cutting (Huband & Tantam, 2004); or that of a dynamic around vulnerability in self-injuring men (Russell, Moss, & Miller, 2010). More generally, qualitative research confirmed that the men and women using self-injury made sense of their experience. They saw it as neither random nor irrational, but as a behaviour imbued with significance within the context of their personal and social history.

What these 'unitary' approaches could not capture however was the multi-layered meaning-making process surrounding the phenomenon. Any of these studies' participants could arguably have contributed different insights had they been recruited elsewhere; where one study identified a narrative of chaos, another could have brought

out symbolic overspill or a theme of secrecy. Meaning-making is neither a linear nor a unidimensional process: different narratives can coexist around a given experience, narratives which the narrator will bring forth, even combine, in response to particular internal states and external circumstances. It is this plurality of meanings that the present research tried to engage with.

1.3.2 Aims of the research

Having reached the end of this brief review of the existing literature, it is time to summarize its main conclusions and how they informed this study.

First, self-injury comes across as a complex and multidetermined behaviour influenced by a wide range of biological, psychological, social and cultural factors, something that theories and measures of non-suicidal self-injury are only beginning to address (Nock, 2009). Should an encompassing model of the behaviour ever be developed, its usefulness for therapeutic practice could still be questioned given the highly individual meaning attached to his or her self-harming by each client, meaning which, some have argued, must be discovered anew in each therapeutic encounter (Turp, 2002). It is this individual meaning that was the focus of the present research project, and more precisely the ways in which someone engaging in repetitive self-injury may construct and convey his or her unique experience, leading to the following research question: how does an individual with a history of self-injury make sense of his/her behaviour? [14]

Crucially, using the term 'make sense' opened up not one but several lines of enquiry, including for instance: phenomenological (making sense of the lived experience of self-injury 'in the moment'); autobiographical (making sense of the self-harming behaviour in the context of one's history); and constructionist (making sense of self-injury in the context of broader social, political or cultural paradigms). One could also distinguish between making sense to self and to others; and between making sense deliberately and making sense unintentionally (the latter involving, for instance, unconscious dynamics). Rather than focusing on one reading of the meaning-making process taking place

[14] It is worth acknowledging here that an emphasis on 'making sense' can be seen as problematic. Frosh (2007) in particular argues that qualitative researchers may need to capture and reflect both the fragmentation of subjective experience and the limitations of language.

around self-injury, this research intended to explore several of these dimensions and ultimately to juxtapose them, thus providing a new, multi-layered understanding of the experience of self-injury in the hope that it would inform the practice of counselling psychology and inspire further research into the phenomenon. To that aim it adopted a pluralistic qualitative approach, and it is to this approach, and to other methodological considerations, that the next chapter turns.

1.4 First reflections

My interest in self-injury stemmed from a broader engagement with the rather diffuse field of emotions and emotional coping. While studying for a master in child development I had completed a dissertation on the possible role of trait emotional intelligence in 'protecting' adolescents from the psychological impact of adverse life events. I had later taken the opportunity afforded in the D.Psych. to write a literature review on the construct of emotion regulation, and how emotion regulation skills training could be used therapeutically. It seemed almost a natural progression to focus on a behaviour widely seen as a way to cope with unbearable emotions.

However I was determined to approach this topic from a qualitative perspective. My previous use of quantitative methods had left me dissatisfied, and I hoped my doctoral research would thus parallel, and deepen, the relational and reflexive dimensions of my clinical work. Having first encountered the approach during a seminar at university, I was also excited by the possibilities of pluralistic qualitative research when it came to exploring psychological disorders.

Although I had never self-harmed, I had worked therapeutically with several clients who did, and I was therefore wary of imposing their story or my reactions to and interpretation of it, onto the interviewee's experience. Nor should my own story, and ways of coping with strong emotions, impinge. This would mean first of all opening up space for the interviewee's story through a flexible and sensitive use of the interview schedule; and second adopting an open stance should questions arise regarding my own experience (or lack thereof) so as to establish the sort of collaborative, non-hierarchical relationship so crucial to a project of this nature. Of course, the balance

between facilitative openness and impinging self-disclosure would need to be carefully thought through.

Reflexivity also meant remaining aware of my own distinct identity as a middle-aged, middle-class, white French mother of two trying to make sense of another woman's experience. To that aim I kept a reflexive journal, in which I recorded my immediate thoughts and experiences throughout the project. This helped me better delineate my own material, and keep it separate from that being contributed by the respondent. Keeping a journal also helped me reflect on the research process itself, with its complex, and to me very new, methodology. Given my background in international political economy, with its strong positivist outlook, I expected this qualitative project to be challenging as well as enriching, and I wanted to record my struggles and satisfactions with honesty.

2. Method

2.1 A pluralistic qualitative approach

2.1.1 Rationale for a pluralistic qualitative approach

The project adopted a pluralistic qualitative approach. The assumption behind this relatively new approach to qualitative research is that people's experiences are multidimensional; achieving a more holistic understanding of the way these experiences are described therefore requires the adoption of multiple theoretical and methodological frameworks (Frost, 2011; Chamberlain, Cain, Sheridan & Dupuis, 2011).

That different qualitative lenses will bring forth different aspects of qualitative research data is well known. In an effort to illustrate the value of qualitative work for systemic research, Burck (2005) for instance used grounded theory, narrative analysis and discourse analysis to explore interview material on the experiences of speaking more than one language, producing a rich mix of insights underpinned by a social constructionist framework.

However more recent work deliberately sets out to combine different theories and methodologies, both to capture multi-layered phenomena more fully, and to achieve greater methodological rigour via triangulation. Nollaig Frost's pioneering work for instance crossed several models of narrative analysis to build a fuller account of one woman's experience of her second pregnancy, each of her interpretations contributing a new layer of understanding (Frost, 2009). In the process she was able to extract more meaning from the text, outlining both spoken and unspoken 'sense-making'. Interestingly, while she followed each of her models rigorously, she also showed how one could jump from one to the other before reaching the point of saturation in order to explore the questions raised by each interpretative layer, enabling the researcher to follow (and acknowledge) her particular interests. This mix of rigour and flexibility is further emphasized by Carla Willig:

> Pluralistic qualitative research provides researchers with an opportunity to engage in theory-driven, 'prescriptive' styles of analysis and to generate 'suspicious' interpretations whilst remaining committed to the tentativeness, openness and explorative orientation associated with a hermeneutics of meaning-recollection. (Willig, 2012, p.163)

Pluralistic qualitative approaches may thus offer a middle ground between prescriptive methodological blueprints and fluid, 'methodology-free' research, a way for even relatively inexperienced qualitative researchers to let their creativity and curiosity follow their course without sacrificing methodological rigour.[15] Crucially here, they also resonate with counselling psychology's pluralistic orientation (Kasket, 2012). However these approaches place heavy demands on the researcher in terms of reflexivity, and this at two levels: that of the researcher who must, in typical qualitative fashion, continuously query her motivations, assumptions and social positioning; and that of the approaches themselves, since these must be held in tension throughout (Nolas, 2011).

Still, a pluralistic methodology seemed uniquely suited to a project driven by a vision of self-injury as a hyphenated phenomenon, taking on different meanings in different contexts, even for a single individual. By combining different interpretative approaches, I hoped to build a fuller phenomenological picture of the behaviour, one that would not privilege a particular reading of the meaning-making process from the outset, but explore several of the ways in which a given individual might construct sense around a practice open to so many personal and social interpretations.

2.1.2 Choosing the approaches: IPA, narrative and psychosocial

The same interview was therefore analysed using three different qualitative 'lenses': interpretative phenomenological analysis (IPA); narrative analysis; and a psychosocial approach. Of key interest was the way in which these different approaches might create distinct yet complementary layers of meaning, thus enabling the researcher to better capture the complexity and multidimensionality of self-injury.

[15] For arguments in favour of methodology-free qualitative research, see Chamberlain (2012).

The risk of dissonance between such epistemologically distinct approaches was real. For instance, whereas IPA and narrative analysis attempt to illuminate further the meaning already offered by the participant, thus gaining a richer understanding of the phenomenon being considered, the psychosocial approach, in line with its discursive and psychoanalytical grounding, seeks to look 'under the skin', to explain what is 'really' going on (Hollway & Jefferson, 2005).

However there were points of epistemological and methodological convergence between these qualitative approaches which, it was hoped, would permit the emergence of an integrated outcome, maybe even allow for a form of 'theoretical triangulation' (Frost & Nolas, 2011). First and foremost they all shared an interest in subjective experience and in the influence of sociocultural processes thereon. Further, all three paid close attention to language as the key to meaning-making and identity, and proponents of all three had consequently engaged in the analysis of narratives, seen as a prime means of interpretative enquiry. Thirdly, all three made use of the idiographic method, and of semi-structured interviews. Last, they all placed a strong emphasis on researcher reflexivity. It is also worth noting that the psychosocial approach is itself already pluralistic.

2.1.3 Epistemological stance

Still, the epistemological position underlying each approach required careful consideration. So did the adoption of an overall stance to give the work more coherence, and to help guide methodological and interpretative choices. A postmodernist position was briefly considered (Nolas, 2011). However such a stance did not chime with my own approach to knowledge, either as a researcher or as a practitioner. I was aware that my participant's account of her experience would be shaped by language, history and culture, as would my analysis of it, making direct access to 'how it was for her' an illusory pursuit. But I also believed that the interpretative work could produce some insight into her subjective experience of self-injury, and most importantly, her sense-making around it.

I therefore decided to adopt a position of contextual constructionism: assuming that knowledge is necessarily local, provisional and situational, but that there is such a thing as a phenomenon, and that the same phenomenon can be fruitfully approached by using different perspectives (Madill, Jordan & Shirley, 2000). Crucially, as contextual constructionism sees all accounts as imbued with subjectivity, alternative interpretations need not invalidate each other. However this stance requires that the researcher finds some grounding for her results, either in the participant's account or, adopting a position closer to that of critical realism, in the social practices that underlie the account. Because the researcher's input into the interpretative work is itself context-dependent, it is also essential that she openly states the factors that may have influence her position, be they demographic or theoretical. The implications of this epistemological stance for the multi-layered approach adopted here, and in particular the issue of validation, are revisited in chapter 6.

2.1.4 Expectations and validity issues

At the onset of the project it was anticipated that each of the interpretative lenses used would produce a different picture of what repetitive self-injury meant to the participant. Using the IPA lens would produce phenomenological insight: a 'fresh', here-and-now take on the quality, meaning and significance of the lived experience of self-harm as offered by the interviewee and understood by the researcher. The narrative analysis would, it was hoped, contribute a reflection on the role of language and sequencing in meaning-making, by showing *how* the experience of self-injury had been structured and conveyed to become part of the participant's life story. Last, the psychosocial work would combine a discursive and a psychoanalytical reading of the text to produce a 'thick' interpretation articulating past events and current self- or other-positioning (Gough, 2009).

Whether the three pictures thus drawn would complement or challenge one another remained an open question however, and a crucial one. For instance, the very process of 'revealing' underlying dynamics through a psychosocial reading may end up undermining the more immediate meaning framed using IPA. More generally, the cornucopia of qualitative insights thus generated may confuse rather than help the practising counselling psychologist trying to form a richer understanding of self-harm as

experienced by his client, calling into question the pragmatic value of combining different interpretative strategies (Williams & Morrow, 2009).

2.2 Ethical considerations

Given the intensely private nature of the material to be collected (and maybe put in the public domain through publication), ethics required particular attention.

A first way to approach this issue was to be mindful of professional guidelines as regards informed consent, debriefing, confidentiality and protection of the participants (British Psychological Society, 2010). This entailed explaining the purpose and method of the project, and making sure the interviewee was comfortable with the number, length and nature of the interviews. Confidentiality also needed careful consideration, especially if sections of the interview were to be reproduced in print and biographical details incorporated into the analysis.[16] A written agreement, signed by both researcher and participant, would provide informed consent and allow future use of the interviews.

The potential psychological impact of the interview also needed acknowledging. The consequences of giving an in-depth interview on self-injury and associated memories had to be thought through well in advance, and every effort made to ensure the participant received appropriate support if needed. It was also important to make clear from the outset that the interview would constitute a research, and not a therapeutic, encounter. This meant monitoring the exchange closely, and ensuring that neither my participant nor I slipped into a different mode of relating, as this might generate unbidden emotional changes and interfere with the subjective relating of the experience itself (Brinkmann & Kvale, 2008).

Ultimately it was hoped that by shining multiple lights on the experience of one individual the project would contribute to the better understanding and treatment of a behaviour often seen as particularly challenging from a therapeutic viewpoint, thus indirectly benefiting the participant and others (Turp, 1999; Reece, 2005; Long & Jenkins, 2010). However with qualitative research comes a moral obligation to factor in

[16] This involved altering the biographical details provided in the final write-up in a way that maintained the integrity of the interpretation while protecting the identity of the participant.

the privacy and dignity of the participant's experience, and this would need attending to throughout the project.

2.3 Data collection and analysis

2.3.1 Sampling and recruitment

The decision to focus on a single case was taken for pragmatic and conceptual reasons. Both the depth of analysis envisaged and the constraints of a 3-year professional doctorate made it difficult to consider multiple participants. However in-depth case-study research also presents unique strengths, including the production of concrete, context-dependent knowledge and that of rich narratives, both of which seem essential to learning about a phenomenon (Flyvbjerg, 2006). This may be of particular relevance to counselling psychologists who, like health psychologists and others, draw on research to inform a clinical practice (Radley & Chamberlain, 2001). The adoption of a single case design thus met both the practical and the professional requirements of counselling psychology training.

Since this project relied on a single case, the selection of the participant needed careful consideration. Much of the existing literature has focused on adolescents, known to be at particular risk of self-injury (Klonsky & Muelenkamp, 2007). However, interviewing a minor requires gaining informed consent from both the respondent and his or her legal guardian. By the same token, while there is evidence that self-harm is rife in forensic settings (HM Prison Service, 2011), working with incarcerated individuals raises both legal and ethical issues. For these reasons, a decision was made to involve an adult not in incarceration.

A further issue for consideration concerned whether the presence of a clinical diagnosis should be made an exclusion criterion. As was mentioned above, a substantial proportion of individuals engaging in self-injury present comorbid disorders. The possible impact of these additional difficulties and of the diagnostic labels themselves, on the participant's subjective experience therefore needed to be considered. So did the ethical implications of working with such fragile individuals. On the other hand excluding a potential respondent on the basis of a previous diagnosis would mean

accepting at face value both the specific diagnostic label and the pathologisation of the self-injurious behaviour, thus compromising the ontological stance of the project. In the end the presence or absence of a clinical diagnosis was not made into a selection criterion.

Last, because one of the foci of the research concerned the interviewee's self-constructed history of injurious behaviour, selecting an individual with several years of self-injuring seemed more appropriate; recruiting someone who was still engaging in the behaviour might further ensure greater ease of access into the experience. These criteria were reflected in the phrasing of the recruitment flyer (Appendix B).

To recruit a participant several online self-harm forums were approached after ethical clearance had been gained, and flyers posted in a London university, with plans for posting in several more. However a couple of weeks into the recruitment phase of the project a volunteer came forward through another City University student. That student, then in her third year, had been researching the same area, and had already recruited a sufficient number of participants through an online self-harm forum; when a new volunteer came forward, eager to contribute, she agreed to ask the second year cohort. I immediately forwarded my information sheet to her (Appendix C), and the volunteer, Tina, made contact by email.[17] A brief email exchange followed, in which I further introduced myself, checked that she was of age, and offered to answer any question she may have. I also flagged the potentially upsetting nature of the interviewing process. We agreed on a place and time for the first of what I explained would be a series of two to three interviews.

2.3.2 Interviews

The interview material had to be of sufficient length and richness to provide the basis for multiple analyses. I therefore planned to carry out at least two semi-structured interviews lasting between one hour and one hour and a half, the latter providing an opportunity to explore the themes emerging from the former in the context of a deeper,

[17] All names and identifying details have been altered to ensure participant confidentiality.

and therefore more trusting relationship between interviewer and interviewee (Roulston, 2010).

An interview schedule was developed that would provide enough flexibility to remain 'interviewee-centred', yet also some direction so that enough data could be collected on immediate experience of self-injury, past history around the behaviour, and biographical details (see Appendix D). Each of the interview questions was evaluated along three dimensions: thematic (how relevant is it to the theme of the research); dynamic (how might it contribute to a good interview interaction); and ethical (Kvale, 1996). The same principles applied to the preliminary ordering of the questions, with questions thought likely to be experienced as more 'probing' left for the latter part of the interviewing process.

In the end three interviews were carried out with Tina, at weekly intervals, reflecting her willingness to share her experience and the richness of her material. The interviews took place at City University, in the room normally used by the staff of the psychology clinic where I was then working as a trainee. This location gave me greater control over risk management. The room also provided a comfortable, private space, well suited for discussing personal material. However this location meant that the interviews would take place on my 'territory', tilting the balance of power in my favour, with potential impact on the content and interpretation of the interview material. The fact that I was also using that room in my work with clients created an added difficulty: I would have to be extra careful not to slip into therapeutic mode. To assist in that aim, I deliberately rearranged the seating prior to each interview.

2.3.3 Participant well-being

Prior to the first interview, a consent form was read and signed by both of us, each of us retaining a copy (Appendix E). Tina was also given the contact details of organisations providing support for self-harming individuals (Appendix F). Interestingly, not only was she already familiar with them; she had also made her own arrangements for 'keeping safe' after the interview, scheduling a meeting with her social worker at lunchtime. At the start of our second and third interviews, the resource sheet was produced again, and I enquired about Tina's schedule for the day. Each time she

confirmed that she had set up a meeting with her social worker, partly to help herself through the day should she feel upset after the interview.

Still, knowing that Tina had received a diagnosis of BPD and was still self-injuring made me acutely aware of her potential vulnerability. At the beginning of each interview Tina was reminded that the process would last up to one hour and thirty minutes, depending on how she felt, and that she could ask for an interruption at any time by word or hand gesture (she never did). During the interview itself Tina's state of mind was constantly monitored through careful observation. Twice, when she appeared distressed, this was acknowledged and I asked her if she wanted to pause. Both times she opted to continue. At the end of each interview I asked Tina how she felt and what her experience of the interview had been like. Each time she explained how helpful it was to her to talk about her experience, and how she had surprised herself with her loquacity and self-understanding. This was reiterated in the confirmation emails that were exchanged prior to the second and third interviews.

Particular care was also taken with the ending, on the ground that researchers have an ethical responsibility to 'invest as much care and attention into negotiating the ending of a research project as they would into negotiating access at the start of the study' (McLeod, 2004, p.176). When a third meeting was arranged, it was made clear that it would be the last one; and at the end of the third interview, time was spent discussing how it felt, for Tina, to have come for the last time, and reflecting on what may have been the difficulties and the gains from contributing to the research project.

2.3.4 Transcription and analysis

In preparation for the psychosocial analysis I used my reflexive journal to record immediate impressions and countertransference reactions in the hours immediately following each of the interviews. However a decision was made not to transcribe, or even listen to, the previous interview before carrying out the next. I was aware of the risks involved: an opportunity for probing more deeply might be lost, and relying on my sole recollections might make the second and third interviews more 'interviewer-driven' (Flowers, 2008). But I wanted to keep a (relatively) open mind every time, without letting the mood and content of our previous encounter weigh too heavily. As a result I

limited my preparation to reading my process notes and reorganising the interview guide. In hindsight, I believe it was the right decision: given the short interval between two meetings (a week), notes and questions were sufficient for me to recall key information, yet parsimonious enough not to overshadow the forthcoming encounter.

I carried out the transcription of the tapes in the fortnight following the last interview, to ensure maximum recall of context as well as verbal and non-verbal communications. Because of the nature of the interpretative work to be carried out, the approach chosen was to transcribe in detailed verbatim form, and to include the emotional tone of the conversation wherever possible, including pauses, sighs and so on. Confidentiality was maintained by anonymising the data immediately upon transcription, and by using pseudonyms to protect the identity of the participant throughout. The consent form was kept separately from the data, under lock and key; and the data itself was password-protected and kept in a locked filing cabinet when not in use.

Once transcribed in full, the interviews were analysed using each of the aforementioned approaches in turn, with breaks between segments of interpretative work so that I could return to the text with (relatively) fresh eyes. The sequence to be followed was given due consideration, and a decision was made to use IPA first, narrative analysis second and psychosocial analysis last, in an effort to protect potential phenomenological insights from 'contamination' by more constructed, theory-led interpretations. I also decided to work on all three interviews as a block, only moving to another interpretative lens once I was satisfied that I had extracted sufficient meaning from the whole series. This was to preserve the coherence of Tina's overall narrative, as elaborated over a relatively short span of time (three weeks). However I took care to respect the sequencing of Tina's material, so as not to miss possible repetitions, amplifications, contradictions or reservations from one week to the next.

Each time a rigorous approach was followed as regards the steps of the analysis and the types of questions to be considered, in line with the methodological guidelines identified as most appropriate in the course of the literature survey. Further details regarding the analytical process used for each of the three approaches are given in the next three chapters. Last, Figure 2.1 provides select biographical details on Tina, so the

reader can better engage with the content of the interpretations. As already mentioned, these were altered to preserve anonymity.

Figure 2.1: Select biographical details on the participant

Tina was a 35 year old white female, of Irish catholic background. She had been raised by her mother and father, one of six children, and reportedly abused by her father.

Though she described having self-harmed from an early age, it is only in her teenage years that Tina's self-injuring became known, after she shot herself in the shoulder. A first hospitalisation followed.

Tina was and in out of psychiatric units through her twenties, having received a diagnosis of borderline personality disorder. At the time of the interviews she had been living on her own for three years.

2.4 Reflections on data collection

The speed and ease of the recruitment process took me by surprise, and left me in a state of mixed relief and anxiety lest Tina suddenly pulled out. Learning that she had received a diagnosis of BPD was another source of concern. I was reassured to hear that she had received treatment and was still under the care of a psychologist. I was also relieved when she explained that she had made her own arrangements for safekeeping after each interview. It felt almost as if Tina was taking charge, which helped me challenge my initial sense of her as a helpless woman, and my fear that the interview might 'push her over the edge'. Still, I remained mindful of her difficulties throughout, and of my responsibility as researcher to take every precaution to ensure her well-being.

The interviews themselves were very rewarding. Over the three weeks Tina and I developed good rapport. Relieved of my therapeutic responsibilities I was able to truly listen, and felt that I was opening up a wide space for her, wider than with many of my clients. I tried to use the interview schedule in a flexible manner, rearranging my questions every week to suit our progress and following up on her associations whenever possible. At times I found myself worrying that the material would not be rich or 'original' enough. But I made a conscious effort to stay with the process, and to let

Tina lead the way in a manner that would feel safe for her. I also tried to pay close attention to my own reactions to Tina's material, both during and after the interviews.

The ending felt timely and well prepared, if ever so slightly sad. I was thankful for Tina's time and openness, and I expressed this in a card which I gave her at the close of our final interview, together with the promised M&S voucher. After walking her back to the entrance one final time, I wondered if she would get in touch again. She did not.

The transcription work took five days. As I listened to the tapes I was keenly aware of starting a journey away from the live encounter, and of making choices regarding format and the use of punctuation to signify non-verbal information that would alter the material. Although the dynamic of the interviews had involved both of us, the fact that I was now in command made me a true 'co-author' of Tina's narrative, a daunting but exciting shift. After printing out all three interviews, ready for analysis, I took a break of several weeks, further weakening the link between interviews and material, and in the process achieving a distance from the text which I hoped would enable me to carry out the three distinct segments of my work with greater clarity of intent.

3. IPA reading

This chapter presents the first of three segments of interpretative work around Tina's material, using interpretative phenomenological analysis (IPA) to address the question at the centre of this work: how does someone engaging in repetitive self-injury make sense of her behaviour? In a first section I outline the approach taken, briefly introducing IPA, exploring its relevance to this particular project, and detailing the analytical method followed. I then review the results of the analysis, before drawing on the existing literature to query their significance. A short section relaying my experience of using IPA concludes.

3.1 The approach

3.1.1 Choosing interpretative phenomenological analysis[18]

Interpretative phenomenological analysis is concerned with exploring the lived experience of research participants. True to its phenomenological roots, IPA calls for a bracketing of scientific constructs to focus on subjective experience, conceived as 'a lived process, an unfurling of perspectives and meanings, which are unique to the person's embodied and situated relationship to the world' (Smith, Flowers & Larkin, 2009, p.21). At the same time, its grounding in hermeneutics makes IPA explicitly interpretative: the researcher is asked to develop a new perspective on the participant's experience by using detailed iterative analysis, and by developing an awareness of her own preconceptions. The latter point is of particular import, and refers to the 'double hermeneutic' of the analytical process, since 'The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world' (Smith & Osborn, 2003, p.53). Last, IPA is concerned with the particular. It advocates thorough, systematic analysis and a focus on individual understandings of particular phenomena in particular contexts. This idiographic approach makes IPA especially welcoming of case studies in psychological research (e.g., Eatough & Smith, 2006).

[18] Lack of space prevents a fuller description of the philosophical, theoretical and methodological dimensions of IPA. In what is perhaps the best known précis in the field, Smith, Flowers and Larkin (2009) provide a comprehensive overview.

All three sensibilities made IPA eminently suitable here. First, the diversity of practice and multiple meanings attached to self-injurious behaviour seemed to lend themselves particularly well to the use of a phenomenological approach, as evidenced by previous studies (see Table 1.1). Of particular interest was the way in which an IPA reading might encompass both cognitive sense-making and more unfocused, 'edge of awareness' aspects of Tina's subjective experience (Willig, 2008). As a counselling psychologist in training I was also mindful of the need to pay close attention to my own set of thoughts and beliefs around the subject, and to how they may colour both my interaction with Tina and the analysis itself. IPA's insistence on rigorous interpretation therefore seemed wholly appropriate. Last, the project would focus on a sole case. The fact that IPA seemed an especially popular methodology among qualitative researchers and counselling psychology trainees further increased its appeal, as it might give the work added relevance.

3.1.2 Methodological considerations

From a methodological standpoint, this first, IPA reading of the transcript largely followed the suggestions of Smith and his associates (2009), adapting them to suit the demands of a single case and my own sense of ease with alternative techniques.

The interviews were treated as one set of data. Each of them was analysed in turn, and in similar stages: a first reading was carried out whilst listening to the tape, so as to recapture more of the mood and flow of the interview. At that stage only skeleton descriptive comments were produced in the right margin, outlining what seemed to be especially salient points for the interviewee and querying their meaning in a tentative, free-flowing fashion. These were revisited and expanded upon during a second, line-by-line reading of the text, and initial themes tentatively identified in the left margin of the script, to capture the essence of a particular extract in a succinct and more conceptual set of words. In a third reading those themes that failed to speak directly to the research question were bracketed out, and the relevance of the remaining themes was checked once more against the participant's wording (see the extract in Appendix G).

The salient emergent themes were then 'extracted' and tentatively mapped so as to identify overarching, superordinate themes; in the process connections were drawn

between the themes, and a few of them discarded as they became subsumed under others. For the first interview, this was done using a simple chronological list and rearranging its component parts on paper until distinct constellations emerged; for the second interview, and in an attempt to keep the analytical process fresh, the themes were copied onto separate pieces of paper and rearranged in visual clusters; by the third interview, using a list had come up as the most congenial means of abstracting superordinate themes, and this method was used again. Attention was also paid to how linguistic elements (e.g., choice of metaphors, repetitions) might further support a particular theme.

Throughout, my own preconceptions regarding the functions and meanings of self-injury, and how the behaviour may tie in with the symptoms and aetiology of borderline personality disorder, were held in awareness. Efforts were also made to bracket emerging themes so as to approach each stage of the analysis with an open mind. However it is important to acknowledge that my fore-structures were inevitably modified as the work unfolded. This may account, at least in part, for the perceived fit between the superordinate themes initially identified around the first interview, and the constituents themes listed under the second and third interviews. Still, given that the research bore on a single case, this was in keeping with IPA's idiographic commitment.

A list of superordinate themes and themes was then produced for each of the interviews (Appendix H), in which each of the themes was linked with one or more specific quotes from the text. A table further summarised the themes and superordinate themes identified across the interviews, so as to provide a thematic map of the overall material and further guide the writing-up process (Appendix I).

Although carried out within the limits of the above mentioned double hermeneutics, the analysis that follows is thus the result of a deep, reflexive engagement with the interview material. It followed the hermeneutic circle model of the research process, moving back and forth between words, sentences and the transcript as a whole; and it was carefully documented, with the help of a field journal.

3.2 The interpretation

3.2.1 Analysis

Over nearly four hours of interview Tina offers a complex and multi-layered account of her self-injurious behaviour. In an effort to make sense of her self-harm she weaves together several strands of meaning: a descriptive strand, in which she seeks to describe and explain the behaviour itself; a first contextual strand, in which she relates her self-harm to the distress that sits 'underneath', itself a reflection of her fragile self; a second contextual strand, this time querying the ways both her self-harm and the underlying distress may be linked to her experience of the 'other'; a third, more historical strand where she explores the impact of her family experience; and finally a meta-cognitive strand, in which she reflects on her growing understanding of, and ability to verbalise, her experience of self-harm.

Figure 3.1: Making sense of self-harm: superordinate themes

1. Self-harm as a way of managing life
2. What's underneath: the fragile self
3. What's underneath: experiences of the other
4. What's underneath: experiences of the family
5. Developing a new understanding of self and self-harm

While these five strands are here presented as distinct superordinate themes, they are closely intertwined in practice, for instance when, reflecting on her journey from severe self-harm to a more controlled behaviour, Tina explains that

> I realised then that I, you know, that uh, the self-harm was just the surface, the bit on the surface that other people see, but there is a whole lot more to it underneath.

Exploring Tina's meaning-making process around self-harm therefore meant balancing the need for interpretative themes with that to respect the layered nature of her material. The result is an analysis in which aspects of her experience are outlined within a particular theme and then revisited in the light of another, as a fuller understanding

gradually emerges. As will become apparent below, the theme of control even seems to cut across several subordinate and superordinate themes, to the point when its own subordinate status may become questionable. However the list of superordinate themes proposed here is one that I, as interviewer and researcher, believe best conveys my understanding of the nature and complexity of Tina's attempt to create meaning around her self-injury.

SELF-HARM AS A WAY OF MANAGING LIFE

Throughout the three interviews Tina describes and explains her self-harming. In the process she builds an intricate picture, in which the many forms, triggers and functions of her behaviour are progressively rendered, and its adaptive and problematic dimensions clearly outlined.

A multi-faceted, but ever-present, behaviour

One of the first themes to emerge has to do with the variety of her self-harming: minor or severe; open or hidden; premeditated or impulsive; deliberate or carried out without awareness. What seems to unite what at times almost come across as different phenomena is a sense of continuity since, in one form or another, self-harm has always been with Tina:

> I've self-harmed so much over, like, for as long as I can remember, from doing little things right up to doing massive things, um… So it's been a big part of my life.

Triggers are similarly disparate: 'lots of little things that build up'. Still, stress and mood play a role, as do recollections, initially presented as 'things from the past' and later described more explicitly as flashbacks linked to being abused by her father. Emotions also figure prominently in Tina's account, with self-harm seen as an automatic response whenever her feelings threaten to engulf her: 'it's just, this automatic thing, um… you just get from, um… emotion to… to self-harm'.

While some of her self-harm is impulsive and at times carried out in a dissociative state, Tina describes premeditation as playing an important role. Self-harm then becomes a constant, clandestine obsession:

> The times when I had to have surgery were the times where the self-harm, um, was completely premeditated. I mean I would obsess about it for maybe two weeks, um… and…uh.., so I know that a lot of my self-harm isn't always impulsive. Um, I mean, it's a, it's a strange state of mind to be in, because although you kind of, uh, during those two weeks you have like, um, you know you get on with your normal day to day things, um, as if there is absolutely nothing wrong with you, but in the background you've got this.

Tina's reference to a 'strange', split state of mind is worth emphasizing here; so is the 'as if' quality of her experience, which suggests that a normal front is presented to the world while a more problematic, 'wrong' phenomenon is actually going on in the background. Both are taken up in the next section.

Having control

The 'how' can be planned as well as the 'when', and a scenario played out again and again, giving Tina a precious, indeed essential sense of control:

> It's like I've got control over something, and that's something that I can control.

This repetitive construction suggests more than mere emphasis. Running her scenario through her head gives Tina control over 'something' at a time when everything seems out of control; it also gives her something *to* control, i.e. something to work on, make her own, absorb herself into:

> it's like you're in this bubble. It's like, you can… you… you can block everything else that's going on outside but also you could divert your attention from how you're feeling.

Tina also compares her self-harm to a Sat-Nav kit, a ‘way to monitor things’, keep things in check, maybe not lose herself.

However in the process she often reaches a point where backing out is no longer an option:

> the strange thing is that, um, as I approach that, that date, then I start getting doubts in my head: do I really want to do this? Um... But because I have obsessed about it for so long, it’s like: I have to do it. And you know, it’s like: no, I made this decision, I have to do it.

By that point Tina often feels that self-harm is the only way out, and she overcomes her last minute qualms. It is as if she has entrapped herself: from something she can control, self-harm has turned into something that controls her.

‘This awesome sort of rush’

The act itself is marked by an absence of pain, coupled with an ‘awesome sort of rush’, which Tina compares to a rush of adrenaline and describes as a sort of sensory awakening, her inner numbness finally dissipating:

> during those times when I’ve started to self-harm, like I’m in, like I’ve started to cut for example, that I… I start to feel something again, um... I don’t mean like, um, any pain in my arm, but there’s this rush, this… There’s something there again, that wasn’t here before.

This rush has an ‘addictive element’ to it though, and this pulls her back. Tellingly, the theme of self-harm as addiction is present in all three interviews, Tina variously drawing parallels between self-harm and drugs, tobacco, and alcohol. Here again, she outlines a complex relationship between her and her self-injuring, one in which her control over the behaviour is at best questionable.

Cutting the bad

The image of Tina as a woman at war with herself also ties in with what she describes as the punishment function of her self-injury; the act is then driven by Tina's self-hatred, her sense of being 'a bad person'. During some dissociative episodes this struggle takes on a particular, more extreme form: no longer recognising her limbs as her own, she tries to sever them:

> it's probably part of why I've cut quite deeply on my arms, is that I have this sense in me that I want to remove them.

Cutting off the bad, 'alien' parts of herself might be seen as a desperate attempt by Tina to restore integrity to a compromised self, a theme that will be further developed in the next section. However the fact that the act takes place in an altered state of consciousness also places it outside her control.

The following extract brings this out even more clearly:

T. it's just like the time passes and I know when it's over, and, um, sometimes in those times I'll have self-harmed, um… and, that's really frustrating for me, cause… because… it's almost like I'm fighting so hard not to do it that maybe it's coming out in another way, and… you know, it's such a strong, um… pull towards it, that I'm doing that unconsciously or something, um… [*sighing*] Um…and that can be really frustrating, um... [*sounding tired*] yeah… Well more than frustrating, um… that's…

D. More than frustrating.

T. Yeah, it's… scary, it's, um… [*sighing*] It's anxiety-provoking, um… It's… in a way it kind of makes you, makes me feel crazy.

Here Tina brings out the frustration and anxiety her irrepressible behaviour creates in her. The harder she fights her urge to self-harm, the more the behaviour seems to elude

her, becoming the product of unconscious, i.e. uncontrollable, forces. Instead of helping her feel in control, self-harm can thus expose her at her most out-of-control: 'crazy'.

Touching the void

Tina's discussion of the aftermath of cutting or shooting herself stands in stark contrast with this image of internal warfare. It is also indicative of how deeply self-harm seems embedded into the fabric of her life, this time from an existential perspective. In one of the most severe episodes the act is followed by a profound sense of calm as Tina contemplates her own death:

T. as I was lying on the floor I was thinking: this is what it's like to die. And…

D. And how was that? Was that scary? Comforting? Strange?

T. It was, I mean I think, maybe to start with it was a little bit scary, and then in some way it was, it was almost the most calm I've ever felt, um… So… Yeah, that's... yeah… It was almost like: now I've got no worries. It was almost like that whole chatter in my head just left.

In that moment at least Tina seems to be finally at peace, her stance one of acceptance and serenity. Her description of the 'warm feeling of blood' she experiences further evokes a sense of almost womblike comfort.

Tina's relationship with death is also an important theme in its own right, suggesting fascination and a desire to challenge life's boundaries:

> And quite often it's… it's been my head that… I don't know if I've actually had this narrative in my head about it but it's like a feeling maybe, but I've had: how badly, how close to death can I get, without actually dying?

Significantly, the theme of self-harm as control (over life and death) is again implicit in this last extract. Taking her body right to the edge seems a way for Tina to assert

ultimate control, perhaps a last resort when her inner life and outer circumstances become truly unmanageable.

Communicating distress

In addition to mediating her relation to herself, self-harm is for Tina an essential form of communication with others, a way to make them realise how much emotional pain she is in. This indeed constitutes one of the most pervasive themes across the interviews. Because she cannot convey the magnitude of her distress verbally, Tina communicates it through her actions, and her scars:

> The scars on my arms they are kind of… almost represent how I feel inside, um… They kind of tell… I don't know, they kind of tell a story or something, they sort of… They like… allow other people… For me they allow other people to see the magnitude of how difficult things can get.

The term 'allow' is worth considering: Tina's scars are both story and barometer, something for others to read if, and only if, they want to understand her better. They bring the inside out, but they 'allow' rather than force or confront.

Still, underlying her self-harm is a hope that others will react, that she will be helped. Behind her first self-inflicted injuries, when as a young child she picked at her nail until it fell, was the comforting certainty that the school nurse would fix it; and if her self-harming gets so severe when staying on hospital ground, it is partly because

> in hospital there's always gonna be someone there to rescue you, um… You know there's always gonna be someone that's gonna go round and do ticks every 15 minutes or half an hour or an hour or whatever, and so… um… for me maybe that makes my self-harm even worse.

But self-harm is a flawed mode of communication, one which can too easily be distorted by uncomprehending nurses and medics, and turned against Tina. Although her act bears 'no malice', instead of being heard she is labelled 'manipulative',

'attention-seeking', a 'time-waster' or someone who 'obviously likes pain'. As her distress deepens, her self-harm increases:

> I already felt bad, I mean I didn't actually need anyone to, to…say that was a bad thing cause I… bad thing… the word 'bad' is maybe not the best word that is but… I already knew that I wasn't, and I felt bad about it, I felt guilty about it. But then that on top of it… Um, hearing that, this was like: I just feel even worse now, you know. And so then you get this cycle where you feel worse after, so maybe just to communicate how bad you feel you self-harm again, and it's just like this vicious cycle that it's really hard to get out of.

There are several important issues to note in this brief extract. As her attempt to communicate her pain backfires, Tina's guilt and distress are compounded by the negative, judgmental reaction of others, a theme that will be further explored in the third section. Yet this only leads Tina to try harder, in a desperate effort to make others realise. Far from being in control, she becomes trapped in a vicious cycle in which self-injury, despair and the need to be heard seem to feed off each other.

A way of managing life, in and out of hospital

The impact of hospitalization figures prominently in Tina's narrative. Like self-harm, hospital has been an important part of her life, and the two are closely linked in her mind. While the triggers and functions of her behaviour are many, being in hospital seems to act as a all-round catalyst: it gives Tina a signal that she is at the lowest ebb, and has 'nothing to lose'; it takes away most of her control over her life (even as medication takes away whatever control she still has over her thoughts); it means that she is surrounded with people who want to know how she feels, so that she just reverts to the only way she knows how to express pain; and it offers her an almost fail-proof safety net. Being sectioned means self-harming more, as cutting becomes a way of managing the pressures of hospital life.

Conversely being out of hospital, like being away from family, coincides with a reduction in the behaviour. But self-harm remains a part of her life, something that will 'work' when feelings become unbearable, and more generally a means for her to

manage, sometimes out of awareness, her difficult relationship with herself and with the world.

> It is a bit like taking a tablet when you've got headache, um… You know… although it's the wrong term, you know, it's not helpful, you know in the short term that it does… serve a function, it does do something for you, um… especially when the other options are really hard, like talking to someone.

As such, one gets a sense that Tina's self-harm can neither be completely eliminated, nor made sense of in isolation.

WHAT'S UNDERNEATH: THE FRAGILE SELF

In her efforts to understand and explain her self-harm, Tina returns time and again to the distress that lies 'underneath' it. In doing so, she reveals the many facets of her fragile sense of self, and some of the powerful feelings her cutting taps into.

The distress underneath

Just underneath, close to the surface as befits an identifiable trigger, are the 'flashbacks from the past' that enter her head when she least expects them; then…

> Then the bad feeling itself, like the distress itself, um… That almost feels like you're being sucked underground, like you're just being… the life is being drained from you, that, um… One minute you just feel completely like… you… you just can't function to do anything, like make a cup of tea and… and the next minute you feel like, um… You know sometimes I've this image of, um… like these thoughts, like they're being… pushed into my head, um… and it's almost like there's so much going in there, um… that there isn't any room left.

In this short account Tina describes two distinct experiences, which seem to occur in rapid succession: being drained of all vitality, 'sucked underground', turned into an empty, helpless vessel; and then having her mind forcibly filled with thoughts, until 'there isn't any room left'. While seemingly in stark contrast, these experiences both

involve a total absence of control on Tina's part and rather porous boundaries, since her life can be 'drained' and thoughts 'pushed into' her head.

Tina returns to these experiences, and how they relate to her self-injuring, throughout the interviews. However along the way she introduces experiential variations, painting a complex picture of what may lie 'underneath'. For instance she speaks of a confusing numbness that 'kind of feels like kind of empty, like an empty shell or something'. Self-harming then means feeling something again, the rush dispelling the sense of emptiness. At times the numbness resembles dissociation: things and people seem 'strange' and Tina no longer feels connected to reality, or to herself:

> it can feel like, you know, I'm not me in a way, like I'm not, like, uh…[*pause*] It's almost like I'm looking at me.

As already mentioned, at such times she may cut quite deeply what no longer feel like her arms.

The numbness can also 'feel quite powerful', like a shield around her, a force acting on her behalf, making people move out of her way on the main street, and the pedestrian light go green as she walks to the traffic lights. The experience tends to be short-lived however, and to be followed by 'this massive nosedive, um, where this rush of everything just comes in'. Cutting might offer a way to cope with this onslaught of 'bad stuff'.

The experience of being overwhelmed, filled up, is indeed another theme common to all three interviews. Sometimes thoughts are the problem, with Tina's head 'flicking' like a late night TV. At other times Tina struggles with a 'snowball of feelings', to the point that she cannot think ahead and stop herself from cutting. She becomes stuck in time:

> see when you get really distressed or really anxious or overwhelmed, you can't think… It's really really hard to think beyond the next minutes or the next few seconds even. It's like: I can't stand this any longer, um... So you don't… it's like you just don't have this foresight. You don't have, um… you know, it's really really hard to be able to stop yourself, to say, you know: this time next

week I'm gonna have another scar on my arm or, you know, even in a couple of hours' time, I might end up having to go to hospital, and I hate hospitals. But, you know, it's just that, you know, you can't see past the next few seconds or minutes; because it feels like forever.

It is worth noting that Tina's subjective experience of time and how it frames her self-harming constitutes a distinct if somewhat elusive 'theme' across the interviews, whether she refers to the exact moment when she injures herself ('that moment'), or to the endless wait for help that follows.

Crashing down

Even in good times Tina's distress can only be kept at bay for so long, as the pressure slowly builds up. This she conveys using several metaphors, including a roller-coaster, an airplane the engine of which suddenly blows off and, perhaps most movingly, a tale:

T. It's almost like, when I've had that powerful feeling, I've like filed away, my head has filed away all the bad stuff, um… But then it starts to maybe, leak out, and it's, uh… I suppose it's a bit like… I don't know what it is, is it a fairy tale or a, story about the little boy who puts his finger in the hole in the dam, um.

D. Um.

T. And so, um, it's almost like the only thing that's holding the dam is this, you know, this tiny little thing holding it in there, um, and, like… I think the story goes this way that the boy takes his finger out of the hole in the dam and the whole dam comes crashing down, um… That's the little weakness there, and then… so, um…

This extract illustrates several important aspects of Tina's experience: her sense of inner split, since it is her 'head' that files away the bad stuff; her almost mechanical understanding of the pressure created by her negative feelings (perhaps a reflection of her engineering background); her sense of her own fragile equilibrium, dependent on 'this tiny little thing', the small finger of a little boy.

Interestingly the story of the boy who stuck his finger in the dyke and saved the Netherlands actually ends well, the boy being rescued at dawn by a parish priest and hailed as his country's saviour. But for Tina there is no happy ending, just an exhausting back and forth:

> Sometimes the hardest thing is that… you know sometime someone will say: 'Well, I know you're feeling bad now, but you know that after a few hours or a day or two you'll feel fine again.' But then in my head as well I'm thinking: but then a few days after that, a few hours after that, I'll feel rubbish again. And that just feels like this kind of roller coaster, like up and down, and up and down [*smiling/laughing*]. You know, it's really hard to keep on a level.

Tina's experiences can be neither controlled nor properly monitored, and she humorously bemoans the lack of an 'internal gage'. Against the background of a self out of control, the need for self-harm to act as a SatNav system takes on a fuller meaning. It also echoes the 19th century practice of bleeding patients to restore balance to their vital humours, thus possibly reflecting an experiential 'truth'.[19]

Divided and confused

Tina's account also suggests a lack of inner unity, with separate selves co-existing more or less harmoniously. At times being able to 'split' herself has definite advantages. When stuck in a difficult or longwinded conversation she quite enjoys having 'a little person' at the back of her head who is taking notes so she can appear engaged whilst drifting off in her mind. When planning her next self-harm she can keep up appearances whilst nursing her growing obsession.

But her divided inner world can also be challenging. Sometimes the separate Tinas disagree and she reports vigorously admonishing herself, notably around her cutting: 'I've even said to myself, out loud: "Tina, you don't want to do this, you don't want to do this"'. The struggle generates frustration, anger and guilt, thus compounding her distress. Tina also describes 'different people in my head', constantly 'talking and

[19] I am indebted for this point to my supervisor Carla Willig.

arguing or… sometimes them saying that I'm stupid'. Cutting then becomes a way of silencing the incessant chatter, if only for a moment.

Tina's inner landscape is thus full of confusion, another theme that repeats across the interviews. She evokes her doubts over her actions and how she often finds herself

> debating things in my head, you know: should I, shouldn't I? You know: why did this happen or, or…

She can also question her feelings, with devastating consequences: 'my self-harm got so bad because I just got so confused about how I was supposed to feel'.

Often the loudest voice is also the most judgmental, calling into question Tina's efficacy and intelligence: why can't she do, ask, say? Why is she being so stupid? Why can't she be fine? Here again she shows insight, acknowledging the extent of her self-judgment and the way in which it hampers her communication with others. But her sense of helplessness and inadequacy is easily triggered, and that very ease makes her berate herself even more:

> I end up looking at other people and I think, you know: other people can deal with this, why can't I? It's only just a simple, you know, confusion with the, the train, you know, it's not like, uh, you know, someone's just stolen a thousand pounds from my account or [*smiling/laughing*], from my bank account or something, it's not like that, you know…

Hiding the self

Frustrated with herself, ashamed of her lack of control Tina tries to hide her distress. Speaking of her struggle to 'return to baseline', she comments:

T. And, the funny thing is, I think I, I know, um… well I'm pretty sure that... I, you know, until somebody properly knows me, they won't actually see that in me.

D. Uhu.

T. Cause I'm often wearing a smile on my face. And it is just that sort of, um… it's just me bottling things up, and that has to come out somewhere, and that's where self-harm comes in, um...

Once again self-harm is presented as a form of expression, a way to communicate beyond words. But here it also seems a way to bring out the 'real' Tina: not the fake, coping woman, but the suffering, out of control individual. There is honesty about the act, and about the resulting scars. By contrast language falls short: even when Tina can bring herself to express her pain, she tends to minimize it, both for fear of being judged, and because saying it feels 'scary':

> maybe I will say something like, uh…uh… 'I'm really not having a good day today'. And then I'll say, the next sentence will be: 'but I'm sure it'll be fine tomorrow' or something, or 'I'm sure if I get X, Y and Z done I'll be fine'. Even though I know in my head… that I know I won't be fine. That, you know… But I'm always kind of trying to minimise it.

This backtracking and minimizing runs through the interviews too, with Tina carefully qualifying her most distressing statements, and often adding 'a little' or 'a bit': 'a bit scary'; 'a bit trapped'; 'a little bit like that'.

But scars, like 999 calls, deliver a raw message of distress. As such they can shock and offend, and are best kept hidden, like Tina's feelings. Taking people's stares requires a particular sort of confidence, one that Tina achieves only occasionally:

> There are days when I feel, uh… I feel confident to go out, well not out of my flat so my neighbours see, but it's like, you know, sometimes I will be confident enough to walk down T high street and, you know, just have a tee-shirt on. And I am very… I'm aware that people look at my arms, but you know, I feel confident enough that I can manage it. And there's other days when I'm feeling a bit… not so good and… I don't feel like I can manage people staring at me.

Underpinning this need to hide is a deep fear of being judged. Exploring this, and other ways in which Tina experiences the 'other', further enriches our understanding of her meaning-making around self-harm.

WHAT'S UNDERNEATH: EXPERIENCES OF THE OTHER[20]

Just as Tina's self-harm only becomes intelligible to her when set against her difficult, confusing inner experiences, making sense of her fragile sense of self leads her to take a look at how outer experiences, and in particular experiences of other people, are impacting her. From the first interview onwards, this perceived impact appears to be overwhelmingly negative.

The judging other

The other is first of all seen as judgmental, his input compounding Tina's own tendencies towards self-criticism. Sometimes judgments are explicit, and she reports 'horrible comments', in particular from the emergency personnel tasked with helping her:

> there was a nurse when I was in the ambulance and she, you know, said to the ambulance driver, like I was close to death and she, but I was still conscious enough to be able to hear what people were saying and she said: 'do you get many time-wasters like this?', um… I also had, I think it was a consultant or a registrar when I was in the resuscitation area, at A&E, and I'd cut myself really really badly, quite a lot, and I needed about 50-something staples, um. But he said, when the younger doctor asked him, um, if I should be stitched up or stapled, and the older doctor, who was maybe a registrar or whatever, he said: 'no, just staple her cause she obviously likes pain', um…

Tina's account powerfully conveys the discrepancy between her own subjective distress and helplessness ('close to death', 'really really badly') and the dismissive, objectifying response these elicit from health professionals. Both the nurse and the registrar talk of

[20] When referring to the 'other' the masculine form 'he' or 'his' is used throughout. This is for clarity's sake only, as Tina reports difficult experiences with both men and women.

her in the third person, as if she weren't really present. In so doing, and in their choice of words, they deny both her pain and her right to be helped: she is a waste of time, a masochist. Over time these experiences are internalised. Any hospital visit becomes loaded with negative expectations:

> there's anticipation in me that there's gonna be some negative comment that's gonna be really hurtful, um… so… yeah, I just hate going to hospital.

Actions can speak equally loud to Tina, as when strangers on a bus take a look at her scars and get up to sit further away. But the judgment of others is often implied: a nurse looks at her 'as if I shouldn't be saying stuff like that'; neighbours might come to 'all sorts of conclusions' after seeing her scars.

Crucially, Tina's perception of how others are judging her strengthens her inner critical voice, especially if those judgments are verbalised. She explains:

> you kind of internalize all that and you say those things to yourself as well, and believe them yourself which [*knocking the coffee table slightly*] – sorry - which makes your mood worse, um… so…. which obviously, you know, can lead to self-harm, so…

Others can thus hurt both directly through their words, and indirectly through the way these are then owned by Tina, with consequences for her distress and self-injuring.

The controlling other

Others can also be experienced as probing and controlling, forcing Tina back into her shell. This applies to her first encounter with a mental health professional:

T. […] I was referred to a child psychologist, who was also a psychiatrist as well, and I remember him wanting to, wanting me to talk about this, but I was like, and about other stuff you know, like what'd happened with my dad and stuff, and it was like: this man wants me to talk about this horrible stuff, I don't

understand, and I just wouldn't talk about it. In fact I would sit there… for, you know, the whole hour, and not speak.

D. In silence.

T. And not speak at all. And, quite often, there would be times when he would maybe say three things in the whole hour. That silence was soo [*accentuated*] uncomfortable. And then I, you know, I did feel myself drifting off in my mind, with other things, cause I didn't want to deal with the silence as well.

Here Tina offers a disturbing image of therapeutic work: a distressed 16 year old kept in a room for a whole hour and given a choice between talking about personal, 'horrible stuff' to a stranger, or exercising her only freedom: that to 'not speak', and endure harrowing silence. As was already mentioned, hospitals are presented throughout as coercive environments in which Tina is denied control and space, with severe consequences for her self-harming.

They don't get it

Even beyond their judgment and control, others are experienced as out of touch with Tina's reality, unable or unwilling to understand and validate. This applies to those strangers on the bus who Tina feels may perceive her as a danger when she is anything but ('I only ever harm myself'). It also applies to well-intentioned others who try to advise and encourage:

sometimes you know, and these comments they're probably always well intentioned, but you know when you get someone saying to you: 'Oh, you need to stop being negative, you need to be positive, um…' And I feel like saying: 'I really want to be but I can't, I mean that's just not as simple as that', um… And all the other comments like: 'You need to leave the past behind you', and I feel like saying: 'D'you know what, if I could ask for a part lobotomy to remove those things then I would but I know that's not gonna happen'. It's not that I want to remember stuff but, it just… it's there you know, I can't remove it.

Hearing those words only increases Tina's sense of frustration with herself, with her inability to move on when she 'should be fine':

> You're already frustrated at yourself, so… it actually makes you feel more frustrated at yourself, cause you already feel that yourself but then you only feel, when other people are saying that you're thinking that maybe you're not trying hard enough, and so that kind of compounds it, it just makes it worse so…

Thus, interacting with others mostly seems to further strengthen her critical self and weaken her fragile grip on life. Angry at herself, denied control, privacy and understanding, she may then resort to self-harm as a means to punish herself (and maybe those unhelpful others), reassert her boundaries and/or try to communicate her pain more effectively.

But setting herself apart can also trigger feelings of profound aloneness and despair. Tina describes spending 'an awful lot of time' on her own prior to her shooting incident, and feeling 'really alone', her voice catching for the first of very few times. Elsewhere she explains that her near-delusions of power tend to occur when she spends too much time on her own. Finding the right distance from others, having her own space, therefore seems essential to helping Tina control her self-harm.

So does finding understanding others, a discreet theme that resonates across the interviews as a recent, hopeful development. The role played by these new 'others' relates both to her self-harming ('there's people that can really grasp, that can understand the reasons you're doing it') and to her underlying needs. In an interesting double-entendre, Tina explains that she now has 'an understanding' with her local CMHT that hospital admission is an extreme last resort: at last she seems to have found health professionals who can both understand her and negotiate a mutually acceptable arrangement for her care, thus making her feel heard and in control.

WHAT'S UNDERNEATH: EXPERIENCES OF THE FAMILY

Though she makes brief references to her dad and family in the first two interviews, it is only in the third that Tina presents a more complete picture of her early experiences,

something that may reflect both the interview schedule and a growing trust between us. However there can be little doubt as to the impact these experiences have had on her sense of self, her perception of the other and, ultimately, her self-harm. Indeed, though she characteristically tries to exonerate them from blame, Tina herself makes the connection:

> My parents… if I'm honest my parents are like, part of the reason why I am the way I am, um… part of why I self-harm, um… Not that they're, you know, not that they're directly responsible, it's not that they're holding the blade on my arm or anything but, you know, some of the things that happened just… that's, that's the way it's turned out.

The abuse

First and foremost, Tina draws a clear link between her self-harm and the abuse suffered at the hand of her dad:

> Um… yeah my dad abused me, as I was growing up [*voice catching*], me and my older sister C, and…. So… part of what, um, triggers self-harm for me is like I get lots of flashbacks and, um…

Tina finds the random, intrusive nature of these flashbacks particularly hard to deal with:

> I could be walking down the street and just, you know, be overwhelmed by this image that… it feels like it's in front of me, um, and… You know it's… it's like… it's like a thing I've got no control over, um... so… yeah that's quite hard, and that can, that can trigger, um… that can trigger off, um, the self-harm, um [*sighing*].

As if by extension, unexpected reminders of her filial duties are also a source of considerable upset. Stumbling upon a stand of Fathers' Day cards at the supermarket 'throws' Tina, and prompts a complicated train of thoughts, involving perceived coercion ('it's expected of me to send a Father's Day card, and a Mother's Day card, and their birthday cards as well') and painful pretence:

They all say: “to the world’s number one dad” or “to a wonderful father”, or, you know, “to a special dad” or something like that and, I don’t really want to buy… a card that says that.

More generally, Tina seems determined to protect her newfound space and disturbed by intrusions therein, including by text or phone call. She sees her move to London as ‘the best thing that’s ever happened’, and her occasional visits to the family home as breeding confusion and distress.

Denial

The hypocrisy of a loving Fathers’ Day card also ties in with another important theme: denial. Even as an adult, Tina feels that she had to negate both her difficulties and her past history in order to be accepted as part of the family:

T. I had to… deny outwardly you know, kind of like… sweep everything under the carpet, you know, everything’s fine…

D. Everything’s ok.

T. Yeah, everything’s fine and everything is, you know, nothing… nothing happened in the past, and, you know, or stop thinking about the past, you do your best to move on, um… You know these are kind of words that I’ve heard from my parents, well, from my mum really, um… And, so… uh… Yeah, that’s… that’s hard.

This attitude sheds some light on her perception of others as ‘not getting it’, not wanting to hear, especially where difficult feelings and realities are involved. Significantly, this parental refusal to hear and validate Tina’s story very much extends to her self-harming:

T. I think that was maybe a couple of times I tried to explain but, um…. I actually, I… I’m not sure they’re open enough. Maybe they don’t want to get it.

D. Is it a little bit too personal for them?

T. Yeah, yeah. If I told them, if I pointed the finger and told them everything, um… then that would be too hard for them to listen to… and… so, it's almost like me trying to explain to them that just got closed ears. They're not, they're not really hearing what I'm saying, um, you know…

In any case painful feelings always constituted a no-go area. Tina recalls feeling sad after the death of her grandfather: 'I remember at that time, um, wanting to cry, um, but knowing that I could only just go to my room and cry, I couldn't do it in front of my parents'. At the risk of stretching the boundaries of the interpretative work, one could argue that the perceived negation of Tina's emotions and experience within the family speaks to the theme of the confused self as well as to that of the hidden self, with direct relevance to her self-injurious behaviour.

Trapped

Last, Tina paints the picture of an isolated, restricting family home, where few visitors were allowed and strict rules were enforced: no fun in the kitchen, no talking at the dinner table, no visits to or from friends. From an early age she tried to run away, planning and effecting an escape on her bike at the age of 9, climbing out of the window and walking off the following year, before coming back after a few hours of freedom.

Tina describes having to listen to her parents' reproaches after one such incident:

T. Yeah, it was always my fault, and those times I would just… have them… I could… I was aware of them talking to me, but I would be staring at the floor and in my head… I just had that… Cause the carpet that we had on the floor was quite, sort of patterned, old-fashioned sort of, like flowery designs on it. And I was just in my head, just thinking about these flowers on the floor, and describing them in my head, sort of to block out what they were saying, um… and… yeah… so… And it was like that sort of inescapable thing, um. In a way I suppose it's a bit like the times I've been in hospital, how hospital has felt like to me, like feeling trapped…

D. Ok.

T. Like other people have control over what happens to me, and make decisions about me, and that I can't leave when I want to, um…

Once more a problématique of coercion is outlined: at home, like later in hospital, Tina feels powerless, trapped. When physical escape is not an option she copes by removing herself from the scene mentally, by being both there and not there, a form of splitting which she still uses in similar situations. In this particular instance she uses the design on the carpet as an alternative focal point. Elsewhere, she explains that early forms of self-harm (picking at a nail until it fell) partly served a similar purpose ('It's almost like, there was that wee thing, that I could just focus on').

Importantly, her sense of still being under family control continues to fuel her self-harming. Tina describes the strong feelings of entrapment elicited by reminders of family events such as Fathers Day, or by the position of her parents as 'gatekeepers' to the rest of her family, and especially her siblings, nieces and nephews:

> I don't want to feel that my parents have control over me still, um… And that, really… yeah, it's really… difficult to… get my head round. Even though like I know that, you know, I make the choices now, for me, but in that, that particular… any choices related to my family my parents just have… this control, um, which is what they had when I was growing up, you know… And that's, that's really hard. It makes it really hard to move on, um… And so I just, I suppose... when things get overwhelming I just… Self-harm is what I do.

Tina's experiences of the family, as she was growing up but also as she lives them today, caught up between her need to belong and her bid for freedom, thus form another, inescapable layer in her meaning-making around self-harm.

DEVELOPING A NEW UNDERSTANDING OF SELF AND SELF-HARM

The fifth and last superordinate theme is of a different sort: no longer descriptive or explanatory, but reflective. Here Tina looks back on her journey towards greater self-

understanding and self-expression, and in the process offers new ‘keys’ into her meaning-making.

A new awareness

Several times during the interviews Tina contrasts her past ignorance or confusion with her newfound understanding of her self-injuring. Whereas she used to be ‘clueless’, she now surprises herself with her insight into the behaviour:

T. I was actually… um… Cause I see my psychologist on the Tuesday, when I saw her yesterday I said to her, you know, that I’d surprised myself from coming here, how much my… Well it’s not just having the words for it, but having the awareness of how self-harm, what it means for me and what… you know… how it affects me and… you know, and my reasons for doing it.

D. Um.

T. And I was actually really surprised how great an awareness I have.

Once again, the process of understanding - or making sense of - her self-harm is inextricably tied to that of making sense of her emotional difficulties in general; and to do that Tina uses several tools. One is observation:

> I’m often thinking about why other people do things, and how they manage to be around other people, and I kind of file it in my head.

Tina gives several examples in which she attempts to make sense of a situation and of her own response thereto, by looking at the reactions of fellow human beings. This curiosity goes back a long way, to a Tina of 4 or 5 walking away to gaze at the homes of others in a nearby tower block. But benchmarking her behaviours against other people’s can also result in further confusion and a painful sense of inadequacy, thus ultimately prompting further self-harm.

Another tool is the 'scientific' insight gained through her psychology studies, which provides elements of both explanation and external validation of her inner experience:

> I feel that I can trust that, that that's something that's… um… What's the word? More tangible or more sort of quantifiable in a way. And so I, um … yeah, I… through my studies, um.., then I can even take things out of DBT that… um… there are, there's a psychological basis for, um, and… you know, say to myself: people have jobs for doing this, people do lots of research, people you know, spend their lives, you know, studying this, so, it can't be rubbish.

The more Tina reads about psychological research and phenomena, the more she can construct meaning around her distress and behaviour and attach value to them since they are no longer 'rubbish'. Significantly in light of her past history of denial and invalidation, developing a scientific understanding of her difficulties also gives them a new reality: 'it's like saying: oh, now I know it's not all in my head'. The interviews are thus interspersed with references to statistics, the neurobiology of addiction and emotions, the psychological basis for behaviour, reflecting Tina's attempt to make scientific sense of her self-harm. While no overall scientific explanation for her self-injuring emerges from the text, this process also seems to give her a new sense of control over it, since 'understanding that actually helps me reduce doing it'.

Saying it loud

Alongside her new awareness, Tina reports a new ability to label and verbalise her experience:

T. Now, probably in the last couple of years through doing DBT and through my studies, I actually have the words for things. Or maybe I had the words for things before but I just didn't know how to apply them to me, um…

D. Things like feelings.

T. Yeah, yeah. It's almost like, um... Yeah, that's… the word… what's the word? The words for emotions just didn't apply to me. Or the words were just a waste of time.

While Tina continues to attach enormous importance to selecting the right words, sometimes to the point of hampering her communication, knowing how to apply them is helping her in several ways. First, she can finally seek help: after impulsively cutting, she manages to stop herself by calling a supportive other and openly stating her resolve: 'I just said: "Look, this is what I've done, and I don't want to do it anymore".' Words are thus presented as an alternative to self-harm, and using them better as a way to reduce it.

But words are also the essential building blocks of meaning-making, and therefore instrumental to understanding and measuring change: having briefly narrated her journey at the beginning of the first interview, Tina smiles:

> when I say it all in one thing long, you know when I say that out loud it loud of makes me realise how far I've come so… It's good.

Even using the word self-harm seems like an achievement, a victory over the judging other; and at the end of the third and final interview, Tina openly expresses her surprise and her pride at having been 'able to talk so much' and given the researcher 'a lot to type up', hoping that it will in turn help self-harming others. By enabling her meaning-making and strengthening her fragile sense of self, words can thus also provide Tina with a new sense of control over her self-harm.

However she remains cautious: having developed a better understanding of her self-harm may help her manage it better; so may being able to talk about it. But words can still fail sometimes, and self-harm remains an easier option. Words can even act as triggers, and Tina carefully distinguishes between constructive ways of talking about self-harm (e.g., our interviews) and not so helpful ways of talking about it (e.g., sharing self-harm memories with fellow patients). Tina's meta-reflection around language and understanding is thus an integral part of her efforts to make sense of her self-harm, and of her progress and difficulties in controlling it.

3.2.2 Discussion

The analysis presented above has thus identified several frames of meaning-making around the experience of self-injury: a descriptive frame in which Tina outlined the important and complex role played by self-harm in her life; three more contextual frames, in which Tina explored what may be sitting 'underneath' the behaviour in terms of self and others, including her experiences of family; and finally a reflective frame, in which Tina evoked key elements of the meaning-making process itself. In this brief discussion section I bring out some of the ways in which these themes may echo others from the literature on self-injurious behaviour, and inform therapeutic work. In so doing I am careful not to step away from Tina's own frames of reference, less I take the interpretative process too far and produce a reading that she would not recognise or accept.

SELF-HARM AS A WAY OF MANAGING LIFE

Tina's description of self-harm as being an integral part of her life, a way of managing its multiple pressures, is one frequently encountered in the literature on self-harm, especially when it uses first-person testimonies (e.g., Pembroke, 2004; Sutton, 2007). Here, like indeed in other pieces of qualitative enquiry, the emphasis is on the partly adaptive nature of self-harm: it may not be a perfect or harmless way to cope, but in the words of Tina: 'it works'. The implication seems clear: working towards a reduction, or even a complete elimination of the behaviour may well be justified, but only if this goal is endorsed by the client herself.

That self-injury can take many forms, respond to different triggers, and perform a wide range of functions for the individuals engaging in it is also well known from both quantitative and qualitative work (see chapter 1). David Klonsky's (2007) review for instance points to affect regulation, self-punishment, communication, the generation of feeling to combat dissociation, sensation seeking and control as key functions, all of which are reported by Tina.

However two aspects of her experience come out as especially significant: one is the very multi-functionality of the behaviour in a single individual; the other is the

importance of control, a theme that surfaces again and again in the analysis. For Tina the use of self-harm is a means to assert or reassert her control over self and life; paradoxically, it is also the blatant manifestation of her lack of control over her feelings and circumstances. Both aspects speak to the necessity for the clinician to explore the nature and meanings of self-injury for each individual client from a phenomenological perspective, and to reflect on the ways these may play out in the therapeutic relationship. Questions are also raised regarding the potential impact of inpatient treatment when perceptions of the hospital as a coercive environment, perhaps mirroring adverse family experiences, may lead to further and more extreme acts of self-injury (see also Motz, 2001).

WHAT'S UNDERNEATH: THE FRAGILE SELF

Tina's account of her inner turmoil and how it often spills over into self-harm echoes other accounts of the phenomenon (e.g., Babiker & Arnold, 1997). Her efforts to make sense of what's underneath the act also speak to the literature on affect regulation. The 'bad feelings' powerfully described by Tina, her sense of never being 'on a level', her episodes of depersonalization can be read as indicative of pervasive difficulties in regulating her emotions, which often include 'insufficient control of impulsive behaviors related to strong positive and negative affects' (Linehan, Bohus & Lynch, 2007, p.583).[21]

Her overall confusion, her constant challenging of thoughts, actions and feelings, even her loud inner critique also suggest a fragile sense of self. Her self-harm then becomes a way to provide a focal point and/or assert personal boundaries, albeit temporarily. What may be especially striking here is the way in which these various 'markers' of psychological difficulties seem to co-exist in a fluid, and perhaps mutually reinforcing way. Making sense of the powerful, ever-shifting experiences underlying her self-harm becomes for Tina a challenge in itself, perhaps preventing reconstructive rescripting until usable 'keys' are finally found.

[21] Given her enthusiasm for dialectical behaviour therapy it is likely that Tina would endorse such a reading.

WHAT'S UNDERNEATH: EXPERIENCES OF THE OTHER

The role of negative other-related perceptions in self-injury seems to have so far received less attention. One finds some evidence of interpersonal skills deficits among self-injuring individuals, which may result in lower perceived social support (Muehlenkamp, Brausch, Quigley, & Whitlock, 2012). But it is only recently that the social context of self-injurious behaviour became a focus of interest among researchers. Tina's account of her lived experience thus sheds a unique light onto the sort of world she may inhabit.

However perceived criticism and rough treatment by health care professionals have been identified in several studies, one of them even referring to 'hostile care' (Harris, 2000). Tina's experience of the judging and disapproving 'other' through her interactions with certain medics and nurses, and this at a time of heightened vulnerability is thus reflective of a widespread perception among self-injuring individuals. The interlacing of themes produced by the analysis gives this finding additional depth: being labelled and criticised is not only hurtful; it can also echo past mistreatments, thus compounding emotional distress in complex and profound ways, and directly feeding into the self-harm itself. This finding further supports the need for health services to respond more sympathetically to the plight of those who self-injure, a need that has lately been increasingly recognised (Longden & Proctor, 2012).

WHAT'S UNDERNEATH: EXPERIENCES OF THE FAMILY

As stated in chapter 1, the link between childhood abuse and self-injurious behaviour is complex, and probably mediated by factors such as emotional dysregulation. My interpretation of Tina's experience neither supports nor invalidates this proposition. However in her particular case, flashbacks of sexual abuse emerged as a key identifiable trigger, while the physical and emotional abuse she reported at the hand of her father chimed with her sense of self and other in significant ways. Here again Tina's account resonates with those of many others (e.g., Babiker & Arnold, 1997; Sutton, 2007).

The invalidation of her experience at the hands of her family was also an important theme. The denial of Tina's reality and feelings seemed to run from the abuse itself right

through to her later mental health difficulties. Tina reported confusion over her feelings around her family, and showed open distress when describing her dilemma between being 'let in' by her parents and being true to herself. These findings can be related to others, showing the impact of invalidating family environments on later self-injuring (e.g., Martin, Bureau, Cloutier, & Lafontaine, 2011). Conversely, Tina's reported satisfaction with the interviewing process may have a lot to do with the way I bore witness to her account, thus providing much-needed validation of her subjective experience.

DEVELOPING A NEW UNDERSTANDING OF SELF AND SELF-HARM

The last superordinate theme takes the analysis in a different direction, no longer concerned primarily with the 'raw' experience of self-harm as conveyed by Tina, but with the meta-awareness she has developed around it. Here the research question at the core of this project (how does an individual engaging in repetitive self-injury make sense of her behaviour) is taken literally, and the interpretative work turns to the process of meaning-making: as she constructs a narrative around her self-harm, Tina also reflects on her journey towards understanding and expression, offering a further frame of meanings around the act. Self-injury becomes the mindless act of a 'clueless' sufferer, the silent cry of a wordless victim. When seen in the context of recovery, meaning-making becomes a slow, deliberate process of self-enquiry, reflection and verbalization. The parallels with therapeutic work are obvious, and were not lost on Tina herself, who remarked that spending time discussing her self-harm with me may have been therapeutic in itself.

The idea that being able to reflect and communicate around self-harm can be crucial to recovery is lent further support by qualitative research (e.g., Craigen & Foster, 2009). However attending directly to the client's meaning-making process could give the therapist additional insight. In Tina's case, finding an approach (DBT) that matched her need for evidence-based psychological understanding and clear, tool-based guidance seemed key to a better management of her self-injurious behaviour. This should be of value to counselling psychologists, whose training places particular emphasis on integrative work and reflexivity.

Overall this first reading of Tina's account produced a rich, intricate picture of her sense-making around self-harm, one which resonated with much of the existing literature yet, as befitted its phenomenological intent, brought out her individual subjective experience.

3.3 Reflections on the use of IPA

Using IPA to develop a first interpretation of Tina's account proved challenging in several respects. Firstly, presenting a layered account of Tina's meaning-making around self-injury was not without risk. Like other phenomenological approaches, IPA is concerned with the lived experience of the participant, not its origins. Digging too deep might take away from the immediacy of the approach, and maybe obscure the phenomenon itself. Yet Tina's account seemed to foreground the underpinnings of her self-harm to such an extent that experiences of the self and others became an essential part of the interpretation. To complicate matters further, one theme, that of control, appeared time and again and I had to decide whether to make it a superordinate theme in its own right or keep it as a leitmotif. Having consulted other works I chose the latter, for fear of distorting the overall picture. But my self-doubt lingered. Still, throughout the analytical work I took heart in the explicit openness of the approach, its recognition that the analyst is trying both to 'give voice' and to 'make sense', and in the process may 'transcend or exceed, the participants' own terminology and conceptualizations' (Larkin, Watts, & Clifton, 2006, pp.113-4).

Bracketing my assumptions by holding them in awareness proved a second challenge. Not only did it require that I not 'commit' to a particular theoretical or diagnostic understanding of Tina's experience; it also meant not letting my ongoing work with another self-injuring young woman colour the interpretative work. I tried to keep Tina's picture in mind as I worked, and to immerse myself in the individuality and 'messiness' of her narrative. Yet my counselling psychology training, as well as my prior interest in self-harm and in emotional dysregulation, probably informed my own meaning-making process around the text, for instance by framing some of the connections drawn between the behaviour and its psychological underpinnings.

Not getting drawn into a more narrative or discursive reading of Tina's account represented a third challenge. IPA's boundaries can be stretched to accommodate elements of other approaches, and in particular narrative analysis with which it has been said to have 'a natural affinity' (Eatough & Smith, 2008); and indeed I found myself attending to both linguistic and non-verbal cues throughout the analysis. Yet knowing that two more interpretations were planned which would pay close attention to these and other elements made me draw a somewhat artificial boundary around my IPA reading. This difficulty, probably inherent to the use of a pluralistic approach, is revisited in chapter 6.

Overall however I enjoyed the work immensely, especially the clustering and writing up of themes to create a tapestry that would mirror and enhance Tina's own efforts at sense-making.

4. Narrative readings

This chapter turns to the second of our interpretative approaches, this time using narrative analysis to explore Tina's sense-making around self-injury. A first section introduces the approach and clarifies the epistemological position adopted. Two distinct pieces of narrative analysis are then presented, one bearing on a single narrative episode and the other on the meaning of self-harm in the context of Tina's illness narratives. As before, the chapter ends with a brief reflexive section.

4.1 The approach

4.1.1 Narratives and stories

> If you want to know me, then you must know my story, for my story defines who I am. (McAdams, 1993, p.11)

Narrative approaches to psychology take as their premise the central role of stories in human life: born complex creatures into a complex world, we use stories to make sense of our experience and to define our identity. These stories are part family inheritance and part ongoing construction; they are temporally organised, with a beginning, middle and end; and their creation and sharing enable us to engage with our social world (Murray, 2008). Studying narratives thus provides the researcher with a means to understand how individuals make sense of their world and selves.

Unsurprisingly given their emphasis on language and cultural embeddedness, narrative approaches can at times embrace a social constructivist, even relativist epistemology, assuming that individual stories are by definition ever-shifting constructions with no underlying reality or unity. But some among narrative researchers are primarily concerned with the lived experience of the individual, seen as possessing some degree of coherence and continuity, and thus adhere to a (critical) realist epistemology (e.g., Crossley, 2000). As already explained in chapter 2 the stance adopted here stands somewhere in the middle, and can best be characterised as contextual constructionist.

4.1.2 Choosing one approach…or several

Narrative research comes in many flavours, with different authors privileging different conceptions of the self, different ontologies, different foci of interest. For instance, whereas McAdams argues that 'the story is inside of us' (McAdams, 1993, p.12), Gergen regards the self-narrative as 'a linguistic implement constructed and reconstructed by people in relationships, and employed in relationships to sustain, enhance, or impede various actions' (Gergen & Gergen, 1983, p.156). These divisions are largely mirrored in researchers' choice of narrative approach, some focusing on *what* is being told; others on *how* (Smith & Sparkes, 2006).

Of particular interest here is the way in which narrative analysis, especially when applied to accounts of personal experience, can emphasize one or more of the following: the content of a text; its form or structure; the dialogic process between narrator and listener; and/or the way the narrative is 'performed', implying a positioning of storyteller and audience (Riessman, 2003). Also of relevance is the fact that the interpretative work can take in the text as a whole, concentrate on the properties of a section thereof, or combine the two in order to bring out the complexities of the underlying subject, for instance human identity. Indeed, it is not unusual for narrative researchers to cross interpretative lenses around a given text, and in the process lend support to the sort of pluralistic design adopted in the present work (e.g., Lieblich, Tuval-Mashiach, & Zilber, 1998; Hiles & Čermák, 2008; Frost, 2009).

In determining which narrative approach (or approaches) would be used here, the research question, the data, and the potential contribution of these different emphases to the overall interpretation were all key considerations. IPA had already produced a rigorous analysis of the content of Tina's interviews, whilst the forthcoming psychosocial reading of the text was expected to bring out its performative elements. Focusing on the linguistic properties of the narrative therefore seemed a priority, and after a careful re-reading of the text a long, temporally-ordered narrative episode was selected for detailed structural analysis (Gee, 1991). In addition, the overall form or type of Tina's narrative would be tentatively interpreted so as to better frame the personal significance of her experience of self-harm in the context of her life story (Frank, 1995). Choosing this twofold approach meant effectively adding an extra layer of pluralism to

an already demanding methodological design. Yet the extra effort also held the promise of a more nuanced, and it was hoped novel, reading of Tina's rich material.

4.2 Making sense of an episode of self-injury using Gee's poetic reading

McAdams defines nuclear episodes as 'those scenes from our past that are the climaxes of different acts of the life story'; they 'represent our subjective memories of particular events, in particular times and places, which have assumed especially prominent positions in our understanding of who we were and, indeed, who we are' (McAdams, 1993, p.296). The study of nuclear episodes or memories can thus provide unique insight into an individual's sense of self and story.

While Tina's interviews contained a number of significant mini-narratives around self-injury and early memories of family life, one, developed at the closing of the first interview, seemed especially meaningful in the context of the present work. In it Tina described 'the first major self-harm that I did that people knew about'. This episode marked a turning point in her experience of self-injury, both because of its severity and publicity, and because it led to her first hospitalisation in a psychiatric ward. A thorough structural analysis therefore seemed warranted, and Gee's (1991) linguistic approach was chosen for its rigour, level of detail and sensitive approach to narrative texts.

4.2.1 Gee's poetic approach

In a seminal piece published in 1991, Gee sets out to show how the very structure of a text raises interpretative questions at a number of different levels. By paying attention to these linguistic and paralinguistic clues whilst drawing on his contextual knowledge, the analyst can develop a fuller, richer interpretation of the text. Using the free-flowing 'language sample' produced by a young woman diagnosed with schizophrenia, Gee explores the contribution to the interpretative work of five distinct levels of structure and meaning in the text (see Table 4.1). Importantly these levels are hierarchically organised: each makes its own contribution whilst also amalgamating that of the levels below it.

Table 4.1: Gee's five levels of structure and meaning in a narrative text

LEVEL	FORMAL MARKING	ROLE IN INTERPRETATION
1. Line and stanza structure	patterning	ideas and perspectives on characters, events, states, information
2. Syntax and cohesion	word order and grammatical words	logic and connections
3. Main line/ non-main line	verbal system and aspect	plot
4. Psychological subjects	grammar	point of view
5. Focusing system	pitch and stress	image/theme

Source: Gee (1991)

Crucially, when parsing the text to bring out its structure equal importance is given to meaning and linguistic/prosodic characteristics. For instance, a line is made up of one or more 'idea units', each containing a new piece of information (or focus) and a unitary intonation contour (or pitch glide); in turn, the line possesses a central topic and is intonationally disconnected from other lines. Lines are grouped in stanzas, each stanza capturing a particular scene or vignette, and stanzas with similar themes are arranged into strophes and broader parts. By rearranging the text in this way, the researcher gains new insight into its structure, and thus its meaning.

4.2.2 Analysis

Working out the structure of a particular segment of interview material requires careful attention both to its content and to the way in which it is said by the interviewee. Here this meant listening to the extract several times, each time focusing on the way Tina used pitch and hesitations to accentuate certain words and/or mark a shift in focus from one line or stanza to the next. The text was correspondingly arranged in lines, stanzas, strophes and parts, with "/" separating idea units within individual lines (see Figure 4.1).[22]

[22] The text was also parsed for legibility by removing non-verbal clues from the original transcript including 'uh/um', punctuation and mentions of vocal/facial expressions; see Gee (1991) and Riessman (1993) for similar approaches to the text.

Figure 4.1: Tina' first major episode of self-harm, parsed using Gee's (1991) model

PART ONE (The context)

STROPHE ONE (Opening up)

STANZA 1 (Working for the lady)

1. When I was 15/ just before my 16th birthday
2. I was working for this lady who
3. She was a prison officer/ she had pedigree dogs that she showed
4. And so I got a job with her looking after her dogs

STANZA 2 (Going to the police)

5. And then I was working for her/ working for her for a few months or almost a year or something
6. And I told her that my dad was doing some things to me/ that he was abusing me
7. And she encouraged me to go to the police
8. So just before my 16th birthday/ when I was 15/ I went to the police about it

STANZA 3 (Staying with the lady)

9. And then because I had quite a good relationship with this lady
10. I stayed with her
11. And they had suggested me going into foster care/ which I didn't want to do cause it would have been with strangers

STROPHE 2 (On my own)

STANZA 4 (A lot of time on my own)

12. But then/ leading up to me shooting myself
13. She was/ cause she was a prison officer she worked quite long hours/ twelve-hour shifts sometimes/ night shifts
14. And I would quite often spend quite an awful lot of time on my own

15. And I did/ at the time I did have a social worker/ but I saw her once a week

STANZA 5 (GCSEs)

16. And, as well as that it was my GCSE year/ so the pressure with exams as well

17. To be honest the exams were like/ way down on my list of priorities so

18. I did actually pass them/ which was amazing

19. But yeah the pressure of that and

STANZA 6 (The shock of leaving my family)

20. The time spent on me own because I came from

21. My family is quite a big family/ there is five of us kids/ it was always a busy house and

22. The shock of leaving that to being on my own

23. Considering what I'd just told the police

PART 2 (The act)

STROPHE 3 (Rehearsals)

STANZA 7 (Looking at the gun)

24. So a few times I knew she kept her gun under her bed/ and I

25. Strangely it was just in/ like some sort of shoebox type thing/ it wasn't locked in a cabinet

26. So I knew she kept it there/ and when she wasn't in the house I would go take it/ I would go into the lounge with it and

27. Look at it

STANZA 8 (Figuring the gun out)

28. I think at first it was just curiosity/ I wanted to know what it/ what it felt like/ how heavy it was and/ you know and what you could do with it

29. And it's strange because after I shot myself the police asked me how did I figure out how to use it/ cause they thought that R/ this lady/ had shown me how to use it

30. And I remember feeling quite insulted that they thought/ I was that stupid that I couldn't figure it out for myself

31. But obviously over a few weeks/ I figured out how to use it

STANZA 9 (Ready to pull the trigger)

32. And there were times when I would sit in her lounge/ and I would have the barrel of the gun in my mouth with my finger on the trigger

33. And be ready just to pull the trigger

STANZA 10 (Powerless and alone)

34. And it wasn't/ it wasn't really the actual/ it was again it was having that power/ that something that I could control/ that you know I can decide what happens to me

35. Cause everything else then just felt/ just felt like once I'd opened my mouth and said what/ what's happened/ what was happening to me/ what my dad was doing

36. Then I felt like/ then everybody else just had control/ that I didn't have any say in what happened/ or any final say in what happened

37. And so that just kind of yeah/ I felt really powerless then/ and really alone

STANZA 11 (Wanting to but not doing it)

38. So quite often I would go into her lounge and experiment

39. And want to do something but not actually do it

STROPHE 4 (Doing it)

STANZA 12 (Choosing the day)

40. And then/ I think I may have decided a few days prior that you know/ on such and such a day I was maybe/ I think it was either a Tuesday or a Wednesday/ on this particular day that this was when I was going to do it/ and I'm trying to remember

41. On that particular day I think I had to/ I had cousins young cousins who lived down the street from me/ from where I was living at the time/ and their parents wanted me to baby-sit/ and there was that that I had to do and

42. I partly couldn't face that either

43. So that was the day that I decided I wanted to do it

STANZA 13 (Choosing the spot)

44. She/ R the lady that I lived with she had an anatomy book in her/ in one of her bookshelves

45. And I remember looking through this anatomy book and thinking to myself/ where could I shoot myself that it would be bad enough that/ people would realise how/ how much pain I'm in emotionally/ but that wouldn't be so bad that/ I would die

46. And then so I figured out that/ shooting myself in the shoulder was where to do that

47. So that's where I shot myself just here

STANZA 14 (Doing it)

48. So I remember going/ taking the gun/ went into her garage

49. She had a garage that was attached to the house

50. And I went by the back garden into her garage and

51. Yeah I shot myself there

PART 3 (The aftermath)

STROPHE 5 (First impressions)

STANZA 15 (A big shock)

52. I remember at the time it was/ yeah the initial thing I didn't feel any pain

53. It was like a complete shock in a way/ I was like astounded that I'd actually done it

STANZA 16 (Freaked out)

54. And I remember/ one of the most vivid memories I have about it is

55. You know I think where I'd shot myself there was maybe some muscles or tendons or something/ or nerves or something in there that were/ that when I shot myself my whole arm just twisted/ twisted like it was really unrecognisable as an arm

56. It just like/ that freaked me out the most/ I still have that memory that thing about it that freaked me out the most

57. And that was immediately I think/ as the bullet was going through me

STANZA 17 (This warm feeling of blood)

58. Then I remember then this warm feeling of the blood

59. At the time it did not occur to me that it was blood/ but this warm feeling of/ obviously it was the blood going down my chest

STANZA 18 (Calling for help)
[Were you scared?]

60. Not at that very moment

61. I think my first impulse or my first thought was to go to the phone

62. So I went to the phone and/ phoned 999/ said I needed an ambulance

63. And I vaguely remember/ I think it was a woman I spoke to and/ I can't remember exactly what I said to her

STANZA 19 (Scared)

64. But the next thing I was then lying on the floor near the phone/ and I remember then feeling scared/ cause I was still bleeding and it's then I could feel pain and/ then I felt like I/ yeah that's/ I was actually

65. I seem to remember a lot actually/ I remember lying saying to myself/ I wish I hadn't done this/ I wish I hadn't done this

STROPHE 6 (The rescue)

STANZA 20 (Banging and shouting)

66. And the next thing I could hear people banging on the door

67. And it was the police obviously

68. Then they/ I think they got in through the back door

69. Yeah it was just all them/ all the police shouting/ with their guns in their hand and you know/ me lying there

STANZA 21 (Lying in the dark)

70. And I think I remember that the room that I'd gone to the phone/ that was the nearest room with a phone/ that was at the back of the house/ and it was a bedroom/ and the light bulb in that bedroom wasn't working

71. I remember lying there/ it was getting dark and I remember lying there

72. And I remember the police/ I could hear the police going around the house but I/ it was like they couldn't find me

73. And that felt like forever

STANZA 22 (Found)
[Did you want them to find you?]

74. Yeah I think I did yeah

75. And I think maybe I called out to one of them

76. And then they/ they dragged me out into the hall so they/ cause there was no light in the bedroom and

77. Yeah and then I was

STANZA 23 (Closing my eyes)

78. But I remember the whole time that/ that from then on/ I remember being aware of everything but just closing my eyes

79. And it wasn't that I wasn't conscious but I just

80. I was like a dead woman I didn't want to deal with what was happening around me/ cause there was too much happening

STANZA 24 (Not dealing with it)

81. And I've done that other times when I've self-harmed/ you know/ when it gets to the point that/ other people have to come and help me/ then I just close me eyes because I can't deal with it

82. It's like I don't want to see their faces or I don't want to/ deal with what/ you know/ with everything else that's going on around because

83. Yeah it's hard enough dealing with what I'm thinking of I suppose/ at the time

Level 1: line and stanza structure

Figure 4.2 presents an outline of Tina's narrative in terms of stanzas, strophes and parts. This patterning provides an overall framework within which to read the other levels of meaning; it also orients the reader to the text's main ideas, events, characters or states.

Figure 4.2: Outline of the narrative in terms of stanzas, strophes and parts

PART 1. THE CONTEXT

STROPHE 1. OPENING UP
Stanza 1. Working for the lady
Stanza 2. Going to the police
Stanza 3. Staying with the lady

STROPHE 2. ON MY OWN
Stanza 4. A lot of time on my own
Stanza 5. GCSEs
Stanza 6. Leaving the family

PART 2. THE ACT

STROPHE 3. REHEARSALS
Stanza 7. Looking at the gun
Stanza 8. Figuring the gun out
Stanza 9. Ready to pull the trigger
Stanza 10. Something that I could control
Stanza 11. Wanting to but not doing it

STROPHE 4. DOING IT
Stanza 12. Choosing the day
Stanza 13. Choosing the spot
Stanza 14. Doing it

PART 3. THE AFTERMATH

STROPHE 5. FIRST IMPRESSIONS
Stanza 15. Astounded
Stanza 16. Freaked out
Stanza 17. This warm feeling of blood
Stanza 18. Calling for help
Stanza 19. Scared

STROPHE 6. THE RESCUE
Stanza 20. Banging and shouting
Stanza 21. Lying in the dark
Stanza 22. Found
Stanza 23. Closing my eyes
Stanza 24. Not dealing with it

The text follows a temporal sequence, with part 1 presenting the context in which Tina's self-harm took place, part 2 describing the process whereby she first rehearsed and then executed the act, and part 3 narrating Tina's experience in the immediate aftermath of the shooting. Within each part, strophes delineate broader themes. Strophe 1 is about Tina's relationship with the female prison officer who encouraged her to report her dad's abuse. Interestingly the patterning of the text suggests Tina's growing proximity to this lady, from working for her in stanza 1, to telling her about the abuse and being encouraged by her to go to the police in stanza 2, before finally staying with her instead of being sent to 'strangers' in stanza 3.

By contrast strophe 2 is about solitude, and how this set Tina up to shoot herself. The break with the happy resolution suggested in stanza 3 (staying with her lady friend) is clearly marked at the beginning of stanza 4 ('But then'), which outlines Tina's growing sense of disconnection. Stanzas 5 and 6 complete the picture by bringing forth academic pressures and the 'shock' of leaving the lively family house, both physically and psychologically ('considering what I'd just told the police').

Part 2 is about the acting out of Tina's distress, and opens with 'So', thus making clear that her turn to self-harm is a direct result of the isolation described in strophe 2. Strophe 3 is about gradually mastering the gun. In stanza 7, Tina describes taking the gun to look at it, an act she justifies in stanza 8 by reference to curiosity and a desire to figure the weapon out. Stanza 9 shifts the focus to Tina's multiple death rehearsals with a turn to conditional tense ('I would'). Stanza 10 is more reflective, querying the rationale behind Tina's actions at that time, and emphasizing her sense of powerless and, once again, of disconnection. Stanza 11 echoes stanza 9 in both content and form (two lines), and provides a coda to the strophe.

At the beginning of strophe 4, the expression 'And then' marks a new shift, also audible on tape in Tina's more resolute tone of voice. In that strophe Tina no longer experiments, she turns to action, first choosing the day in stanza 12, then where to shoot herself in stanza 13, and finally pulling the trigger in stanza 14. Tina purposeful approach is embedded in the structure of stanzas 12 and 13, where an analysis of situation or options is concluded in a similar way: 'so that was the day', 'so that's where I shot myself'. It is also conveyed by the brevity of stanza 14: whereas stanzas 12 and

13 contain more details, as Tina actively tries to remember the chain of events and thoughts that took her to finally injure herself, stanza 14 is made up of four short lines, starkly descriptive of her final actions and given an air of inevitability by the opening word ‘So’ (see below).

Stanza 14

So I remember going/ taking the gun/ went into her garage
She had a garage that was attached to the house
And I went by the back garden into her garage and
Yeah I shot myself there

Part 3 looks at the aftermath of the shooting, and is first remarkable by the absence of any syntactic or psycholinguistic opening marker except for a short pause at the start of stanza 15. This further emphasizes the matter-of-fact presentation of the act itself in stanza 14: Tina moves swiftly on to a reflection on her feelings in the moments immediately following the shooting; of her feelings in the moments immediately preceding it she does not speak. And yet the very focus on sensations and feelings in stanza 15 marks a profound shift in the narrative: through part 3, Tina presents herself as mostly passive, helpless and overwhelmed; she no longer plans and acts, she feels and waits. Strophe 5 recounts her first impressions in great detail. There is the initial shock of having finally ‘done it’ in stanza 15, only to be ‘freaked out’ by her arm’s involuntary twisting in stanza 16. Stanza 17 describes the warmth of the blood running down her chest. In Stanza 18 Tina calls for help, her first ‘thought’ in the midst of strong sensations and feelings. The strophe ends with Tina brutally coming to her senses after passing out (‘But the next thing’) and experiencing fear, pain and regret in stanza 19. Interestingly Tina’s description of regaining consciousness is mirrored in a reflective intonation at the end of line 65, and in her surprise at the detail of her recollection in line 66 (‘I seem to remember a lot actually’).

The last strophe, strophe 6, narrates Tina’s rescue by the police, contrasting their noisy irruption onto the scene in stanza 20 with her lying in the dark, seemingly ‘forever’, in stanza 21. When her solitude is finally broken in stanza 22, the experience proves overwhelming: Tina closes her eyes (stanza 23). Stanza 24 reads like a coda to the

strophe, in which Tina reflects on ‘other times’, and on her inability to process her inner and outer experiences around self-injury once others come to her help.

This first reading of the text thus provides a clear set of events, characters (Tina, the lady, family members, the police, the 999 operator, the gun), and themes (connection versus solitude, mastery and agency versus passivity, doing versus experiencing). As such it forms the bedrock for the subsequent analysis.

Level 2: syntax and cohesion

Gee (1991) sees the syntactic system of the text as providing cohesion and spelling out the ‘logic’ of the narrative. As was already alluded to above, this is indeed the case here. Throughout the use of ‘and’, ‘and then’ and ‘so’ strings Tina’s experiences, decisions and actions together, creating a strong narrative and at times an almost ‘logical’ sense of progression. From strophe 2 onwards, it is as if self-harm had been set in motion, the unavoidable outcome of growing isolation and of Tina’s efforts to regain a degree of control over life. At the same time other expressions (e.g., ‘But then’, ‘But the next thing’) introduce minor breaks in the action or experiencing, jolting the reader/listener into paying heightened attention.

The repetition of certain words and phrases is also noteworthy. Stanza 1 for instance opens with the line ‘when I was15/just before my 16th birthday’. Stanza 2 ends with a similar turn of phrase (‘just before my 16th birthday/ when I was 15/I went to the police about it’), making time and event more salient: this was when it all started, when everything changed. The inverted repetition, and the symmetry between stanzas 1 and 2 that it creates, also introduces a lulling effect, placing a contrasting emphasis on the conclusion ‘I went to the police’. In stanza 10, line 35 also presents an interesting syntax (‘what’s happened/ what was happening to me/ what my dad was doing’): here the effect is to emphasise the enormity and unspeakability of the abuse, since it takes Tina three attempts to designate it. Elsewhere repetition is used for emphasis (e.g., ‘that freaked me out the most’ in line 56; ‘this warm feeling’ in lines 58 and 59; ‘I remember lying there’ in line 71). Though full interpretation requires attention to other levels and linguistic cues, syntax is therefore an integral part of Tina’s meaning-making around the event.

Level 3: main line of the plot

The third level of analysis and meaning concerns the distinction between the main line of the plot and the material off that main line. The former can be traced back to main clauses in the text and to the perfective aspect thereof (i.e., in past tense narratives, the simple past tense or historical present), thus excluding states alongside generic, repeated and habitual events (Gee, 1991). However questions can be raised regarding seemingly incidental comments. Here for instance Tina's remark concerning her GCSEs ('I did actually pass them') constitutes a main clause with perfective aspect; yet it comes across as an aside, and as such was eventually excluded from the main plot. Figure 4.3 presents the main material from Tina's narrative.

Figure 4.3: Main line material signalling the basic plot of the narrative

STANZA 2 (lines 6, 7 and 8)

1. I told her that my dad was doing some things to me/ that he was abusing me
2. She encouraged me to go to the police
3. I went to the police about it

STANZA 8 (line 31)

4. I figured out how to use it

STANZA 13 (line 46)

5. I figured out that/ shooting myself in the shoulder was where to do that

STANZA 14 (lines 50 and 51)

6. I went by the back garden into her garage
7. I shot myself there

STANZA 18 (line 62)

8. I went to the phone and/ phoned 999/ said I needed an ambulance

STANZA 22 (line 76)

9. They dragged me out into the hall

According to Gee (1991), level 3 helps the reader suss out the significance of the narrative, but only in conjunction with other levels; it throws up questions, to be answered later. For instance, the process of figuring out the practicalities of the shooting is given a central place in the plot, yet the gun is not named as the chosen weapon in any of the main clauses. Does that signify its accessory role, the gun being a mere tool in the hands of planning/thinking Tina? On the other hand, whilst the main line narrative seems to put Tina firmly in charge, her actions themselves appear so logical as to become inevitable, as if shooting herself was the obvious conclusion to her engagement with the lady and her gun. The latter in particular takes on the sort of 'ready-to-hand' quality described by Heidegger (Mulhall, 1996); it almost calls out to be used by Tina.[23] Last, one is struck by the skeletal nature of the plot and, by contrast, by the abundance of contextual and feeling material.

Level 4: psychological subjects

Level 4 is concerned with the grammatical subjects of main clauses in the text (whether main line or off main line), since these 'are "psychological launching points" in a stanza; they represent points of view from which the material in a stanza is viewed, what the narrator is "empathizing" with', whether animate or inanimate (Gee, 1991, p.23).[24] In order to get a proper feel for each stanza's psychological subjects however, Gee recommends excluding extra-narrative comments which take the narrator outside the stanza (e.g., 'I remember'), and what he calls 'dummy subjects' because they do not designate anything (e.g., in 'it was just curiosity'). Table 4.2 lists the psychological subjects identified in Tina's narrative.

Of particular interest when studying level 4 of a text is the way in which the narrator's stance changes. Here one notices a gradual reduction in the number of psychological subjects or stances: in part 1 Tina shifts subject several times, moving between 'I', 'she' (the lady), 'they' (it is not clear whether this refers to the police or to social services), 'the exams' and 'my family'.

[23] I am indebted for this point to my supervisor Carla Willig.
[24] In his own example Gee includes waves alongside girls and horses (Gee, 1991).

Table 4.2: Psychological subjects in each stanza (line numbers in parentheses)

STORY DIVISION	PSYCHOLOGICAL SUBJECTS
PART 1	
Stanza 1	I (2), she (= the lady, 3), she (3), I (4)
Stanza 2	I (5), I (6), she (= the lady, 7), I (8)
Stanza 3	I (10), they (= the police? social services? 11)
Stanza 4	she (= the lady, 13), I (14), I (15)
Stanza 5	the exams (17), I (18)
Stanza 6	my family (21)
PART 2	
Stanza 7	I (24), it (= the gun, 25), it (25), I (26), I (26)
Stanza 8	I (28), I (31)
Stanza 10	I (37)
Stanza 11	I (38)
Stanza 12	I (42)
Stanza 13	she (= the lady, 44), I (46)
Stanza 14	she (= the lady, 49), I (50), I (51)
PART 3	
Stanza 15	I (53)
Stanza 16	I (56)
Stanza 18	I (62)
Stanza 19	I (64)
Stanza 20	I (66)
Stanza 21	I (72)
Stanza 22	they (= the police, 76), I (77)
Stanza 23	I (80)
Stanza 24	I (81)

In part 2 however the range of psychological subjects narrows, to include only ‘I’, ‘it’ (the gun) and ‘she’ (the lady). Interestingly Tina’s lady friend now seems to perform merely an instrumental role, not unlike that of the gun (‘she had an anatomy book’; ‘she had a garage’), leaving Tina very much at the centre of the stage. This is also true of part 3, where ‘I’ is used throughout with a single exception (the police). By then Tina seems fully immersed into her sensations, feelings and thoughts, while the world is either invisible (police searching the house) or deliberately kept at bay (closing her eyes).

Level 5: focusing system

The fifth and last level of interpretation concentrates on the use of pitch glides within each stanza. In the English language a pitch glide signals the focus of a sentence, the information that the speaker judges especially important and/or new. In Gee's approach pitch glides not only help define distinct idea units, they also mark the most salient aspects of the narrative, 'the key images or themes out of which we are invited to build an overall interpretation of the narrative' (Gee, 1991, p.27). These can then be interpreted in the context of the other structural insights garnered through the analysis.

Despite listening to the tape several times, it proved impossible to locate the pitch glides in each idea unit: Tina's delivery was often flat, and I had therefore relied on content and pauses/hesitations as well as pitch glides in my earlier patterning. However in each stanza a few words or expressions did come out as bearing a more pronounced pitch and these are presented in Figure 4.4 below. Using Gee's notation, material from different lines within a stanza is separated by a cross hatch ('#'), while material from different units within the same line is separated by a comma. A few words were given especially strong emphasis in Tina's narration, and these are underlined.

Figure 4.4: Focused material within each stanza

PART 1

STROPHE 1

Stanza 1	15 # this lady who # pedigree dogs # a job with her
Stanza 2	for a few months # some things <u>to me</u>, abusing me # <u>encouraged</u> # 15
Stanza 3	I stayed with her # into foster care

STROPHE 2

Stanza 4	shooting # quite long hours # an awful lot # I did
Stanza 5	GCSE year # way down # <u>pass them</u>, <u>amazing</u>
Stanza 6	time # shock

PART 2

STROPHE 3

Stanza 7	under her bed # shoebox, locked # take it, into the lounge with it # look at it
Stanza 8	curiosity, what it felt like, heavy, <u>do</u> with it # after # stupid # how to use it
Stanza 9	on the trigger # the trigger

Stanza 10 again, I can decide # any say, any final say # powerless, alone
Stanza 11 experiment # to do

STROPHE 4
Stanza 12 decided, on such and such a day # cousins, young cousins, baby-sit, there was that # face that # that was the day, do it
Stanza 13 anatomy book # bad enough, bad # in the shoulder # that's
Stanza 14 her garage # back

PART 3

STROPHE 5
Stanza 15 initial # shock, astounded that I'd actually done it
Stanza 16 vivid # muscles or tendons or something, or nerves, my whole arm, unrecognisable as an arm # freaked me out the most
Stanza 17 warm # warm
Stanza 18 impulse # vaguely # exactly
Stanza 19 the next thing, then feeling scared, it's then I could feel pain # a lot

STROPHE 6
Stanza 20 banging on the door # the police # all them shouting, their guns in their hands, me lying there
Stanza 21 light bulb # lying there # I could hear the police, they couldn't find me # forever
Stanza 22 they dragged me
Stanza 23 from then on, aware of everything # too much happening
Stanza 24 other people have to come and help me, I can't deal with it # everything else # thinking of

Once the narrative's focusing system has been outlined, a final interpretation can be offered that takes into account salient aspects in all five layers of meaning. Part 1 sets the scene for Tina's self-harm, and this at several levels. First stanza 2, which describes Tina's disclosure to the lady and her subsequent reporting of the abuse to the police, contains an inordinate quantity of main line material: these are the actions that set everything in motion, marking a turning point in Tina's life story (and not, interestingly, the abuse itself); the way her exact age is underlined, twice over stanzas 1 and 2, further confirms this. The importance of Tina's relationship with the lady is also marked throughout strophe 1: the relationship deepens, from work to confidante and supporter (strong tonal emphasis on the word 'encouraged'), and on to housemate/surrogate parent (an alternative to foster care). The flow of psychological subjects in stanzas 1 and 2 is also noteworthy: I – she – she – I – I – I – she – I. Stanza 3 comes almost as a

conclusion, a sort of happy ending for Tina, despite the mention of indistinct 'they' in line 11.

Opening with 'But then', strophe 2 marks a brutal shift. There is no development in the main plot, though passing her GCSEs is hailed in hindsight as an unexpected achievement (focus on 'amazing'). Instead Tina outlines the combined psychological pressures she gradually comes under 'leading up to me shooting myself', including the effect of a lack of social interaction, exam stress and 'the shock of leaving' (and betraying?) her real family. Tina's account remains largely factual, with no use of emotion verbs. Yet the expression 'on my own' is repeated three times (lines 14, 20 and 22), and Tina's growing sense of isolation accentuated in words if not in pitch ('awful', 'shock'). In stanzas 5 and 6 the narrative also turns more disjointed. Sentences start and end abruptly. If strophes 1 and 2 share similar features (overall length, number of stanzas), they frame contrasting realities and end very differently: Tina staying with a trusted friend away from her abuser (and having had her own say in her living arrangements: 'I didn't want to') in stanza 3; Tina in shock, on her own, away from the hustle and bustle of family life after having reported her dad to the police in stanza 6. The structure of part 1 thus underlines the gap between what may have been young Tina's idealised vision of her new life, and the lonely, fractured reality she finds herself in.

Part 2 is about Tina's response to loneliness, and perhaps disappointment: harming herself, in a dramatic yet premeditated way. Once again the narrative unfolds in two stages, and thus two strophes. In strophe 3, the focus is on Tina and the gun. Little happens, with the only main line material concerning Tina's successful mastery of the weapon ('I figured out how to use it'). There is great unity of place, expressed both in the content and in the rhythm of the strophe: in stanza 7, and then again in stanzas 9 and 11, Tina describes sitting in the lady's lounge by herself, experimenting with the gun. This repetition feels like a chorus, amplifying the habitual, almost ritualistic nature of the act. The comparative length of the strophe is also noteworthy, its six stanzas charting the growing readiness of Tina, as she progresses from looking at the gun to putting the barrel in her mouth. Interestingly while the theme of aloneness is ever-present ('I' and 'it' the only subjects), and in stanza 10 poignantly conveyed with a strong emphasis on the word 'alone', mastery is what the strophe is about. Tina is now

in charge, with verbs like ‘know’, ‘want’, ‘figure out’. Pitch glides are more perceptible, and accentuate terms like ‘I’ and ‘do’. Playing with the gun, rehearsing self-harm, gives Tina a sense of control in the midst of her powerlessness. Lines 35 and 36 are especially illuminating, describing first Tina as the helpless, silent victim of paternal abuse and then, once she has finally opened her mouth, as the equally voiceless, powerless victim of her new circumstances. By contrast figuring out the gun is proof that she is not stupid, and her finger on the trigger gives her ultimate control over her own fate. The two short lines of stanza 11 conclude the strophe, showing Tina finally primed for action.

Strophe 4 turns to the act itself. It is shorter at three stanzas, yet more eventful, with three items of main line material, including the actual shooting. As already discussed above, stanzas 12 and 13 have a similar structure, each recounting in some detail one of Tina’s practical decisions, while stanza 14 is short, terse and factual, the actual shooting a mere logical step in Tina’s overall plan. The lady returns as a psychological subject, but now seems relegated to a subsidiary status: she no longer does anything, merely provides the means. Tina is the one in charge. Interestingly however others, and in particular family, are also in evidence, though not as subjects. Self-injuring is presented as a means to thwart unbearable family expectations (accentuation of ‘there was <u>that</u> that I had to do’, and of ‘I partly couldn’t <u>face that</u> either’); and as a carefully weighted way to communicate her emotional distress (strong pitch glide on ‘bad enough’ and ‘bad’). Though Tina relishes her sense of control over life and death she wants to live, and through careful premeditation she instrumentalises her act of violence. In the process she shows little emotion: if strophe 3 hinted at a lonely helpless girl with a barrel in her mouth, strophe 4 is all about planning and doing.

As previously explained, the lack of transitional words or clear psycholinguistic markers between the shooting in line 51 and the after-shooting in line 52 seems noteworthy. Yet stanza 15, with its two lines, may be seen as a transition in itself: still very much a part of Tina’s self-injurious actions, yet with a new, explicit focus on feelings and experiencing. This focus sets part 3 apart, and accounts for the fact that ‘I’ is this part’s only psychological subject, except for a single shift to ‘they’ (the police) as they erupt into the scene of the self-shooting and drag her out into the light, an act of violence as much as rescue. Like the others, part 3 comprises two distinct episodes or

strophes, this time of equal length (five stanzas). In strophe 5 Tina tries to capture her sensations and feelings in the immediate aftermath of her self-harm, from shock at having finally 'done it', to being 'freaked out' (repeated twice) by the involuntary twisting of her arm, to the warm feeling of her blood (repeated again, with the word 'warm' heavily accented both times), followed by her call for help and 'then' (emphasized) and only 'then', pain and fear. Several aspects of this strophe merit attention. First, the rhythm imparted by the alternating of short stanzas describing raw sensations, and longer ones describing more complex actions (twisting of the arm, calling 999), and arguably mirroring Tina's shifting awareness. Then the thorough, methodical nature of Tina's reminiscing: stanzas 15 to 19 provide what seems a blow-by-blow account of her inner experience, anchored in a clear (if subjective) timeframe: 'at the time' (line 52); 'immediately' (line 57); 'then' repeated twice (line 58), 'at the time ' again (line 59), 'at that very moment' (line 60), and 'then' (strongly accentuated, line 64). She later expresses surprise at the detail of her recollection. By contrast, despite providing the sole segment of main line material her impulsive call for help is only 'vaguely' remembered (with emphasis on the word 'vaguely'). Stanza 19 closes on a litany as Tina, now lying scared and in pain, repeats to herself 'I wish I hadn't done this/ I wish I hadn't done this'. By the end of the strophe all pretence at control and detachment has gone.

Strophe 6 sees Tina's sensorial bubble being pricked with the noisy intrusion of the police, 'banging' and 'shouting', with their 'guns' in their hand (all of which accentuated). The contrast with Tina's situation, lying alone and in the dark, is stark. Whereas in strophe 5 she had confidently anchored her narrative in time, now she loses her chronological bearings: the wait feels 'like forever'. Yet the way she is eventually 'dragged out' into the hall, and into the light, almost feels like a violation, and her act of closing her eyes an instinctive response. The strophe concludes with a coda: in stanza 24 Tina relates this first major episode of self-harm to others and outlines a consistent pattern. Her choice of words in line 81 is worth considering: when other people 'have to' come and rescue her, is it because she leaves them no choice (calling emergency services) or because far from empowering her, self-harm ultimately reduces her to a state of complete helplessness? What is clear is that the aftermath of her act leaves her overwhelmed: unable to confront the (reproaching?) faces of her helpers and deal with 'everything else' going on around her, and struggling to process her own 'thinking'

(accentuated in the text). Perhaps this last stanza also captures the complex, contradictory relationship Tina has with control and agency: wanting to act, yet at the same time wanting others to deal with the consequences of her actions.

4.2.3 Discussion

Gee's linguistic approach to the text, with its close attention to structure and prosody, provided a further reading around Tina's narrated experience of self-injury. At times this reading seemed to echo the thematic analysis carried out in chapter 3, where self-harm had similarly been presented as a way to achieve control over life and as a means to communicate distress. However the detailed interpretation of this highly significant episode also focused attention on new elements. One was the importance of social connection or disconnection: Tina's act was framed as the direct result of losing touch with family and lady friend and finding herself alone, an experience she both described and embedded into the text (e.g., through her choice of psychological subjects). The act of shooting herself became a dramatic call for attention and help, albeit one that she ultimately could not face up to.

Also in evidence was the relationship between Tina and her weapon of choice, the gun, which became a psychological subject in its own right. Strophe 3 outlined a process of habituation whereby she familiarized herself with the weapon's feel: its weight, the sensation of the barrel in her mouth. Always the scientist (see previous chapter), Tina described a behaviour initially driven by curiosity and based on experimentation. But the repetitive nature of that process (reflected in the length and structure of the strophe itself) suggested that Tina was also rehearsing severe self-harming, gradually breaking down her self-protective psychological barriers and developing mastery over her own instincts, a key precondition to violence against the self (Joiner, 2007). The repetition also gave Tina's preparations a ritualistic feel, possibly adding to her sense of control.

The richness of this single episode of self-injury was also noteworthy, confirming its status as 'nuclear episode'. Within its 24 stanzas it encompassed a complex account of Tina's actions and reactions, one which blended external circumstances and inner experiencing in making sense of her act. Taking the interpretative work further, one could reflect on the centrality within of the two thematic lines dear to life story analysts,

power and intimacy (McAdams, 1988). In Part 2 of Tina's narrative self-shooting became a way to affirm mastery (over fear) and effect impact (on others); however it could also be read as a response to a lack or loss of intimacy, a desperate attempt to make others notice and empathise, as prefigured by Part 1. Part 3 exposed the futility of Tina's actions: in Strophe 5 she lost control over her body and senses, and ended up mired in guilt and regret; in Strophe 6 her sense of isolation and helplessness was heightened by the brutal intervention of the police. Both the inner logic and the self-defeating nature of Tina's act were thus given a powerful expression, one that Gee's approach rigorously articulated.

4.3 Self-injury and Tina's illness narratives

But Tina's self-harm did not begin and end with this episode, however significant. Instead, it accompanied her through life, from the beginning ('as far as I can remember') to the time of the interviews. It therefore seemed an important thread in her life story, one that might both reflect and express her sense of self. Exploring the meaning of Tina's self-injuring in the context of her overall story required a different form of narrative analysis however: more holistic in its approach to the text, perhaps also more sensitive to Tina's understanding of herself as someone who repetitively self-injured.

4.3.1 Frank's illness narratives

Having considered several frames of analysis (e.g., Gergen & Gergen, 1983; McAdams, 1993), a decision was made to use that proposed by Arthur W. Frank (1995). Frank sees stories as 'the self's medium of being'; in the context of illness, stories also 'have to *repair* the damage that illness has done to the ill person's sense of where she is in life, and where she might be going' (Frank, 1995, p.53). Frank argues that those engaged in such narrative repair work tend to use three main illness narratives, often in combination: a restitution narrative ('Yesterday I was healthy, today I'm sick, but tomorrow I'll be healthy again'); a chaos narrative, which Frank describes as "an anti-narrative of time without sequence, telling without mediation, and speaking about oneself without being able to fully reflect on oneself' (Frank, 1995, p.98); and a quest narrative, in which the illness becomes a journey, with new meaning as its destination.

Far from being passive, helpless victims of their fate, ill people are thus presented as 'wounded storytellers', drawing narrative power from their sick body.

The more I read her interviews the more Tina appeared to me as a wounded storyteller and the story weaved around her self-harming as an illness narrative; in turn, Tina's cutting could be seen as a way in which her narrative was being expressed *through* the body, thus also echoing Frank's interest in the 'body-self' and the 'acting out' of illness. I also felt that this approach, with its emphasis on the empathic bond between teller and listener, would bring out some of the dialogic aspects of the interviewing process, hitherto largely neglected. I did however refrain from pushing my discussion of the positioning of Tina's narrative too far, for fear of undercutting the third and last segment of interpretative work (see chapter 5).

Last, Frank's insistence that one should think *with* stories, experience them as affecting oneself and not 'merely' try to analyse them, seemed a valuable counterpoint in this analytics-heavy research project, and one which deeply resonated with my own ethical and clinical stance, a point that is further taken up in the last section.

As for method, the first step of the work consisted of reading through the three transcripts again in order to immerse myself anew in Tina's overall narrative. I then re-read them once more, this time holding in mind Frank's heuristic frameworks. The idea was not to shoe-horn Tina's story into one or more of his illness narratives, but rather to try and disentangle narrative threads and in the process recognise 'what basic life concerns are being addressed and how the story proclaims a certain relation of the body to the world' (Frank, 1995, p.24). I was also mindful of the way in which the narratives might combine and interrupt each other, both across and within individual interviews.

4.3.2 Analysis

From getting better to bearing witness

All three of Frank's illness narratives could be found in the telling of Tina's story around self-injury. During the first minutes of the first interview, Tina volunteered a clear, tightly sequenced restitution narrative. Given the chronic nature of her difficulties,

the basic storyline of the restitution plot was somewhat twisted: instead of 'yesterday I was healthy, today I am sick, tomorrow I'll be healthy again', Tina's story outlined moderate, secret episodes of self-harming in childhood, followed by severe self-harming requiring in-patient treatment, followed by reduced self-harming after what appeared to be a successful course of specialist treatment. Interestingly, each of these stages took place in a different setting, from family home to hospital to independent accommodation, and suggested a different degree of agency on her part, from acting in secret, to being sectioned, to finally actively seeking help and moving abroad. Having figuratively retraced her steps and come to a place where her self-harm was 'significantly reduced' Tina expressed satisfaction, first with a soft laughter, and then verbally: 'I suppose when I say that all in one thing long, you know when I say that out loud it kind of makes me realise how far I've come so… It's good.' To borrow from McAdams (1993), the tone of this first narrative episode was resolutely optimistic: Tina the child had struggled; Tina the young adult had been very ill; the more mature Tina had found her own space, gained new control over herself, and could look to the future with hope.

Tina's restitution narrative was briefly foregrounded again in the third interview, in response to a question on possible ways in which her self-harming had changed over time:

T. Um, significantly it's reduced, um... I was actually thinking the other day that I haven't, I have had like countless operations because of it, um, and it's almost two years now since I've had one, which is a big thing for me. Cause, you know, I could have had, maybe five operations a year at one point, and, you know, that's, it's a big thing to go a whole two years without an operation, um… so… yeah, that's… [*sighing*] um… And the other thing as well is that the more… the greater the gap between self-harm, the more you're, the more you've left it behind you, say the last self-harm, the easier it gets to be able to challenge it. Because then you realise how… much better things are when you don't self-harm…

In this extract Tina emphasized both the reduction in her self-injuring and how much of a 'big thing' it represented in the context of her story. Her cutting seemed a barometer

of her health, and its decreased severity an indication of her progress in life and therapy. She also spun a narrative of hope: after looking at the past with its 'countless operations', and taking stock of the surgery-free present, she framed a future when challenging her cutting might become ever easier. Self-harming might finally be 'left behind', and the integrity of the body restored.

In this process of regaining control over self and body, Tina saw therapy, and in particular dialectical behaviour therapy (DBT) as having played a key role: it provided her with 'strategies', 'tools', 'skills', 'something tangible, something that you can use'. Just as importantly, it gave her a new sense of direction, a map in the midst of her confused experiential landscape:

> you can see like a goal, you can see: right this is point A and we're going to point B; and this is how I want to do it, by doing X, Y and Z. You know, you can see where you're going.

Being under the ongoing care of her therapist ('my psychologist') also seemed to provide Tina with reassurance: a place to check in, make psychological sense of her experience and keep track of her progress on a weekly basis. There was thus a clear restitution thread in Tina's story, an episodic sense of being 'on the mend', both mentally and bodily, largely thanks to a new, more helpful course of treatment.

But there were also glimpses of a quest narrative. Frank describes the quest story as being that of finding a voice: the narrator has been on a journey and has emerged from this experience not 'cured' but changed, in possession of a wisdom which he now wants to share with others, 'perhaps to make a difference to the unfolding of their stories' (Frank, 1995, p.127). This desire to share with others her own experience and maybe make a difference was clearly present in Tina's narrative, from the very first interview:

> I think, um, I think because, you know, some of the reactions that I've had, not so much here in England but in Ireland, reactions from some health, not all, but some health professionals that, you know the whole thing about being manipulative and attention-seeking and all of that, I feel in a way that it's quite

important for me, for people to see that it's not what it's about. And so I'm quite happy to talk about it if, you know, it makes a difference, um, you know.

The third interview ended on a similar note:

D. How was it to have the last interview?

T. Um… I'm quite… I know, um… I'm not very good at using the word 'proud', I usually used the word 'chuffed', but yeah, I've got to say I'm quite proud of myself I've done it… yeah… cause I know this is gonna… help other people.

D. Yeah.

T. Um… you know, people that are maybe in the situation that I was in two or three years ago, and even people that are, sort at the same stage that I am now, you know this, you know this is gonna help, so.

More generally, and as already discussed in the previous chapter, throughout the interviewing process Tina displayed a reflective stance, using our conversations to actively make sense of her self-injuring and how it fitted with her inner and outer experiences. Even though her meaning-making was very much ongoing, Tina's story could thus be seen, in part at least, as a story of change: from being the 'clueless' victim of circumstances and mental processes, to becoming the aware, empowered manager of her own life and emotions, and witness to the difficulties encountered by those who self-harm. Nor was Tina's testimony limited to the storying of her experience: her offer to show me her arms because 'it may help you' further emphasized the communicative function of self-injury itself, the embodied dimension of her illness. Together we looked at her scars, big and small, 'significant' and 'superficial', and it did indeed help me from both a relational and a phenomenological standpoint. I felt closer to her in that moment, physically and emotionally, and deeply engaged in a common process of sense-making around her self-injury. To use Frank's terminology, Tina's quest narrative also made her self-harm an essential part of her 'living testimony'.

Self-harm and chaos

Still, behind her new awareness of and increased control over her self-injuring lurked a third narrative, one that may have been unspeakable at times of acute distress and still conveyed a painful experiential truth. In chaos narratives life does not get better: the wound is just too raw, the danger ever-present. The chaos story is thus best seen as 'an *anti-narrative* of time without sequence, telling without mediation, and speaking about oneself without being fully able to reflect on oneself' (Frank, 1995, p.98). One of its distinguishing features is the absence of narrative sequencing: the speaker appears frozen in an uncontrollable present, full of fear and hopelessness. The following extract, taken from the beginning of the third interview, offers a glimpse into Tina's chaotic world.

T. I get times where, um, sometimes where, like days where I don't remember a few hours or, a day or so…

D. Um.

T. I mean it's just like the time passes and I know when it's over, and, um, sometimes in those times I'll have self-harmed, um… and, that's really frustrating for me, cause… because… it's almost like I'm fighting so hard not to do it that maybe it's coming out in another way, and… you know, it's such a strong, um… pull towards it, that I'm doing that unconsciously or something, um… [*sighing*] Um…and that can be really frustrating, um... [*voice trailing off*] yeah… Well more than frustrating, um… that's…

D. More than frustrating.

T. Yeah, it's… scary, it's, um… [*sighing*] It's anxiety-provoking, um… It's… in a way it kind of makes you, makes me feel crazy [*smiling/laughing*], um… and… then I'm really really self-conscious, cause I worry that, you know I'm doing things and I'm not aware of it, and then, so, does that mean then that I say things and do things to people that I'm not aware of as well… Which nobody's ever said that I have, but, you still have that worry in your head that, you know…

> And then… what makes it worse is just that, um, that I'm always so careful about things I say and do that, um, that… that's a big anxiety or upset that I did something that I wouldn't normally do and you know, that's… scary [*smiling/laughing*], um… so… yeah… [*smiling/laughing; clearing her throat*]

In Tina's account of her first episode of major self-harm the use of the syntactic structure 'and then' gave the narrative coherence and logic. Here however its introduction can be seen as a further indication that her narrative has turned chaotic, undercutting itself (Frank, 1995). The content of Tina's story suggests a complete loss of control, from unconsciously hurting herself to (maybe) unconsciously hurting others, from being 'always so careful' to not being aware. The intermittent use of the second person is noteworthy, as it may represent an attempt to draw her listener in, to help her understand what cannot be truly conveyed, or alternatively indicate a lack of connection with her own experience. Yet Tina's narrative is also punctuated by half smiles and soft bursts of mirthless laughter: it is as if she was trying to minimise the dramatic impact of her narrative, to lighten up dark words like 'crazy' and 'scary'.

Interestingly at this point I appeared to shy away from her pain and interjected a restitution storyline, effectively moving Tina's narrative along, in a different direction.

D. But the way you understand your self-harming has changed, you said, over time, especially over the past two years.

T. Yeah.

Because they sit on the edge of both despair and speech chaos stories are hard on the listener, who may then undercut the narrator in an unwitting attempt to alleviate her own anxiety. This is arguably what happened here: I cut in with an upbeat remark, as if unable to bear Tina's fractured narrative and trying to restore a more optimistic tone.

A similar sequence of speech events emerged towards the end of the third interview, where Tina presented her self-harm as a way to manage her life when other options, like talking, seemed even harder. Once again she foregrounded a chaotic narrative in which she lost all bearings, including her sense of the future. Her powerlessness was further

accentuated through the repetition of the word 'really' and she once again alternated between first and second person grammatical constructions.

T. [*pause*] Yeah I suppose that self-harm is kind of, is an easier option in a way. Easier in the sense, well… easier in the sense that, you have… some… um… you know that… that it will work, at least for the short term. And that's… See when you get really distressed or really anxious or overwhelmed, you can't think… It's really really hard to think beyond the next minutes or the next few seconds even. It's like: I can't stand this any longer, um... So you don't… it's like you just don't have this foresight. You don't have, um… you know, it's really really hard to be able to stop yourself, to say, you know: this time next week I'm gonna have another scar on my arm or, you know, even in a couple of hours' time, I might end up having to go to hospital, and I hate hospitals. But, you know, it's just that, you know, you can't see past the next few seconds or minutes; because it feels like forever.

Like before, as Tina's narrative continued to unfold her struggle to maintain a sense of self was also given syntactic emphasis with the use of 'then' to mark her erratic moves from one crisis to the next:

> And then even when you say to yourself: well… [*clearing her throat*] Like I know now I say to myself: crisis… remember, crisis is only short term. Then you say… sometimes you say to yourself, well, that's ok. But, you know, I will have this crisis now for a few hours, or a day or two, and then I'll have a nice couple of days when I'm sort of… more on a level, I can manage things. But then, a couple of days later I will have this crisis again, and it just feels like it's never ending. And even when you have that sort of break between crises [*smiling/laughing*], um… you know… It's all… that's all in the back of your head. It's always there, that, um… you know… I don't know when I'm gonna feel completely overwhelmed again, um… And that's just, that really… yeah [*voice trailing off*]. It kinda limits what, you know, what your life's up to. Because you start avoiding things, you start avoiding situations that you know are gonna stress you. But then sometimes avoiding things only makes them pile

up so… so then that's another stress, you know, so… It's so hard to manage, um… It's just… yeah… [*smiling/laughing, voice trailing off*]

Again Tina expressed a lack of control over life and self, which echoed her accounts of dissociation. In her chaotic narrative self-harm seemed to represent both action and surrender, control and loss of control. Unwilling to end the last interview on such a hopeless note, once again I steered Tina away from her distress by bringing her back to a restitution story.

D. But obviously you've become more able to manage this, since…

T. Yeah.

D. … you said it's been two years since you've had an operation.

T. Yeah, yeah.

The contrast between the structured, progressive narrative drawn at the beginning of the first interview and the fractured, hopeless story glimpsed at the end of the third was stark. Maybe anxious to express more of her 'true' self, maybe emboldened by our growing intimacy, Tina may have seized this last opportunity to give her self-harming a much darker shroud, one that better captured her underlying anguish, to my unwitting yet obvious discomfort. Yet her ability to verbalise her distress, to communicate it to me in a felt, intelligible manner, also spoke to her emerging sense of self: Tina could now reflect on the presence of chaos in her life; in other words, stand outside chaos.

Perhaps echoing that feeling, or perhaps responding to my 'prompt', Tina then spent the last few minutes of the last interview emphasizing anew the awareness gained, the usefulness of DBT, and her pride at having taken part so others could be helped. Looking back, I was reminded that one function of a quest narrative is to hold chaos at bay; maybe that is what this final exchange was also about: anchoring Tina more firmly in the transitional space between chaos and health.

4.3.3 Discussion

Using Frank's illness narratives as heuristic devices took the interpretative work in a different direction: no longer seeking to identify overarching themes, or to pick up linguistic and prosodic clues, but placing her account of self-injury within a broader meaning-making process, one concerned with her overall sense of self. Frank's respectful emphasis on the intertwining of threads in illness stories was especially valuable. In Tina's narrative, like indeed in most stories of illness and the self, restitution, quest and chaos seemed to alternate; self-harm was therefore imbued with a plurality of meanings: barometer of emotional health and physical integrity; living (and bodily) testimony of distress and survival; self-defeating attempt at controlling the uncontrollable. Recognising these different meanings, and how they fitted with Tina's understanding of her mental illness and life story, shed a different light on her experience of, and sense-making around, self-harm. The fact that Tina was still self-injuring at the time of the interviews was also worth bearing in mind, the way she held contrasting narratives in tension a reflection of her struggle to reconcile her new understanding of and greater control over self-injury with her enduring emotional difficulties. Past research on deliberate self-harm and illness narratives amongst previously injuring participants had found that chaos narratives tended to describe past actions and quest narratives the self-harm-free present (Sinclair & Green, 2005). There was no such sequencing here.

The expression by Tina of multiple voices also raised important questions with respect to their construction, what Frank refers to as polyphony and heteroglossia in illness narratives: the former emphasizing the way in which the speaker's voice resonates with that of significant others; the latter pointing to the multiple codes of language borrowed in the process of storytelling (Frank, 2012). These aspects of meaning construction are further explored in the next chapter.

Additional insight was gained by paying attention to the response different narrative voices may elicit in the listener. As was shown above, on several occasions I unwittingly ignored Tina's chaotic narrative and encouraged her to construct a more optimistic picture of her self-harm and inner world. In so doing I may have emulated past listeners, whether clinicians or significant others, who could not sit with the

intensity and disjointedness of her experience and in their denial merely confirmed that she could not be heard. By bringing in the dialogic dimension of the narrative, Frank's approach thus laid out the contribution of the other (including the researcher) to the meaning-making process, and how it may constrain the production of a narrative as well as enable it. Inasmuch as the construction and sharing of a narrative is generally regarded as having therapeutic value, this last point also has significant implications for clinical practice.

4.4 Reflections on the use of narrative analysis

I found the plurality and openness of the narrative approach both appealing and daunting. Being able to select my very own mix of interpretative foci and models meant I could tailor the analysis both to the requirements of my project and to what I perceived to be the salient features of Tina's account. For instance, the length of the material made a microanalysis of all three interviews impossible within the time and space imparted. Furthermore the interview guide used, though quite flexible, had shaped the telling of Tina's story: instead of a long narrative with a beginning, middle and end, the transcript contained a succession of loosely, and to some extent thematically organised segments, some recognisable as 'stories', others less so.[25]

By combining the structural analysis of a segment of text with the holistic framing of Tina's illness narratives I was able to zoom in and out, and in the process illustrate how my participant's story-making made sense of her self-injuring. However I was also wary of opening my work to a charge of arbitrariness: why this approach and not that one? This segment and not another? The relative freedom afforded by a narrative approach thus meant added responsibility for my methodological and interpretative choices, and I spent a considerable time weighing my options and making sure the combination of narrative lenses eventually adopted would be both appropriate and coherent.

In more practical terms, I occasionally struggled with the requirements of Gee's approach: Tina's flat delivery made it difficult at times to identify prosodic elements in the interview segment, and I wondered to what extent my command of English (for me a

[25] For a fuller discussion of the nature of stories and narratives, and in particular the defining role of sequencing within, see Riessman (1993) or Crossley (2000).

second language) might cloud the analysis. Overall however I appreciated the rigour and transparency of his layered approach to the text, and the way glimmers of meaning seemed to bounce across levels in the final reading.

My experience with Frank's narrative approach was very different. I tried to follow his injunction to think 'with' rather than 'about' the text, and found his illness narratives to be great listening devices. Expressed through multiple voices Tina's story felt real, authentic. I also felt more openly involved in the meaning-making process: no longer 'neutral' scribe and analyst, but co-producer, witness, fellow human. However this greater freedom and expressivity also raised doubts. Writing about Tina's narratives felt at times like writing fiction, albeit a fiction created with Tina in mind and supported by her text. Would I end up romanticizing her narrative, an accusation previously levelled at Frank (Bury, 2001)? And most importantly, would the result be robust enough? Keeping an eye on the explicit criteria for evaluating narrative studies proposed by Lieblich and her associates (1998) – width, coherence, insightfulness and parsimony – provided some reassurance. So did my efforts to firmly ground the interpretation in Tina's account, in line with my contextual constructionist epistemological stance.

Still, I derived great satisfaction from being able to pay attention to form as well as content, and from recasting Tina's story empathetically. In the process I developed a more intricate reading of her meaning-making around self-harm, one in which the patterning and expression of her experience took on a new importance.

5. Psychosocial reading

In this third and last reading of Tina's material an attempt was made to contextualize her meaning-making around self-harm, both in relation to the culture and discourse she had drawn on, and in relation to her own psyche and family relations. Despite the obvious socio-cultural embeddedness of the phenomenon and the existence of a rich psychodynamic literature on the subject, the literature review had failed to identify a single exploration of self-injury combining discursive and psychoanalytical readings. It was therefore hoped that this third interpretative lens would shed new light on the research question at the heart of this project: how does an individual who engages in repetitive self-injury make sense of her behaviour? This time however the expression 'make sense' would take on a different meaning: no longer making sense to self through phenomenological exploration or the storying of experience; but making sense to others, including through unconscious communications.

The chapter first provides a short introduction to the field of psychosocial studies, and discusses the value and difficulty of combining discursive analysis and psychoanalysis. In the process the methodological and epistemological issues raised by the choice of a psychosocial lens in the context of this project are elucidated. A second section presents the analysis carried out on Tina's interview transcripts. A discussion of the findings follows, providing a critical appraisal of the approach. As always, a brief reflexive section concludes.

5.1 The approach

5.1.1 Psychosocial studies and psychoanalysis

> The psyche dynamically alters that which society imposes upon it
> (Cavaletto, 2007, p.262)

With roots in critical social psychology, sociology, psychoanalysis and feminist social research, the field of psychosocial studies can be described as 'a critical approach interested in articulating a place of "suture" between elements whose contribution to the production of the human subject is normally theorized separately' (Frosh & Baraitser,

2008, p.350). Of particular interest here are efforts to bridge the divide between the social and the psychological by combining the insights of two contrasting approaches to human experience: discursive analysis and psychoanalysis.

The logic behind this tentative articulation seems reasonably straightforward: exploring the contribution of unconscious processes to discursive positioning and language construction should enable the researcher to inject a psychological dimension into a discussion of the individual's socially constructed reality, thus bringing together inner and outer experiences.

However the two approaches rest on different epistemological stances. For discursive analysts, individual reality is socially constructed; the constructive and performative aspects of language therefore constitute the only valid focus of analysis. In other words discursive analysis is firmly grounded in a social constructionist position. Psychoanalysis, on the other hand, is predicated on the existence of an internal reality, one that can be investigated and 'known', albeit indirectly. Through the use of such techniques as free association or dream analysis, and by paying close attention to the intersubjective dynamics between analyst and analysand, the analyst can bring to light the psychic structures and processes that underlie meaning-making. It could be argued that psychoanalysts thus subscribe to a realist epistemology.

In order to resolve this conflict psychosocial researchers have adopted a critical realist stance, one that assumes the existence of enduring underlying psychic processes (e.g., desires), yet accepts that these can only be known imperfectly, not least because they may manifest in an unusual and puzzling way (Willig, 2012). But they vary considerably in their belief that inner psychological mechanisms can indeed be accounted for. Some place identifiable unconscious conflicts and psychic defences at the centre of the interpretative work (e.g., Hollway & Jefferson, 2005 and 2012). Others, rejecting this approach as futile and deterministic, opt for a Lacanian perspective in which 'the unconscious is understood and used not as a "thing" with a specific location, but rather as a domain of experience which is outside of our awareness but is nevertheless constitutive of that awareness' (Saville Young & Frosh, 2010, p.516). Of particular import in this latter version are textual clues or 'glitches', linguistic moves that point to a failure to symbolize. This emphasis on language and

reluctance to define an underlying 'reality' takes the proponents of a Lacanian approach closer to social constructionism.

5.1.2 Choosing a stance

Developing a psychosocial interpretation of Tina's account therefore required that I choose a set of psychoanalytically-informed theoretical concepts, a choice that would carry considerable implications in epistemological and methodological terms. After careful consideration, I opted for a Kleinian reading of the text, thus positioning my work at the 'realist' end of the critical realist spectrum. There were several reasons for this. Firstly, this stance would be compatible with that of contextual constructionism adopted so far, thus enabling me to triangulate, maybe even integrate my readings. Secondly, a Kleinian approach seemed one way of putting into practice my commitment to working therapeutically with enduring underlying psychological constructs and processes. The use of biographical and developmental information was also habitual in my clinical work. Last, I was curious to see how a dual focus on Tina's family dynamics and on our transference/countertransference might open up new vistas of interpretation. I therefore decided to follow the approach proposed by Wendy Hollway and Tony Jefferson (2012).

5.1.3 The method

Though they are keen to point out that their work uses 'psychoanalytically informed' methods and concepts rather than psychoanalytic ones, the interpretative approach developed by Hollway and Jefferson pays particular attention to unconscious defences: both participant and researcher are seen as 'defended subjects', and the task of the researcher is to offer a reading of the participant's account that is informed by possible underlying conflicts, using constructs drawn largely from object relations theory. To achieve this, the researcher relies on several sources: the contradictions and inconsistencies present in the text; biographical information, especially that concerning childhood experiences and family dynamics; and the researcher's own emotional response to the interview, as documented in a field journal.

Several aspects of this approach deserve to be briefly discussed here, starting with its 'hermeneutics of suspicion'. Though interested in the participant's 'face value' account, Hollway and Jefferson argue that it will naturally gloss over inner motives and contradictions, many of which may elude the participant's conscious awareness. Bringing those contradictions and underlying psychic structures to light should therefore produce a fuller, truly *psycho-social* picture of the meaning-making taking place around a particular experience.

However this requires the collection of rich personal data, both biographical and textual. To gather such data Hollway and Jefferson use what they call free association narrative interviewing (FANI), a form of interview that uses open-ended questions, invites the narrator to share their story, avoids 'why' questions, and lets the participant set the sequencing, content and pace of the interview to a large extent, so that 'pathways of associations' can emerge. Building on Bion's notion of therapeutic containment, they also advocate the use of two interviews, ideally one week apart, so that trust can develop between participant and researcher:

> the researcher is implicated at every stage, often unintentionally, in what can and cannot be thought and said. Usually (when conditions of trust are established), a containing interview relationship enables participants to relax the defences that could otherwise show up as talk limited to what is already familiar and intellectually fenced. (Hollway & Jefferson, 2012, p.151)

As was discussed in chapter 2, the form and scheduling of Tina's interviews largely abided by these recommendations, opening up space for her complex, and possibly contradictory sense-making around self-harm to emerge.

Also interesting is the strong emphasis placed on the role of unconscious intersubjectivity in the interviewing process. In practice, the approach requires that the researcher carefully records her first impressions, paying attention to how she responds and relates to what the participant is saying; that she analyses the co-production of data through the flow of questions and answers, once again looking at the contribution of unconscious dynamics between defended researcher and defended subject; and

considers the extent to which containment may or may not have been provided so that a freer, richer narrative may emerge (Hollway & Jefferson, 2012).

The analytical work proceeds in stages. First the text is considered at face value and its key themes identified. Then it is read in context: all the information gathered through the interviews, biographical and textual, is mustered in an effort to locate the defended subject and raise questions concerning the narrator's choice of discursive positions. In a third stage, psychoanalytical concepts are brought in to make sense of inconsistencies, contradictions and discursive investments. Last, reflexivity is utilised to alert the researcher to the ways in which she contributed to the reconstruction of meaning.

A similar approach was followed here, with one exception: by the time the psychosocial analysis started the themes of the interviews had already been explored. The work therefore began with a careful re-reading of the three interviews, paying attention to how language had been used by both Tina and me. As I was reading I asked myself questions about what was being said and how it was being said. I then repeated the process, this time line-by-line, combing the text in order to see how its features (terminology, grammar, metaphors…) delineated certain interpretative repertoires, which in turn supported particular discursive constructions and positionings (Potter & Wetherell, 1987). In identifying the latter I also drew upon my biographical knowledge of Tina. Throughout I remained alert to possible contradictions and inconsistencies. I then began writing my analysis up, albeit tentatively, so as to clarify key themes and illustrations.

The next step consisted of drawing on psychoanalytical concepts, within an object-relations framework, to interpret Tina's discursive constructions in relation to self-injury. Last, I returned to my field journal, and to the detailed notes taken after each interview, to incorporate an intersubjective layer of analysis in my reading of the text, i.e. provide 'a space for checking out the researchers' responses to the research participant and thinking through what these responses might signify' (Frosh & Saville Young, 2008, p.113).

5.2 The analysis

Over the course of the three interviews Tina adopts a complex, at times almost contradictory positioning, the main purpose of which seems to be to affirm her as a credible source of information and insight around her experience of self-injury, whilst at the same time exonerating her from blame for her behaviour. As will be shown below, this positioning can be usefully explored through a combination of discursive and psychoanalytical lenses.

Tina as a fragile 'deep thinker' around her experience

From the beginning of the first interview Tina positions herself as an external, reflective observer of her own experience. Her replies are full of hesitations, rephrasings, caveats and precisions, suggesting that she is both a 'deep thinker' (her term) and a careful wordsmith. At times her use of pauses and markers creates the impression that she is thinking 'live', digging deep into her memory to create a meaningful and accurate account, as in the following extract:

> Other times, um, I would… Yeah I would kind of experiment with doing different things, and then I suppose as I got older, um… uh…

The way 'I would' is left hanging, and is then followed by a definite 'Yeah', creates the impression of someone following a trail, one which at times disappears in the undergrowth only to reappear, unmistakable. This positioning is especially clear in the segments where she engages in recollection of past events. The picture that emerges is of Tina working hard to provide the researcher with the material she needs, and doing this with transparency and honesty: letting her into her thought processes, even volunteering a 'tour' of her scars. In doing so Tina may be responding to my own cue: my opening line ('Now Tina in your first email to me, you mentioned that you had self-injured on countless occasions, you said.') can be read as an expectation that she will indeed provide details to match her claim; my later probing around the pattern of her self-cutting again positions her as the possessor of unique personal knowledge. And sharing that knowledge she eagerly does, sometimes in a didactic fashion as evidenced

by her intermittent use of the second person, most commonly used in guiding people through a process.

It could be argued that Tina's frequent use of the terms 'probably' (e.g., 'probably started off with', 'I was probably thinking'), 'maybe' (e.g., 'maybe it does', 'maybe kind of an elation') and 'I suppose' (e.g., 'I suppose during that time', 'I suppose when I say that') undermines her effort: she may be working hard, but a lot must be hypothesized, especially when it comes to Tina's own felt experience. At the end of the day her memory and understanding remain partial, and the factual details and precisions she provides in places may ultimately function as warrants for her efforts at remembering and truth-telling, a way to convince the researcher of the value of her account despite its subjective and at times inchoate quality (Edwards & Potter, 1992).

Yet, and somewhat paradoxically, her cautious phrasing itself may at times serve a similar purpose, as in this description of her 'over-thinking':

> Yeah, and I wanna, I feel like I can't slow, slow myself down, um… And it's strange because I… I think, well, maybe it's just my perception but I think that… I'm not sure whether people actually see that, that I'm thinking really fast, um…

The extract shows Tina at her most tentative, caught up between wants and feelings ('and I wanna, I feel like I can't'), openly wondering about her perceptions. Of particular interest here is the way she acknowledges the 'strange', highly subjective and possibly invisible nature of her experience in advance of her listener, thus pre-empting a possible questioning of its validity. Together with her obvious efforts at sense-making, this complex warrant (almost a three-part list) ends up strengthening her credibility as a reflective truth-teller even as it conveys her emotional fragility. It thus exemplifies the arduousness of the task as presented by Tina throughout our work together: sharing her raw and possibly disturbing experience without compromising her credibility as a co-researcher. It may also be interesting to think of this in terms of shoring up her fragile self-esteem.

Tina as knowing yet out of control

A similar tension exists around Tina's positioning as newly enlightened and 'knowing'. The narrative is shot through with references to Tina's novel understanding of her self-harm, thanks to therapy and her own psychology studies. Time and again she uses the expression 'I know' (e.g., 'I know why that is', 'I know now', 'I know where that comes from'), thus emphasizing her insight, which she explicitly associates with a reduction in her self-harming behaviour. In what is otherwise an intensely personal narrative, she also interjects bits of information with a rehearsed, almost generic feel: for instance stating, seemingly out of the blue, that 'some of it it's about punishment', as if underpinning her position with a broader, psychological understanding of the functions of self-harm.

Yet the extent to which being a knowledgeable observer of herself translates into greater control over her self-injury is repeatedly called into question. Indeed, throughout the interviews Tina constructs a dualistic position for herself: the position of hard-working, insightful and capable Tina; and that of dependent, clueless and out-of-control Tina. Capable Tina can analyse her self-harm and thus regain control over it. Out-of-control Tina is swayed by inner and outer forces. At times she seems uncertain which version to put forward:

> So I was rushing out of the flat, um, I had a glass, um, where I'd just had a drink of orange juice for my breakfast, and I accidentally dropped it on the kitchen floor, and it smashed everywhere and my first instinct was just to lift a piece of glass and to cut myself with it. Um… But, uh… so in that way it was, yeah I suppose it was impulsive, um… But, um… I was able to stop myself, um, quite quickly actually… which was good.

In this extract Tina describes a recent episode of 'minor' self-injury. The first sentence captures the action. Interestingly, after a couple of typical hesitations it becomes quite free-flowing, creating an impression of spontaneity uncharacteristic of Tina's presentation of her account in the interviews. The account then stops abruptly, and becomes hesitant as Tina shifts to her observer position, tentatively labelling her actions ('in that way', 'I suppose') and thereby stepping back from her out-of-control self. She

then gives Capable Tina the leading role ('I was able to stop myself'), and even commends her self-control ('which was good'). Tina's positions as observer and 'controller' of her self-harm thus appear complementary, showing her as a woman in the process of developing awareness *and* control.

The back and forth between Tina's two positions is perceptible throughout the text. Of particular import here, it is also at the heart of her depiction of the experience of self-harm, as in the following segment:

> I think sometimes, I know it sounds strange but, um, when I know I've got X, Y and Z done, then I do the self-harm. But the strange thing is that, um, as I approach that, that date, then I start getting doubts in my head: do I really want to do this? Um... But because I have obsessed about it for so long, it's like: I have to do it. And you know, it's like: no, I made this decision, I have to do it. And even when, um, like for example the cutting, um, even when I know I'm just about to do it, at that moment I, I've even said to myself, out loud: 'Tina you don't want to do this, you don't want to do this'.

Several things are worth noting here. First is the disclaimer that opens up the extract: 'I know it sounds strange but', a turn of phrase that repeats through the transcript and constitutes a classic way of warding off a negative attribution to the self (Willig, 2008). Here Tina may be trying to pre-empt attributions of 'madness', a theme that is further developed below. But she also appears to signal the actual incommunicability of her experience just as she is about to attempt to narrate it. The effect may be to exonerate her of responsibility: others may not understand, but she tried. Or it may merely emphasise the 'otherworldliness' of her experience, acting as a warning to those, like myself, who attempt to analyse it. Tina then builds an image of self-harm as a planned activity, the timing of which she controls ('when I know I've got X, Y and Z done, then I do the self-harm').

However this image is soon replaced by another, in which Tina appears wrecked by contradictory impulses. Significantly these impulses are given voices of their own, a rhetorical device known as footing and generally deployed to enliven an account and make it more believable (Goffman, 1981). In this extract, as in several others across the

text, Tina uses footing to bring her inner conflict around self-cutting into sharp relief: 'do I really want to do this?' says one self; 'I made this decision, I have to do it' says another. Once again Tina positions herself as split, a dualistic position which seems to achieve several effects on the listener: on the one hand, Tina is presented as the victim of her own poorly integrated sense of self; on the other, she comes across as trying very hard, even crying out *loud*: 'Tina you don't want to do this, you don't want to do this'. This discursive positioning enables her to avoid blame for her behaviour, thus counterbalancing the 'negative' impression that could have been created by her description of a premeditated act in the opening sentence.

Elsewhere in the transcripts Tina achieves a similar effect by referring to 'some power in me', or to 'someone else at the steering wheel'. One is reminded of the blame often attached to self-injury, notably by medical staff (Arnold, 1995); a blame that Tina herself reports as being open and pervasive and one important reason why she decided to come forward to present a more 'accurate' picture. In part at least, Tina's discourse can be interpreted as an attempt to defend against accusations directed at those who self-harm for being 'manipulative', 'opportunistic', and 'attention-seeking'.

Self-harm as an addictive, externalised behaviour

In line with this positioning, Tina portrays her self-harm as governed by external forces. Some of these forces are circumstantial (family dynamics, work stress, hospitalisation, over-medication). Others stem from her psychological processes but, like in the example given above, are 'externalized'. Tina's insistence on the addictive nature of her self-injury, already discussed in chapter 3, provides one illustration of this:

> I don't know if it's physical or psychological or what it is, but there's something about it that keeps bringing you back to it.

In this formulation, self-harm becomes the subject and Tina the passive object 'brought back' to the behaviour again and again. Significantly, addiction is also the construction she chooses when trying to make sense of her behaviour for her parents' benefit, comparing self-injuring to smoking. This is of course an imperfect analogy, as confirmed by their repeated inability to 'get it'. But it is arguably one that enables Tina

to deflect blame from both them ('I was not really able to tell them the whole story') and herself.

Here is another example:

> And quite often it's… it's been in my head that… I don't know if I've actually had this narrative in my head about it but it's like a feeling maybe, but I've had: how badly, how close to death can I get, without actually dying? Um… And I don't know I… I don't know how it's a, like… I almost feel like I want to justify it now, but I don't know why I do that. It's just a thought that comes into my head, um… I'm not sure where it comes from or what…

This extract illustrates the way Tina repeatedly constructs her experience as something that goes on in her head, and without any intent, or indeed full understanding on her part, once more externalising the internal. Here the more severe forms of self-harm she engages in are described as driven by a desire to 'flirt' with death: 'how close to death can I get, without actually dying?' Yet the nature of this desire or drive (one is reminded of Freud's Thanatos) is heavily qualified: it is maybe a narrative, or a thought, or a feeling; Tina doesn't know much about it ('I don't know' repeated four times); indeed she is 'not sure where it comes from or what'. Equally significant is the use of the phrase 'I almost feel like I want to justify it now but I don't know why I do that', which here works as a warrant to the listener that Tina is merely trying to articulate a troubling experience, not hiding or excusing an underlying motivation. All these can be seen as rhetorical devices deployed for blame reduction, once more suggesting a tension between Tina's positioning as an open, insightful analyst of her own behaviour, and the way she attempts to deflect responsibility for it.

Interestingly, the preceding extract also conveys some of the fascination self-injury exerts on Tina, how 'enthralled' she is to her dance with self-destruction (Joseph, 1982). Here the notion of self-harm as addiction takes on a slightly different meaning: the

behaviour may be irrepressible but it is also pleasurable, something that Tina herself hints at twice:[26]

> Well, I'm not saying the self-harm is pleasurable but, there's almost like an addictive part to it…
>
> It's almost like, um, I wouldn't say I get pleasure out of it it's probably not the right word, but maybe some sort of… [*sighing*] I don't have a word for it.

The way these hints are constructed further reflects Tina's communicative challenge: how to claim the position of honest, self-aware participant whilst at the same time denying self-gratification in relation to what in her experience is seen by others as an objectionable behaviour. One way to achieve this is to qualify her more open, intimate statements very heavily, as in the examples above.

Once again it is worth noting that illness narratives can function as defensive disclaimers, especially when dealing with complex and/or controversial conditions (Horton-Salway, 2001). Establishing authenticity and accuracy is a major concern in such narratives, which may also be filled with external attributions as interviewees work to convince the interviewer that their illness is neither willingly self-induced nor indeed self-serving. A similar dynamic seems to be at play here: Tina's account is steeped in detail and reflexivity, and built to make her come across as a credible witness engaged in a painful battle with thoughts, feelings and, most importantly here, a behaviour that she did not chose and cannot fully control.

In that respect dissociation presents a particular challenge for Tina: whilst not being able to remember why or how she self-injured can be seen as the ultimate form of exoneration from responsibility, it is one that does not sit easily with her position as knowing and capable Tina. This may explain her unusual use of external insight when accounting for the behaviour ('I've been told that that's dissociation, that I just completely can't deal with what I'm doing and I just shut it away'). Unable to explain

[26] One is reminded of the autoerotic dimension of self-injury so central to psychodynamic formulations of the behaviour (e.g., Gardner, 2001). This dimension also transpires in Tina's evocation of the 'warm feeling of blood' that accompanies the act in the aftermath of her more serious episodes.

or even provide a full account of her dissociated actions, Tina resorts to citing another base of knowledge, possibly in an attempt to avoid damaging her credibility (Pomerantz, 1984a).

Tina as the rational observer of a 'tangible' phenomenon

Throughout the interviews Tina positions herself as a 'scientist', and her credibility as an intelligent, rational observer is repeatedly bolstered: by reference to her academic achievements (passing her GCSEs despite family and inner turmoil, doing well with her current course of study, including the research component); by the 'medic-like' use of impersonal anatomical terms to describe her injuries ('I'd cut through arteries, veins, tendons and ligaments and stuff'); by her knowledge of the importance of neurochemical circuitry (e.g., the adrenalin behind the 'rush') and of psychology generally; even by owning to the father-daughter transmission of a logical, scientific bent, exemplified by their common engineering training.[27]

It is within the context of this positioning that her deployment of mechanical metaphors to frame her experience of self-injury can be read: her mood swings are likened to an airplane crashing or a roller coaster; the way inner tension builds up to the growing pressure of water behind a dam. The forces at play almost seem measurable, 'tangible' to use one of Tina's adjectives. Importantly, they are also formidable. This construction thus achieves a threefold purpose: confirm Tina as a valid, 'objective' co-researcher; frame self-injury as the direct (and perhaps inevitable) effect of powerful, mechanistic forces (gravity, hydraulic pressure); and excuse Tina's powerlessness. Also interesting is Tina's reporting of her coping strategies in metaphorical terms: she describes 'filing' her emotions for later discussion and 'taking notes' in her head so she can keep a conversation going, both suggestive of a methodical, organised, 'grown-up' approach to her difficulties.

From a discursive perspective, Tina's efforts to position herself as a reflexive, analytical observer of her self-injuring can be read as a way of resisting popular representations of

[27] Developing a fuller psychodynamic formulation of Tina's emotional difficulties would entail querying her intellectual and professional identification with her father, possibly a way to affirm separation from a mother described as emotional and teenage-like.

the mentally ill, typically seen as simple-minded, irrational or violent (Roth Edney, 2004). Significantly, Tina's own depiction of an inpatient ward echoes such conceptions:

> all these people did these weird things, it was like: what is this place? Um… You know… People screaming, and people… I remember this woman, um, elderly woman who was bald but she had a wig, but she kept taking it off and throwing it at people. I remember then, I was moved into a bay with three other women, um, and this woman opposite me all she would eat was apples, and I couldn't figure it out in my head. I was thinking in my head: why does she only eat apples? Now I know it was probably cause she had an eating disorder or something, um…

Although the very topic of the interviews forces Tina to engage with a seemingly 'crazy' behaviour (a term she only uses once to describe her experience, and with difficulty as suggested by a shift in her emotional tone), she constructs for herself and for her self-harm a position of logic: first by presenting a vivid picture of a 'mad' ward as experienced by her confused adolescent self following the shooting; and then by emphasizing that she now 'knows' that the woman opposite her in the psychiatric ward probably had an eating disorder. As for her cutting, it serves a function ('it does something', 'it works'), even becoming a modern compass, a 'SatNav'. Set against prevalent images of mental illness, Tina's positioning as a co-scientist may thus be related to her determination to distance herself from the 'insane', a move made all the more necessary by her perceived status in the family as

> the daughter that's been in a mental hospital, St G of all places, um, that is like, was originally an insane asylum, um, the daughter who has all these scars on her arms[28]

It may also be linked to the interview situation itself, and to my own input into it. From the beginning I place Tina in the position of knowledgeable informant and adopt a flexible but probing stance which she may be responding to, for instance asking her:

[28] For lack of supporting evidence, the extent to which Tina identifies with this image of the 'crazy daughter' remains an open question.

‘Can you think of the sort of things that you would feel, that you would say?’ By identifying repetitive self-injury as a topic worthy of investigation, I also signal interest in the psychological underpinnings of the phenomenon, thus orienting Tina further. Last, the fact that we are both psychology students may act as an equalizer, enabling Tina to occupy the position of co-researcher with added confidence.

Self-harm as failure of containment and surrender to a caring other

But Tina’s discourse also creates another, child-like position for herself. Some of the expressions she uses during the interviews have a childish feel: her being in a ‘wee-bubble’ for instance; or, when offered the possibility of DBT treatment, her insistent ‘when is it gonna happen, when is it gonna happen’. Significantly, I occasionally join in the construction of that childlike position, at one point encouraging Tina to ‘Take a sip’ as she reaches out for coffee in what could be regarded as a rather maternal counter-transferential response.

Exploring the motivations behind this particular discursive investment requires further foray into the psychoanalytical realm. For instance, Tina’s choice of a childlike position may be linked with an unconscious longing to remain a child, innocent and good, instead of becoming like her mother and father, presented as callous and self-serving. Tellingly she compares herself to her much younger siblings and not, as she would have in the past, to her elder sister who now is ‘like a clone of my mum’, and ‘quite forthright’ (i.e., blunt and insensitive).

Her positioning could also reflect a deep sense of child-like helplessness, perhaps best expressed in her dam metaphor. In it she tries to describe what it is like for her when the ‘bad stuff’ that she has tried hard to ‘file away’ starts to ‘leak out’:

T. I suppose it’s a bit like… I don’t know what it is, is it a fairy tale or a, story about the little boy who puts his finger in the hole in the dam, um,

D. Um.

T. And so, um, it's almost like the only thing that's holding the dam is this, you know, this tiny little thing holding it in there, um, and, like… I think the story goes this way that the boy takes his finger out of the hole in the dam and the whole dam comes crashing down, um… That's the little weakness there, and then… so, um…

Here the dam appears to symbolise Tina's attempt to keep her inner turmoil contained. However it is faulty, there is a 'little weakness' requiring further containment, and all that stands in the way of mounting hydraulic pressure is the finger of a little boy, a 'tiny little thing'. From a discursive standpoint, this construction conveys a dual message: that she is trying; and that she cannot be held accountable. But the metaphor also speaks to the fragility of Tina's inner world. She is like that little boy: child-like, unable to stem the powerful flow of her own emotions. According to Bion (1967), the capacity to metabolize painful experiences requires a capacity for containment, for thinking through rather than acting out. In turn, this supposes the presence of an attuned caregiver whose empathic responses the infant will gradually internalise. In the absence of such capacity for containment, inner distress will 'spill out' as feelings are evacuated through action. In the case of self-injuring individuals, the spilling out of blood can be regarded as a visible expression of this spilling out of unprocessed experience (Turp, 1999). In Tina's metaphor, the little boy simply cannot contain the water forever; when it finally spills out, the flow is powerful enough to take the whole dam with it.

Her metaphor is also interesting in the way it echoes the fairy tale quality of some of the early memories she narrates in the third interview. There she portrays herself as a young runaway, repeatedly trying to escape a bleak and violent family home yet ultimately pulled back by her inability to fend for herself in the world. She invests the position of resourceful but ultimately helpless 'orphan' ('I never really felt that my mum and dad really… were my mum and dad'), her innocence a poor protection against the evils visited by self-absorbed and 'out-of-control' adults.

Tina adopts a similar position of child-like innocence in other contexts, most notably the hospital where she is first sectioned following her self-shooting and which she describes as an alien and incomprehensible environment: 'I did not have a clue'; 'I probably didn't know what a psychiatric ward was'; 'it was like: what is this place?'.

The medical personnel she interacts with remain nameless ('these two doctors', 'this nurse'), and participate in the construction of a helpless patient by appearing to take charge without ever explaining their actions, even using an infantilizing vocabulary:

> And these two doctors came along, and I don't remember them saying to me that they were psychiatrists or psychologists or something like that, but they came along and they said: 'We're gonna, we're gonna take you to the special ward in the hospital, where we can help you.' And it was like: I did not have a clue what they were talking about.

Interestingly, young Tina is later presented as resisting this treatment: trying to figure things out, asking about her care, refusing to answer the intrusive questions of a child psychologist. From clueless child she becomes thoughtful, defiant patient, once more signalling a tension in Tina's discourse around her sense of agency, and maybe some ambivalence in her relationship to care.

Tina's depiction of another act of self-injury, carried out whilst an adult psychiatric in-patient, lends further support to this interpretation:

> I was in the PICU, and I'd been given 15 minutes leave, and I managed to get to the shop in that time, and buy some blades, and went into, um, the ladies bathroom in another area in the hospital, and I cut quite deeply, and then, um… as I was bleeding on the floor, um… It was like the life was draining out of me, I could feel it, and, uh… You know I, I suppose I cut so deeply that, you know, that I was, if I was left long enough I probably could have died but, um, you know, somebody found me and…

The contrast between the first and second halves of the extract is worth dwelling on. In the former Tina positions herself as resourceful ('I managed to get to the shop in that time') and determined ('I cut quite deeply'). But the last sentence is constructed as tentative ('I suppose', 'it was possible that', 'probably'), with several pauses, giving it a more reflective tone, as if Tina was only now realising how close to death she had come. It also appeals directly to the researcher ('you know' used three times), inviting her to reflect on the seriousness of the act alongside Tina. The result is to position Tina

as a defiant child: cunning and decisive, yet perhaps not fully aware of the implications of her acts. Read with an eye to the attribution of responsibility, this discourse also exonerates her and indirectly condemns the hospital for failing in its duty of care (like her parents?), a condemnation she fully and repeatedly articulates in the interviews.

Yet in Tina's own words, one important reason why hospitals seem to trigger more self-injury is the fact that 'in hospital there's always gonna be someone there to rescue you'. Elsewhere she recalls falling in the playground on purpose as a young child, 'because then I would have to go to the school nurse, and the school nurse would be able to fix it'. Tina's self-harm, like her childlike presentation, may therefore also be a way to evoke caring responses from others, to be looked after. Gardner speaks of a psychic conflict within self-injuring young women: on the one hand is the malevolent, overwhelming mother, an engulfing object they are trying to 'cut off'; on the other 'a depleted, hungry baby part' that longs to be taken care off (Gardner, 2001, p.71). In its most extreme forms, Tina's self-harm may therefore be seen as an attack on the internal bad object *and* a form of surrender to the care she craves but cannot ask for, a surrender made tolerable by its very necessity. This surrender is powerfully rendered in the extract analysed in the previous chapter, where Tina describes how 'when it comes to the point that other people have to come and help me, then I just close my eyes cause I just can't deal with it'. It is as if through self-injury Tina turned herself into a passive, helpless child that others 'have to come and help'.

Feelings and discursive positioning: anger and guilt

Though Tina describes being swept by 'a snowball of feelings', emotion words tend to be used selectively in a narrative laden with 'think' words. This is in line with her efforts to construct herself as an 'objective' informant, and perhaps also as someone able to articulate her experience instead of acting it out. Still, two feelings keep reappearing, the discursive construction of which also contributes to Tina's complex positioning around self-injury.

The first one is anger, around which Tina seems to build a rather ambivalent position for herself, as shown in the following extract.

T. So I kind of beat myself up in both ways, um… so…

D. Do you get angry at yourself?

T. Yeah, I think I do, but I think I have a big problem with anger because I don't really want to deal with it, um… I have never lifted a hand on anyone in my life before, nor will I, and that's just not, that's just not what I would do, um… And I don't like, I don't like what anger makes people do, and so for me it feels wrong to actually express anger. Um, so, I tend to hold it in a lot, um… until, you know… Like I know now it's funny cause I was, I was talking about this to my therapist yesterday, my psychologist, and, um… Now, probably in the last couple of years through doing DBT and through my, I actually have the words for things. Or maybe I had the words for things before but I just didn't know how to apply them to me.

This extract is remarkable in several respects. First, my orienting Tina to her possible anger at herself takes us in an unexpected direction: violence against others. Further, she volunteers an emphatic example of extreme case formulation ('never', 'anyone', 'nor will I', 'just not what I would do'), conveying the strength of her feelings and leaving no room for disagreement or qualification (Pomerantz, 1984b). In the next sentence she draws a link between this stance and her own experience - but keeping it impersonal and vague ('what anger makes people do'), no more than a hint at possible events in her past, before restating her position on dealing with/expressing anger, this time giving it a moral frame ('wrong'). Her reasoning ('And', 'so', 'so') then takes her back to the issue of processing her own anger, though she stops short of any explicit reference to self-injury, instead leaving the consequences of her anger unsaid ('until… until, you know…'). It is as if the subject could not be verbalised.

The next sentences suggest this might indeed be the case: first there is the reference to something 'funny' (emphasized with a smile), a term that seems inappropriate to the context and content of her anecdote and may be there as a means to lighten up the mood, hers as well as mine; then the reference to a recent discussion with her psychologist, a familiar and comforting figure. Last, Tina brings up the subject of 'words': having the words, applying the words. Set against what may have been a

wordless hint at violence against the self, her proud acknowledgment of a new capacity to symbolise emotions seems designed to strike an optimistic note, once again signalling a more capable, self-reflective Tina; yet the discrepancy lingers. Thus, while Tina appears to position herself as insightful and therefore harmless since she can use words instead of acting out, her discourse also suggests a darker, perhaps more primitive side.

Here again, bringing in psychoanalytical concepts can help illuminate Tina's positioning. Klein (1933) describes infancy as a time of intense anxiety arising from the child's fear of his own aggressive impulses, themselves the manifestation of a 'death instinct'. Developmentally ill-equipped to deal with this struggle between the urge to destroy and the urge to preserve, the infant projects it outwards, to be handled by the primary caregiver. Should the latter prove nurturing and responsive, a good experience or 'loving object' will be taken back (reintrojected), strengthening the infant's life-enhancing impulses and enabling him to handle inner aggression. If however empathic attunement is lacking (and Tina's description of her mum as self-absorbed and invalidating suggests this may have been the case), then the infant will come to internalise a hostile, 'dependency-hating' object, reinforcing the destructive instincts. Overcoming internal aggressive impulses becomes even more difficult where they have been reinforced by the internalization of an abusive object (Nathan, 2004). The self-injuring individual would then discharge an inner hostility perceived as uncontrollable in a way that feels comparatively safe: by turning aggression inwards, thus remaining dissociated from her hate for the persecuting other.

Tina's 'flirtation with death' could thus be seen as a manifestation of her powerful destructive instincts, instincts that she appears both to satisfy and to keep in check through self-harming. In turn, her emotional investment in the position of safe, non-threatening individual - a theme that repeats (invariably through the medium of extreme case formulations) through the interviews - would reflect her dissociation from her underlying aggression. The following extract provides some evidence for this interpretation:

> Well, I've been on the bus sometimes and… and I've… you know had a tee-shirt on, it was a hot day, just had a tee-shirt on and… so people could see the scars, and there's a couple of occasions where someone was just about to sit

> down right beside me, and I could see that they looked at my arms and they got up and moved away, and sat somewhere else. And so I wondered if people think that… that I'm a danger to them, which is, like, for me that's like, completely an alien concept. I've never ever lifted a hand on anyone else, it's only ever, I only ever harm myself, um… And I would never even… it just, for me it just seems inconceivable, um… […] So, it's just against my nature to do that, and… But I often wonder, if people look at my arms, if they think I'm a danger to them

Here Tina contrasts her gentle nature with what she regards as others' perception of her, i.e. as a danger to them. Once again she uses an extreme case formulation to affirm her harmless 'nature': hurting others is 'completely an alien concept'; she has 'never ever' harmed 'anyone' and 'only ever' harms herself; even the hypothetical possibility of her committing such an act is ruled out ('I would never even'). Sitting in front of Tina during the interview I clearly sensed her hurt and outrage at how fellow bus passengers seemed to have interpreted her scars, and felt that her reading of their reactions did tie in with popular representations of the mentally ill as 'dangerous' (Roth Edney, 2004). But the very strength of Tina's disowning of *any* aggressive impulse raises the possibility of projections onto others of her dissociated fear of her own destructive instincts; after all the passengers' reaction might have been motivated by no more than a general discomfort, and people looking at her arms may be feeling sorry for her rather than scared. Trapped in her inner struggle with often overpowering death instincts, Tina may be misreading her fear for that of others. Most importantly here, the symbolic association between her scars and the dangerous part of her self seems strong.

The second feeling explicitly discussed during the interviews, guilt, is described as ever present but also as reportedly harnessed by Tina in her attempt to control her behaviour:

> When the self-harm comes into my head, I'll be able to um… be a little bit objective about it, you know, this is how you feel afterwards, um… You always feel guilty, cause you feel you're wasting everybody's time, you know, you've, you know, you've ended up in A&E and, you know, people in A&E have better things to do, and all these things go through your head, um… And the other thing is that, um, yeah this whole debate in your head, it just goes, gets bigger and bigger, because you start… on top of the worries that you already had before

> you self-harmed, now you feel guilty, now you feel, um… Yeah now you feel… you've done something really wrong, um…

This extract reveals another interesting ambiguity in Tina's discourse around self-injury. Throughout her interviews self-harm is constructed as a tremendous source of guilt, something made very clear here by the choice of an extreme case formulation ('You always feel guilty'); by the tonal emphasis placed on the word 'always'; and by Tina's use of the second person to describe the way she vigorously argues with herself over the behaviour. However here Tina also adopts a defensive position, externalising her self-harm ('comes into my head'), and suggesting that the guilt itself is imported, tied in with the messages of uncaring dismissal received from others ('people in A&E have better things to do'). It is also harmful since it just adds to the 'debate' and 'worries' in her head, making Tina a victim twice over. While a cursory reading of this extract might emphasize Tina's crushing sense of guilt and responsibility for her actions, a discursive focus shows her acknowledging the guilt but undermining its very foundations, and in the process denying responsibility for her actions *and* feelings. Her last sentence ('now you feel… you've done something really wrong') provides the finishing touch by exonerating Tina from a moral standpoint: guilt is what turns self-injury from an act that is not *really wrong* into one that is.

Shifting to a psychoanalytical reading provides a different, but possibly complementary perspective. Here Tina's pervasive sense of guilt would be fuelled by a punitive superego, that critical part of her psyche so much in evidence during the interviews. Born from the introjection of significant objects in Kleinian thinking, the superego appears to be especially critical in the case of abuse victims, who seem to take on the guilt and responsibility of the act (Gardner, 2001). The emotional, physical and sexual abuse reportedly visited on Tina by her father might therefore feed her physical and ideational self-attacks and constitute another, perhaps an essential, motivation behind her insistent discursive positioning as the blameless victim of circumstances and inner dynamics. Drawing on her biographical account and on psychodynamic concepts, one can interpret the preceding extract as capturing something of Tina's battle with her superego. Importantly, her self-hatred and guilt would crystallize around her self-injury, in an endless cycle of attack and expiation. A psychosocial reading of the text thus

brings to light the possible contribution of unconscious dynamics to Tina's meaning-making around her self-injuring.

5.3 Discussion

This third reading of the text brought out its performative dimension, identifying Tina's discursive positions and repertoires and exploring their potential underpinnings using a combination of discursive and psychoanalytical lenses. Of particular interest was the way in which Tina seemed to construct a dual position for herself: as capable, hard-working Tina on the one hand, and as out-of-control Tina on the other, each pole a potential means to deflect criticism for her behaviour. Further readings suggested the two additional positions of scientist and child, possibly variations on the original split construction. Tina's meaning-making around self-injury seemed to be largely articulated around these positions: at times it was framed as an observable, almost mechanistic phenomenon (notably in her engineering metaphors); at times as an addiction; always as an externalised behaviour over which Tina had limited power, however hard she tried to understand and control it.

As was discussed above, possible motivations for Tina's constructions could first be searched in broader social discourses around self-injury and mental illness. Constructing self-harm as an irrepressible behaviour, and herself as rational and trying hard to cope, enabled Tina to counter views of self-injury as the wilful, self-serving and manipulative act of a 'crazy' person. Like other illness narratives her account thus seemed to function, a least in part, as a defensive disclaimer. Her carefully chosen words, her appeals to science, her efforts to separate the young Tina from her new mature and enlightened self all seemed to participate in this effort. It is worth noting that the researcher was fully involved in this process, not only orienting Tina to specific aspects of her experience but also representing the 'other' she needed to convince.

However bringing in psychoanalytical concepts added another dimension to this interpretation of Tina's discursive moves and outlined, albeit tentatively, some of the unconscious dynamics underpinning her sense-making around self-harm. An exploration of her childlike positioning emphasized the helplessness behind her self-injury, and the way in which the act might reflect a failure of containment, a literal

'spilling out' of blood and emotions. The analysis also suggested that Tina's self-harm might fulfil a critical, but seemingly unconscious, communicative function: to express her primal, unspeakable emotional needs in such a compelling way that others would have no choice but to come to her rescue, enabling her at last to fully surrender to their care. Last, a closer look at Tina's discursive constructions around anger and guilt revealed that both might be central to her behaviour and this in ways she did not show awareness of. Her self-injury became both site and symbol of a struggle between life-enhancing and destructive instincts. The same unconscious dynamics could be called upon to further explain Tina's discursive efforts to free herself from blame. Object relations theory thus enriched the interpretation by allowing a deeper understanding to emerge, understanding that was nonetheless grounded in textual analysis.

So did the incorporation of countertransferential insights.[29] Tina presented as a solid-looking young woman, and her demeanour was calm and thoughtful. The way she organised the aftermath of our interviews (meeting up with her social worker so she would have a place to 'take her feelings') spoke to her ability to look after herself, as did her reported use of her own therapy to process the interviews. Yet over the three weeks that I met with her I found myself repeatedly looking after her: getting her a drink and encouraging her to take a sip; checking she was comfortable with the chair and heat; even 'making her better' by shifting the conversation away in those few instances when it seemed to affect her more deeply. In this way I may have unconsciously responded to her child-like side. Looking back on my notes, I found the question 'How old is she?' scribbled under the date of the second interview, suggesting that the discrepancy between her mature behaviour and my countertransferential response may have been troubling me. I also went through a strong emotional episode following our first interview, during which I felt edgy, overate, and finally woke up during the night feeling lonely and distressed for no clear reason. Reflecting in my field journal the following day, I wondered if I had not become the repository of Tina's difficult feelings, feelings that she had reportedly kept at bay during the interview itself, to the extent of declaring at the end that 'mostly it's like I'm talking about someone else'. Though this strong emotional reaction did not repeat after the second and third

[29] Though 'countertransference' seems to be broadly used in the context of psychosocial analysis, the term transferential might have been more appropriate here since I was the one coming to Tina for help with my project (Frosh, 2010).

interviews, thinking back on a possible unconscious communication enabled me to achieve a deeper understanding of the unspoken emotional needs underlying Tina's meaning-making around her behaviour.

5.4 Reflections on the use of psychosocial analysis

This third segment of interpretative work raised a number of significant concerns. First came the perceived danger of 'over-interpreting' the data, a criticism widely voiced in relation to psychoanalysis and one echoed in Frosh and Emerson's (2005) assertion that Kleinian interpretations were top-down rather than bottom-up: superimposed on the data rather than emerging from it. The richness of the psychodynamic literature on self-injury made the danger of superimposing a psychodynamic formulation onto Tina's narrative very real. However Hollway and Jefferson (2012) argue convincingly that in their approach, as in other approaches to interpretative work, a predefined concept remains valuable as long as it helps make sense of the evidence. Drawing on psychoanalytical insights only when they seemed to enrich the textual analysis helped me remain confident that this was indeed the case here.

A second critique often levelled at psychoanalytic interpretation - and indeed at psychoanalysis itself - is that it puts the researcher in the position of expert, solely able to decipher the unconscious meanings of the participant (e.g., Frosh, 2010). Such power imbalance would be irreconcilable with a democratic practice, and therefore raise troubling ethical issues; it might also compound the risk of developing a 'wild' interpretation. One way to address this problem might have been to take the analysis back to the participant (Hoggett et al., 2010). However the very nature of Tina's account, not to mention her fragility, made this at best a questionable option. Instead, efforts were made to maintain a reflexive attitude throughout and to rigorously ground the analysis in the data. I also refrained from pursuing 'hunches' which may have been helpful in the therapy room but would have taken me too far from the text and the research question, for instance regarding the evocative role of symbolic intrusions (e.g., letter though the door or family phone calls) in triggering Tina's self-harm.

Last but not least, I felt uneasy at times with my 'suspicious' reading of Tina's heart-wrenching account, not least because nothing in either my briefing or debriefing had

suggested that her experiential insights would be subjected to this sort of scrutiny. Indeed Willig (2012) questions whether discursive and psychosocial analyses ought to be carried out on accounts of suffering for this very reason. Yet capturing the performative aspects of Tina's story seemed important here, inasmuch as these also conveyed something of her meaning-making around self-injury, this time meaning-making directed at others; and the use of psychodynamic concepts did help me formulate new hypotheses concerning Tina's relationship with her behaviour. How such an interpretation can be combined with the more 'respectful' readings provided by IPA and narrative analysis is a question considered in the next and final chapter.

6. Conclusion

This final chapter revisits both the insights gained and the challenges confronted throughout the project. Combining three interpretative lenses would, it was hoped, enable the researcher to develop a rich, multidimensional understanding of one individual's meaning-making around the experience of repetitive self-injury. However the use of a pluralistic qualitative design also raised significant methodological and epistemological issues. In reviewing how these were addressed, this concluding chapter illustrates the value of qualitative pluralism as a mixed methods approach enabling researchers and scientist-practitioners to engage more deeply with the subjective meanings attached to complex behaviours.

The chapter starts with a review of the study's findings, illustrating the insights produced by each of the interpretations and reflecting on the overall picture thus created. It then queries the significance of the work, and how well qualitative pluralism might fit with the values of counselling psychology. A third section turns to the methodological challenges raised by the approach, and shows how issues of epistemological coherence, reflexivity and validity were addressed. The chapter ends with a final reflection on the author's research journey.

6.1 Crossing interpretative lenses

Interpretative phenomenological analysis

The IPA interpretation produced an intricate, multi-layered account of Tina's subjective experience. In her attempt to make sense of her self-injury, she seemed to plait together several strands of meaning: first she sought to describe the behaviour and its manifold functions, in what could be seen as a descriptive strand; then she drew a link between her self-injuring and the more diffuse emotional distress born of a 'fragile self', in what was labelled a first contextual strand; in a second contextual strand she related both her self-harm and the underlying suffering to her experience of the 'other'; the impact of her early experiences was then echoed in a third, historical strand; finally, Tina affirmed her growing intellectual and verbal grasp of her experience of self-injury in what could be seen as a meta-cognitive strand.

While these five strands were presented as distinct superordinate themes, they were closely intertwined in practice; aspects of Tina's experience came in and out of focus as I moved from one theme to the next, allowing a greater depth of understanding. For instance, the theme of control seemed to cut across several superordinate themes: self-injury helped Tina through life ('it's the only thing I can control'); it was often triggered by the experience of being 'out of control' ('all those things going on in my head'); and it was tied in with Tina's experience of the 'other' ('everybody else had control'), and of the family ('I have to be in contact with my parents, and pretend that everything is ok'). This first reading of Tina's account thus produced a multifaceted and deeply individual picture of her sense-making around self-injury.

Narrative interpretations

The use of narrative approaches produced additional layers of meaning. First came the analysis of a single significant episode of self-harm, using Gee's (1991) approach and paying close attention to linguistic and paralinguistic clues. The resulting reading seemed at times to echo the IPA interpretation, where self-harm had already been presented as a way to achieve control over life and as a means to communicate distress. However this focused, detailed and structured interpretation also pointed to the importance of social connection. Tina's self-shooting was framed as a response to a growing sense of isolation from family and friend, and as an arresting call for attention. The ineluctability and futility of Tina's act were also powerfully expressed, as she moved from mastery (of the gun) and action (the shooting) to fear, guilt and further disconnection. Focusing in depth on language and prosody thus created new insight into the logic and self-defeating nature of Tina's behaviour. It also revealed some of the complex linguistic apparatus underpinning her attempt at meaning-making.

Using Frank's (1995) illness narratives as heuristic devices produced a different sort of interpretation. This time I no longer sought to identify overarching themes within Tina's account of her experience, or to analyse its linguistic and prosodic properties. Instead the personal significance of her behaviour was tentatively framed in the context of her life story. Several narrative threads were identified, each a reflection of Tina's efforts to make sense of her emotional distress: a hopeful restitution narrative, emphasizing her

growing sense of self; a reflective quest narrative, in which Tina's illness became a journey towards self-awareness; and a darker chaos narrative, which tentatively conveyed the more inchoate aspects of her experience. Each of these narratives imbued self-harm with a different meaning: in the first it became a barometer of emotional health and a marker of physical integrity; in the second a survivor's living testimony; in the third the contradictory expression of a never-ending struggle. Recognising the tension between these different meanings, and how each of them fitted with Tina's understanding of her mental distress and life story, shed a different light on her meaning-making process around self-injury.

Psychosocial analysis

The third reading of the text used a combination of discursive and psychoanalytical lenses to explore its performative dimension. Tina appeared to construct a dual position for herself: as capable and hard-working on the one hand, as out-of-control on the other, each pole arguably a means to deflect criticism for her behaviour. Further readings suggested two additional (and possibly related) discursive positions: those of scientist and child. Importantly here, Tina's meaning-making around self-injury seemed to be largely mapped onto these positions: it was framed sometimes as a 'tangible', even mechanistic phenomenon, notably through the use of engineering metaphors; sometimes as an addiction; always as a behaviour governed by external forces, over which Tina had little control.

Tina's constructions could first be related to negative social discourses around self-injury. By constructing herself as the insightful, hard-working but ultimately helpless victim of an irrepressible behaviour, Tina may have sought to deflect blame for an act often portrayed as self-serving and manipulative, and/or a sign of 'madness'. However bringing in psychoanalytical concepts added a further dimension to this interpretation of Tina's discursive moves, by pointing to the way unconscious dynamics may also participate in her sense-making around self-harm. A closer look at Tina's childlike positioning, and at her constructions around anger and guilt, suggested new interpretations for her behaviour: in one, it became a symbolic expression of her inability to contain inner thoughts and feelings; in another, a means to draw caring adults to her side without having to voice her unspeakable needs; in another still, the

site and manifestation of an unconscious conflict between life and death instincts. Unconscious dynamics could also be called upon to explain Tina's discursive efforts to exonerate herself from blame, thus allowing a different understanding to emerge.

Each of the approaches chosen thus produced a distinct take on Tina's meaning-making around self-injury. Yet their respective insights were often echoed and amplified across interpretative divides. For instance, object relations theory shed a new light on the 'fragile self' underpinning Tina's self-harm, a self already explored from a phenomenological standpoint in the IPA analysis. So did Frank's (1995) heuristic framework, Tina's chaos narrative becoming a signpost to the fragmented and partly incommunicable nature of her experience. Rather than undermining each other, these readings could be seen as forming distinct layers of sense-making around Tina's material: marking the potential salience of particular aspects of her experience of self-injury whilst opening up a multiplicity of viewpoints for the researcher to consider. In this way the pluralistic qualitative approach adopted here may have gone some way towards respecting the fragmentation of the study's human subject (Frosh, 2007).

6.2 A different take on repetitive self-injury?

Back to the literature

How did the readings sit with existing research on repetitive self-injury? As could be expected, Tina's account often resonated with previous findings on the aetiology and finality of the behaviour. The 'rush' of cutting, the abusive background, the interpersonal issues were all there, as were attempts to cope with overwhelming emotions, to punish the self, to communicate distress, to combat dissociation and to affirm control. But ticking off existing boxes could hardly convey the uniqueness and complexity of her experience as constructed through the interpretations: its embeddedness in Tina's early family life and developing sense of self; the crushing loneliness behind her teenage self-shooting; the seduction of a close encounter with death and the comforting feel of warm blood; or the way self-injury simply seemed 'to work', helping Tina navigate a tumultuous, and at times chaotic emotional landscape.

Revisiting the clinical models of repetitive self-injury reviewed in the introductory chapter yielded similar conclusions. Tina's emotional roller-coaster and her BPD diagnosis brought to mind Linehan's biosocial model and corresponding dialectical behaviour therapy, an approach Tina herself had described as helpful. But behavioural theorists would no doubt have pointed to the positive reinforcement reportedly received by Tina around her self-harm: the caring school nurse attending to her early injuries; the previously indifferent family flocking to her hospital bed in the wake of her self-shooting. By the same token, Tina's depiction of the way in which self-injury seemed to activate intense feelings of guilt followed by more self-injury matched a key tenet of the experiential-avoidance model; and the reported impact of hospitalisation on Tina's behaviour could easily be read through the prism of psychosocial approaches, with their strong emphasis on the perceived powerlessness born of institutionalisation and the way it may mirror early family experiences (a link drawn by Tina herself). As for the usefulness of a psychoanalytical reading of Tina's account, it was amply demonstrated in chapter 5.

The variety of insights gleaned into Tina's meaning-making around self-injury thus spoke to the value of an approach that opened up rather than closed down, that offered a range of competing yet in important ways complementary readings of an individual's subjective experience, paying attention to form and content, manifest and unconscious; never claiming to speak 'the truth' and certainly not 'the whole truth', but merely engaging in a tentative and reflexive manner with an overdetermined behaviour. In the process, it acknowledged the central role played by the researcher in the production of meaning around behaviours such as repetitive self-injury, thus illustrating once again the co-constructed nature of any exploration of individual experience (Kvale, 1996). With the important exceptions of the psychoanalytical and psychosocial literatures, research on self-harm has often overlooked the complex ways in which researchers both enable and inevitably distort the creation of knowledge around the subject. This project may therefore serve as a modest reminder of the need to pay close attention to reflexivity when studying personally challenging and ontologically disputed behaviours, whatever the method used.

Qualitative pluralism and counselling psychology

The way in which the approach followed resonated with the values of counselling psychology is also of direct relevance here. A first meeting point lay in the emphasis placed on the lived experience of the individual, since

> At its core, counselling psychology privileges respect for the personal, subjective experience of the client over and above notions of diagnosis, assessment and treatment, as well as the pursuit of innovative, phenomenological methods for understanding human experience (Bury & Strauss, 2006, p.120).

The common value placed on reflexivity and intersubjectivity was also noteworthy. But it is perhaps the pluralistic ethos of counselling psychology that made qualitative pluralism such a natural match. Counselling psychologists advocate the tailoring of therapeutic work to the unique needs of each client (e.g., Cooper & McLeod, 2011). In their research orientation they similarly recognise the potential of methodological and epistemological pluralism (Rafalin, 2010). As illustrated in the present study pluralistic qualitative approaches can considerably enrich one's understanding of individual experience. As such they deserve inclusion among the array of methodological options presented in doctoral training programmes, alongside more traditional single and mixed methods approaches.

6.3 Qualitative pluralism revisited

Though rich and rewarding, the approach followed here posed serious challenges for a novice qualitative researcher.

Holding several methodological approaches in tension

The first one was of course the need to achieve a sufficient degree of proficiency in using what effectively turned out to be five different analytical procedures. Being able to rely on the guidance and encouragement of my supervisor proved invaluable. But the work also called for a considerable degree of methodological reflexivity: enough needed

to be known about each approach to design a coherent project and gather suitable data, rich in here-and-now experiencing and historical/biographical details. Yet it also seemed important to maintain some degree of naivety so as to engage with each approach fully and on its own terms when the time came, and not prejudge their contribution or possible shortcomings.

In the end, efforts were made to ensure that every aspect of the data collection, from recruitment to transcription, would factor in the textual requirements of the different analyses to be carried out. Further, each of the decisions surrounding the design and implementation of the project was weighted with an eye to its possible impact on the interpretative work, and carefully documented to guarantee integrity (Williams & Morrow, 2009).

As was discussed in chapter 2, the sequence to be followed was also given consideration and breaks were arranged between segments of interpretative work so that I could return to the text with relatively fresh eyes. Last, all three interviews were approached as a block, and I only moved to another interpretative lens once I was satisfied that sufficient meaning had been extracted from the whole set. This was to preserve the coherence of Tina's overall narrative and to remain 'in approach' throughout each cycle of analysis. Keeping a journal also allowed me to reflect on the research process itself, with its new and complex methodology.

The risk of epistemological dissonance

A second challenge concerned the very real risk of dissonance between three epistemologically distinct approaches. The epistemological position underlying each approach was given careful consideration, as were the requirements of the contextual constructionist stance adopted overall. I took pains to return to the text time and again, using it to ground the interpretation and make it as intelligible and honest as I could. Multiple quotes were also drawn from the interviews, so the reader could engage with the quality of the interpretation more fully.

Because contextual constructionism views the researcher's input into the interpretative work as being context-dependent itself, considerable attention was also paid to personal

reflexivity. Possible preconceptions regarding the functions and meanings of self-injury, and how the behaviour may tie in with the symptoms and aetiology of borderline personality disorder (with which Tina had been diagnosed), were held in awareness throughout the IPA work and beyond. Because of their explicit concern for the dialogical and performative elements of the text, narrative and psychosocial approaches further required an in-depth reflection on my potential input in the interviewing process.

Reflexivity also meant remaining aware of my own identity and how it may colour the interpretative work. One way to verify that my analyses had remained true to Tina's material might have been to share the readings with her; however taking the work back to such a vulnerable participant, and this one year on, would have raised significant methodological and ethical issues. Keeping a reflexive journal enabled me to better delineate my contribution to the meaning-making process. It also met one of the key requirements of the psychosocial approach, with its emphasis on transference and countertransference between interviewer and interviewee. Still, throughout the work I was reminded of the limitations of my undertaking: adopting a multiplicity of analytical lenses might help me not get too wedded to a single theoretical frame, thus opening up my interpretation; but Tina's subjectivity would remain elusive, and my analysis a partial, contextual and co-constructed account of her experience of self-injury.

The issue of validity

Validity needed to be considered. Though well established in psychological research, and eminently compatible with each of the interpretative approaches selected, single case studies are still seen as lacking external validity. Yet case-centred analysis uniquely allows for the exploration of the many facets of subjective experience around a given phenomenon (Flyvbjerg, 2006). Given the research question the ideographic method seemed highly appropriate, and the attention paid to reflexivity and transparency throughout the project helped ensure the trustworthiness of its findings.

So did the coherence of the interpretations offered, both individually and together. At the onset of the project it was anticipated that each of the interpretative lenses used would produce a distinct picture of the participant's meaning-making around repetitive self-injury. Using the IPA lens would produce phenomenological insight: a here-and-

now take on the quality and meaning of the lived experience of self-harm. The narrative analysis might contribute a reflection on the place of language and storying in meaning-making, by showing how Tina's experience of self-injury might have been articulated and expressed to the researcher. Last, the psychosocial work would combine a discursive and a psychoanalytical reading of the text, and in the process bring out the performative dimension of Tina's account and the role within of underlying conflicts.

However one fear was that the three pictures thus drawn would end up undermining each other, or at the very least confuse the reader, thus calling into question the pragmatic value of combining different interpretative strategies (Williams & Morrow, 2009). Instead the picture of Tina's sense-making around her self-injurious behaviour proved both rich and coherent. As was shown above, each of the three paradigms delivered distinct and often thought-provoking interpretations. Further, in addition to providing a measure of methodological triangulation (cf. for instance the cross-analytical centrality of issues around control and mastery), the layering of these different approaches created a tapestry of insights, many of which were reflected across interpretations.

As for the pragmatic validity of the research, i.e. its usefulness to others, feedback from colleagues working with self-harming individuals has so far proved encouraging. However only time will tell whether the multidimensional picture of meaning-making around self-injury presented here proves of interest to other researchers or clinicians, and affords those affected by the behaviour a richer understanding of its individual complexity (Riessman, 2008).

A last point deserves consideration here: the well-being of the participant herself. Applying a qualitative pluralistic approach to the study of severe emotional and behavioural difficulties raises particular ethical issues. Some of the more 'suspicious' interpretations (e.g., discursive or psychoanalytical) may hurt or offend the interviewee if shared, or at the very least appear dishonest to a participant who thought the researcher was solely interested in the nature of her experience (Willig, 2012). Perhaps even more critically, the account needs to be rich, requiring more than one interview around potentially distressing topics. Here it meant subjecting Tina to several hours of interviewing around an intensely private and painful experience. Interestingly however

she consistently reported that the meaning-making process had felt positive, perhaps even 'therapeutic' since for the first time in her life she had focused on her behaviour in depth, and in the company of a listening other. This finding echoed that of others, who showed that participating in qualitative interviewing around self-harm may have a positive impact on vulnerable individuals (Biddle et al., 2013). This suggests that the depth of interpretation associated with qualitative pluralism need not be an issue when exploring severe psychological difficulties, provided the researcher can adopt a sensitive stance.

Overall, there is no doubt that qualitative pluralism places heavy demands on the researcher in terms of reflexivity (see also Nolas, 2011). Yet it also possesses definite strengths and as such deserves greater recognition as one important approach to mixed methods research, notably among 'scientist-practitioners'. First, combining different methodologies and sets of epistemological claims can allow for multidimensional understandings to emerge. This could be especially valuable when exploring the sort of topics devoid of consensus around ontological status so prevalent in the field of psychopathology (Frost & Bowen, 2012). Second, pluralistic qualitative approaches seem to offer a valuable middle ground between prescriptive blueprints and 'methodology-free' research (Chamberlain, 2012), something which may hold particular appeal for qualitative researchers wishing to follow their creativity without sacrificing methodological rigour. Last, qualitative pluralism offers a multifaceted way to engage with subjectivity and meaning-making. It can deepen the way one thinks about the lived experience and its communicability, and as such may hold particular value for those engaged in therapeutic work.

6.4 Final reflections

Developing a pluralistic interpretation of Tina's reported experience of self-injury was a demanding process. Beyond the theoretical and methodological challenges already discussed, I felt that my participant had entrusted me with a unique and courageous narrative, and that I had to do it justice. Yet I was also aware of having taken ownership of her material, and this from the moment I had set out to transcribe the interviews: would she even recognise herself in my interpretations, especially the more 'suspicious' ones? Short of sharing them with her, something I felt uncomfortable doing

for reasons already mentioned, this question would have to remain unanswered. In that respect too, my first foray into qualitative psychological research provided valuable learning.

Overall however, reviewing my journey through the project brings me much satisfaction. I set out hoping to make this piece of research a key aspect of my professional and perhaps personal development through my doctoral training. This was undoubtedly the case. As the picture of Tina's meaning-making around self-injury grew, layer by layer, I found myself revisiting many of the assumptions around self-harm that I had developed as a researcher and clinician, with direct impact on my clinical work. The analysis also brought out the complexity of the communications taking place between researcher and participant, something of obvious relevance to a developing counselling psychologist. Rather than being an 'add-on', my research thus became a thought-provoking extension of my clinical training, an opportunity to consider, in slow motion and from multiple angles, the complex process of sense-making taking place between two people, and to reflect differently on its therapeutic impact. Three years on I feel enriched by the experience, and I am grateful to Carla and Tina for making it possible.

References

Adams, J., Rodham, K., & Gavin, J. (2005). Investigating the "self" in deliberate self-harm. *Qualitative Health Research, 15*, 1293-1309.

Adler, P.A., & Adler, P. (2007). The demedicalization of self-injury: From psychopathology to sociological deviance. *Journal of Contemporary Ethnography, 36*, 537-569.

Adrian, M., Zeman, J., Erdley, C., Lisa, L., & Sim, L. (2011). Emotional dysregulation and interpersonal difficulties as risk factors for nonsuicidal self-injury in adolescent girls. *Journal of Abnormal Child Psychology, 39*(3), 389-400.

Alexander, N., & Clare, L. (2004). You still feel different: The experience and meaning of women's self-injury in the context of a lesbian or bisexual identity. *Journal of Community and Applied Social Psychology, 14*, 70-84.

American Psychiatric Association (2011). DSM-5 Development. Accessed on 13 June 2011 at http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=443

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders*, 5th edition (DSM-5). Washington, DC: American Psychiatric Publishing.

Arnold, L. (1995). *Women and self-injury. A survey of 76 women*. Bristol: Bristol Crisis Service for Women, PO Box 654, Bristol BS99 1XH.

Ayton, A., Rasool, H., & Cottrell, D. (2003). Deliberate self-harm in children and adolescents: Association with social deprivation. *European Child & Adolescent Psychiatry, 12*/6, 303-307.

Babiker, G., & Arnold, L. (1997). *The language of injury: Comprehending self-mutilation*. Leicester: BPS Books.

Bateman, A., & Fonagy, P. (2006). *Mentalization-based treatment: A practical guide*. Oxford: Oxford University Press.

Bateman, A., & Fonagy, P. (2008). 8-year follow-up of patients treated for borderline personality disorder: Mentalization-based treatment versus treatment as usual. *American Journal of Psychiatry, 165*, 631-638.

Bateman, A., & Fonagy, P. (2009). Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disordet. *American Journal of Psychiatry, 166*, 1355-1364.

Biddle, L., Cooper, J., Owen-Smith, A., Klineberg, E., Bennewith, O., Hawton, K., Napur, N., Donoval, J., & Gunnel, D. (2013). Qualitative interviewing with vulnerable populations: Individuals' experiences of participating in suicide and self-harm based research. *Journal of Affective Disorders 145*(3), 356-362.

Bion, W.R. (1967). *Second thoughts: Selected papers on psychoanalysis*. London: Heinemann.

Briere, J., & Gil, E. (1998). Self-mutilation in clinical and general population samples: Prevalence, correlates, and functions. *American Journal of Orthopsychiatry, 68*, 609-620.

Brinkmann, S., & Kvale, S. (2008). Ethics in qualitative psychological research. In C. Willig and W. Stainton Rogers (Eds.), *The Sage handbook of qualitative research in psychology*. London: Sage.

British Psychological Society (2010). Code of human research ethics. Accessed on 10 June 2011, at http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics.pdf

Brown, L.S., & Bryan, T.C. (2007). Feminist therapy with people who self-inflict violence. *Journal of Clinical Psychology: In Session, 63*(11), 1121-1133.

Burck, C. (2005). Comparing qualitative research methodologies for systemic research: The use of grounded theory, discourse analysis and narrative analysis. *Journal of Family Therapy, 27*, 237-262.

Bury, M. (2001). Illness narratives: Fact or fiction? *Sociology of Health & Illness, 23*(3), 263-285.

Bury, D., & Strauss, S. (2006). The scientist-practitioner in a counselling psychology setting. In D. Lane & S. Corrie (Eds). *The modern scientist-practitioner: A guide to practice in psychology* (pp.119-129). Hove: Routledge.

Cavaletto, G. (2007). *Crossing the psychosocial divide: Freud, Weber, Adorno and Elias*. Aldershot: Ashgate.

Chamberlain, K. (2012). Do you really need a methodology? *QMiP Bulletin, 13*, 59-63.

Chamberlain, K., Cain, T., Sheridan, J., & Dupuis, A. (2011). Pluralisms in qualitative research: From multiple methods to integrated methods. *Qualitative Research in Psychology, 8*, 151-169.

Chapman, A.L., Gratz, K.L., & Brown, M.Z. (2006). Solving the puzzle of deliberate self-harm: The experiential avoidance model. *Behaviour Research and Therapy, 44*, 371-394.

Cloitre, M., Koenen, K.C., Cohen, L.R., & Han, H. (2002). Skills training in affective and interpersonal regulation followed by exposure: A phase-based treatment for PTSD related to childhood abuse. *Journal of Consulting and Clinical Psychology, 70*, 1067-1074.

Coccaro, E.F., Siever, L.J., Klar, H.M., Maurer, G., Cochrane, K., Cooper, T.B., et al. (1989). Serotogenic studies in patients with affective and personality disorders. *Archives of General Psychiatry, 46*, 587-599.

Cooper, J., Husain, N., Webb, R., Waheed, W., Kapur, N., Guthrie, E., & Appleby, L. (2006). Self-harm in the UK: Differences between South Asians and Whites in rates, characteristics, provision of service and repetition. *Social Psychiatry & Psychiatric Epidemiology, 41*, 782-788.

Cooper, M., & McLeod, J. (2011). *Pluralistic counselling and psychotherapy*. London: Sage.

Craigen, L.M., & Foster, V. (2009). 'It was like a partnership of the two of us against the cutting': Investigating the counseling experience of young adult women who self- injure. *Journal of Mental Health Counseling*, *31*(1), 76-94.

Crossley, M. (2000). *Introducing narrative psychology: Self, trauma and the construction of meaning*. Buckingham: Open University Press.

Crouch, W., & Wright, J. (2004). Deliberate self-harm at an adolescent unit: A qualitative investigation. *Clinical Child Psychology and Psychiatry, 9*, 185-204.

Davies, D., & Neal, C. (1996). *Pink therapy*. Buckingham: Open University Press.

Eatough, V., & Smith, J.A. (2006). I feel like a scrambled egg in my head: An idiographic case study of meaning making and anger using interpretative phenomenological analysis. *Psychology and Psychotherapy: Theory, Research and Practice, 79*, 115-135.

Eatough, V., & Smith, J.A. (2008). Interpretative phenomenological analysis. In C. Willig & Stainton-Rogers (Eds.) The Sage handbook of qualitative research in psychology. (pp.179-194). London: Sage.

Favazza, A.R. (1996). *Bodies under siege: Self-mutilation and body modification in culture and psychiatry* (2nd ed.). Baltimore: Johns Hopkins University Press.

Feigenbaum, J.D., Fonagy, P., Pilling, S., Jones, A., Wildgoose, A., Bebbington, P.E. (2012). A real-world study of the effectiveness of DBT in the UK National Health Service. *British Journal of Clinical Psychology, 51*, 121-141.

Fliege, H., Lee, J.-R, Grimm, A., & Klapp, B.F. (2009). Risk factors and correlates of deliberate self-harm behaviour: A systematic review. *Journal of Psychosomatic Research, 66*, 477-493.

Flowers, P. (2008). Temporal tales: The use of multiple interviews with the same participant. *Qualitative Methods in Psychology, 5*, 24-27.

Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry, 12*(2), 219-245.

Freud, S. (1917). *Mourning and melancholia*. In Standard Edition Vol.14. London: Hogarth, 1958.

Frank, A.W. (1995). *The wounded storyteller. Body, illness, and ethics*. Chicago: The University of Chicago Press.

Frank, A.W. (2012). Practicing dialogical analysis. In J.A. Holstein & J.F. Gubrium (Eds). *Varieties of narrative analysis* (pp.33-52). London: Sage.

Frosh, S. (2007). Disintegrating qualitative research. *Theory and Psychology, 17*(5), 635-653.

Frosh, S. (2010). *Psychoanalysis outside the clinic: Interventions in psychosocial studies.* London: Palgrave Macmillan.

Frosh, S., & Baraitser, L. (2008). Psychoanalysis and psychosocial studies. *Psychoanalysis, Culture & Society, 13*, 346-365.

Frosh, S., & Emerson, P.D. (2005). Interpretation and over-interpretation: Disputing the meaning of texts. *Qualitative Research, 5*(3), 307-324.

Frosh, S., & Saville Young, L. (2008). Psychoanalytic approaches to qualitative psychology. In C. Willig & W. Stainton-Rogers (Eds). *The SAGE handbook of qualitative research in psychology* (pp.109-126). London: Sage.

Frost, N. (2009). 'Do you know what I mean?': The use of a pluralistic narrative analysis approach in the interpretation of an interview. *Qualitative Research, 9*, 9-29.

Frost, N. (Ed.) (2011). *Qualitative research methods in psychology: Combining core approaches.* Maidenhead: McGraw-Hill Open University Press.

Frost, N.A., & Bowen, C. (2012). Commentary: New pluralistic strategies for research in clinical practice. *Qualitative Research in Psychology, 9*: 27-31.

Frost, N.A., & Nolas, S.-M. (2011). Exploring and expanding on pluralism in qualitative research in psychology. *Qualitative Research in Psychology, 8*, 115-119.

Gardner, F. (2001). *Self-harm. A psychotherapeutic approach*. London: Routledge.

Gee, J. (1991). A linguistic approach to narrative. *Journal of Narrative and Life History, 1*(1), 15-39.

Gergen, K.J., & Gergen, M. (1983). Narratives of the self. In K. Scheibe & T. Sarbin (Eds.), *Studies in social identity*. New York: Praeger.

Goffman, E. (1981). *Forms of talk*. Oxford: Blackwell.

Gough, B. (2009). A psycho-discursive approach to analysing qualitative interview data, with reference to a father-son relationship. *Qualitative Research, 9*, 527-545.

Gratz, K.L. (2001). Measurement of deliberate self-harm: Preliminary data on the deliberate self-harm inventory. *Journal of Psychopathology and Behavioral Assessment, 23*, 253-263.

Gratz, K.L. (2007). Targeting emotion dysregulation in the treatment of self-injury. *Journal of Clinical Psychology, 63*, 1091-1103.

Harris, J. (2000). Self-harm: Cutting the bad out of me. *Qualitative Health Research, 10*(2), 164-173.

Hawton, K., Harriss, L., Simkin, S., Bale, E., & Bond, A. (2004). Self-cutting: Patient characteristics compared with self-poisoners. *Suicide and Life-Threatening Behavior, 34*, 199-208.

Hawton, K., Rodham, K., Evans, E., & Weatherhall, R. (2002, November 23). Deliberate self-harm in adolescents: Self-report survey in schools in England. *BMJ, 325*, 1207-1211.

Herpetz, S., Sass, H., & Favazza, A. (1997). Impulsivity in self-mutilative behaviour: Psychometric and biological findings. *Journal of Psychiatric Research, 31*(4), 451-465.

Hiles, D., & Čermák, I. (2008). Narrative psychology. In C. Willig & W. Stainton-Rogers (Eds). *The SAGE handbook of qualitative research in psychology* (pp.147-164). London: Sage.

HM Prison Service (2011). Female prisoners. Accessed on 20 June 2011, at http://www.hmprisonservice.gov.uk/adviceandsupport/prison_life/femaleprisoners/

Hoggett, P., Beedell, P., Jimenez, L., Mayo, M., & Miller, C. (2010). Working pycho-socially and dialogically in research. *Psychoanalysis, Culture & Society, 15*(2), 173-188.

Hollway, W., & Jefferson, T. (2005). Panic and perjury: A psychosocial exploration of agency. *British Journal of Social Psychology, 44*, 147-163.

Hollway, W., & Jefferson, T. (2012). *Doing qualitative research differently: A psychosocial approach* (2nd ed.). London: Sage.

Horrocks, J., Price, S., House, A., & Owens, D. (2003). Self-injury attendances in the accident and emergency department: Clinical database study. *The British Journal of Psychiatry, 183*, 34-39.

Horton-Salway, M. (2001). Narrative identities and the management of personal accountablity in talk about ME: A discursive psychology approach to illness narrative. *Journal of Health Psychology, 6*, 247-259.

Huband, N., & Tantam, D. (2004). Repeated self-wounding: Women's recollection of pathways to cutting and of the value of different interventions. *Psychology and Psychotherapy: Theory, Research and Practice, 77*, 413-428.

Hurry, J. (2000). Deliberate self-harm in children and adolescents. *International Review of Psychiatry, 1*, 31036.

Jarvi, S., Jackson, B., Swenson, L., & Crawford, H. (2013). The impact of social contagion on non-suicidal self-injury: A review of the literature. *Archives of Suicide Research, 17*, 1-19.

Joiner, T. (2007). *Why people die by suicide*. Cambridge, MA: Harvard University Press.

Joseph, B. (1982). Addiction to near-death. *International Journal of Psychoanalysis, 63*, 449-456.

Kasket, E. (2012). The counsellist psychologist researcher. *Counselling Psychology Review, 27*(2), pp.64-73.

Kennerley, H. (2004). Self-injurious behaviour. In J. Bennett-Levy, G. Butler, M. Fennell, A. Hackmann, M. Mueller, & D. Westbrook (Eds.), *Oxford guide to behavioural experiments in cognitive therapy* (pp. 373-392). Oxford: Oxford University Press.

Klein, M. (1933). The early development of conscience in the child. In *Writings of Melanie Klein*, vol.1. London: Hogarth Press (1975).

Klonsky, E.D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review, 27*, 226-239.

Klonsky, E.D. (2011). Non-suicidal self-injury in United States adults: Prevalence, sociodemographic topography and functions. *Psychological Medicine, 5*, 1-6.

Klonsky, E.D., & Moyer, A. (2008). Childhood sexual abuse and non-suicidal self-injury: Meta-analysis. *The British Journal of Psychiatry, 192*, 166-170.

Klonsky, E.D., & Muelenkamp, J.J. (2007). Self-injury: A research review for the practitioner. *Journal of Clinical Psychology: In Session, 63*(11), 1045-1056.

Koons, C.R., Robins, C.J., Reed, J.L., Lynch, T.R., Gonzalez, A.M., Morse, J.Q., Butterfield, M.I., & Bastian, L.A. (2001). Efficacy of dialectical behavior therapy in women veterans with borderline personality disorder. *Behavior Therapy, 3*, 371-390.

Kvale, S. (1996). *InterViews: An introduction to qualitative research interviewing*. London: Sage.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3*, 102-120.

Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative research*. Thousand Oaks, CA: Sage.

Linehan, M.M. (1993a). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Linehan, M.M. (1993b). *Skills training manual for treating borderline personality disorder*. New York: Guilford Press.

Linehan, M.M., Armstrong, H.E., Suarez,A, Allmon, D., & Heard, H. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, *48*, 1060-1064.

Linehan, M.M., Bohus, M., & Lynch, T.R. (2007). Dialectical Behavior Therapy for pervasive emotion regulation: Theoretical and practical underpinnings. In J.J. Gross Ed.), *Handbook of emotion regulation* (pp.581-605). New York: The Guilford Press.

Linehan, M.M., Comtois, K.A., Murray, A.M., Brown, M.Z., Gallop, R.J., et al. (2006). Two-year randomized controlled trial and follow-up of dialectical behaviour therapy versus therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry*, 63, 757-766.

Linehan, M.M., Schmidt III, H., Dimeff, L.A., Craft, J.C., Kanter, J., & Comtois, K.A. (1999). Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. *The American Journal on Addictions*, *8*, 279-292.

Long, M., & Jenkins, M. (2010). Counsellors' perspectives on self-harm and the role of the therapeutic relationship for working with clients who self-harm. *Counselling and Psychotherapy Research, 10*(3), 192-200.

Longden, E., & Proctor, G. (2012). A rationale for service responses to self-injury. *Journal of Mental Health, 21*(1), 15-22.

Luiselli, J.K. (2009). Nonsuicidal self-injury among people with developmental disabilities. In M.K. Nock (Ed.), *Understanding nonsuicidal self-injury: Origins, Assessment, and Treatment* (pp.157-179). Washington, DC: American Psychological Association.

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology, 91*, 1-20.

Martin, J., Bureau, J.F., Cloutier, P., & Lafontaine, M.F. (2011). A comparison of invalidating family environment characteristics between university students engaging in self-injurious thoughts and actions and non-self-injuring university students. *Journal of Youth and Adolescence, 40,* 1477-1488.

McAdams, D. (1993). *The stories we live by*. New York: The Guilford Press.

McAdams, D. (1988). *Power, intimacy and the life story*. New York: The Guilford Press.

McLeod, J. (2004). *Doing counselling research* (2nd ed.). London: Sage.

McMain, S.F, Links, P.S., Gnam, W.H., Guimond, T., Cardish, R.J., Korman, L., Streiner, D.L. (2009). A randomized trial of dialectical behaviour therapy versus general psychiatric management for borderline personality disorder. *American Journal of Psychiatry, 166,* 1365-1374.

Millard, C. (2013). Making the cut: The production of 'self-harm' in post-1945 Anglo-Saxon psychiatry. *History of the Human Sciences.* Accessed on 2 September 2013 at http://hhs.sagepub.com/content/early/2013/02/05/0952695112473619

Motz, A. (2001). *The psychology of female violence*. Hove: Brunner-Routledge.

Muelhenkamp, J.J. (2005). Self-injurious behavior as a separate clinical syndrome. *American Journal of Orthopsychiatry, 75*(2), 324-333.

Muehlenkamp, J.J., Brausch, A., Quigley, K., & Whitlock, J. (2012). Interpersonal features and functions of self-injury. *Suicide and Life-Threatening Behaviour 43*(1), 1-14.

Muelhenkamp, J.J., & Guttierrez, P.M. (2004). An investigation of differences between self-injurious behavior and suicide attempts in a sample of adolescents. *Suicide and Life Threatening Behavior, 34,* 12-23.

Muelhenkamp, J.J., Kerr, P.L., Bradley, R., & Larsen, M.A. (2010). Abuse subtypes and nonsuicidal self-injury. *The Journal of Nervous and Mental Disease, 198*(4), 258-263.

Mulhall, S. (1996). *Routledge philosophy guidebook to Heidegger and Being and Time*. Abingdon: Routledge.

Murray, M. (2008). Narrative psychology. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp.111-132). Thousand Oaks: Sage.

Najmi, S., Wegner, D.M., & Nock, M.K. (2007). Thought suppression and self-injurious thoughts and behaviors. *Behaviour Research and Therapy, 45*, 1957-965.

Nathan, J. (2004). In-depth work with patients who self-harm: Doing the impossible? *Psychoanalytic Psychotherapy, 18*(2), 167-181.

NICE (2004). Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. Accessed 6 June 2011, at http://www.nice.org.uk/nicemedia/live/10946/29424/29424.pdf. National Institute for Clinical Excellence.

Nock, M.K. (2010). Self-injury. *Annual Review of Clinical Psychology, 6*, 339-363.

Nock, M.K. (Ed.) (2009). *Understanding nonsuicidal self-injury: Origins, Assessment, and Treatment*. Washington, DC: American Psychological Association.

Nock, M.K., & Cha, C.B. (2009). Psychological models of nonsuicidal self-injury. In M.K. Nock (Ed.), *Understanding nonsuicidal self-injury: Origins, Assessment, and Treatment* (pp.65-77). Washington, DC: American Psychological Association.

Nock, M.K., & Kessler, R.C. (2006). Prevalence of and risk factors for suicide attempts versus suicide gestures: Analysis of the national comorbidity survey. *Journal of Abnormal Psychology, 115*, 616-623.

Nock, M.K., & Prinstein, M.J. (2004). A functional approach to the assessment of self-mutilative behavior. *Journal of Consulting and Clinical Psychology, 72*, 885-890.

Nolas, S.-M. (2011). Pragmatics of pluralistic qualitative research. In N. Frost (Ed.), *Qualitative research methods in psychology: Combining core approaches* (pp.121-144). Maidenhead: McGraw-Hill Open University Press.

Pembroke, L.R. (Ed.) (2004). *Self-harm: Perspectives from personal experience*. Chipmunka Publishing, Survivors Speak Out.

Polk, E., & Liss, M. (2009). Exploring the motivations behind self-injury. *Counselling Psychology Review, 22*(2), 233-241.

Pomerantz, A.M. (1984a). Giving a source or basis: The practice in conversation of telling 'how I know'. *Journal of Pragmatics, 8*(5-6), 607-625.

Pomerantz, A.M. (1984b). Extreme case formulation: A way of legitimizing claims. *Human Studies, 9*(2-3), 219-229.

Potter, M., & Wetherell, J. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London: Sage.

Priebe, S., Bhatti, N., Barnicot, K., Bremner, S., Gaglia, A., Katsakou, C., Molosankwe, I., McCrone, P., & Zinkler, M. (2012). Effectiveness and cost-effectiveness of dialectical behaviour therapy for self-harming patients with personality disorder: A pragmatic randomised controlled trial. *Psychotherapy and Psychosomatics, 81*, 356-365.

Radley, A., & Chamberlain, K. (2001). Health psychology and the study of the case: From method to analytic concern. *Social Science and Medicine, 53*(3), 321-332.

Rafalin, D. (2008). Counselling psychology and research: Revisiting the relationship in the light of our 'mission'. In M. Milton (Ed.) *Therapy and beyond: Counselling Psychology contributions to therapeutic and social issues* (pp.41-56). London: Wiley-Blackwell.

Rallis, B.A., Deming, C.A., Glenn, J.J., & Nock, M.K. (2012). What is the role of dissociation and emptiness in the occurrence of nonsuicidal self-injury? *Journal of Cognitive Psychotherapy, 26*(4), 287-298.

Rao, R. (2006). Wounding to heal: The role of the body in self-cutting. *Qualitative Research in Psychology, 3*, 45-58.

Razzaque, R. (2012). An acceptance and commitment therapy based protocol for the management of acute self-harm and violence in severe mental illness. *Journal of Psychiatric Intensive Care*, firstview, 1-5.

Reece, J. (2005). The language of cutting: Initial reflections on a study of the experiences of self-injury in a group of women and nurses. *Issues in Mental Health Nursing, 26*, 561-574.

Riessman, C.K. (1993). *Narrative analysis*. Qualitative Research Methods Series 30. Thousand Oaks, CA: Sage.

Riessman, C.K. (2003). Narrative analysis. In M.S. Lewis-Beck, A. Bryman, & T. Futing (Eds.), *The Sage encyclopedia of social science research methods*, 3 Vol. boxed set. Thousand Oaks, CA: Sage.

Riessman, C.K. (2008). *Narrative methods for the human sciences*. Thousand Oaks, CA: Sage.

Rissanen, M.-L., Kylmä, J., & Laukkanen, E. (2008). Descriptions of self-mutilation among Finnish adolescents: A qualitative descriptive enquiry. *Issues in Mental Health Nursing, 29*, 145-163.

Rodham, K., & Hawton, K. (2009). Epidemiology and phenomenology of nonsuicidal self-injury. In M.K. Nock (Ed.), *Understanding nonsuicidal self-injury: Origins, Assessment, and Treatment* (pp.37-62). Washington, DC: American Psychological Association.

Roth Edney, D. (2004). *Mass media and mental illness: A literature review*. Canadian Mental Health Association. Accessed on 9 July 2013 at http://ontario.cmha.ca/files/2012/07/mass_media.pdf

Roulston, K. (2010). Considering quality in qualitative interviewing. *Qualitative Research, 10*, 199-228.

Royal College of Psychiatrists (2010). *Self-harm, suicide and risk: Helping people who self-harm. College report CR158*. London: Royal College of Psychiatrists. Accessed on 6 June 2011, at http://www.rcpsych.ac.uk/files/pdfversion/CR158.pdf.

Russell, G., Moss, D., & Miller, J. (2010). Appalling and appealing: A qualitative study of the character of men's self-harm. *Psychology and Psychotherapy: Theory, Research and Practice, 83*, 91-109.

Saville Young, L., & Frosh, S. (2010). 'And where were your brothers in all this?': A psychosocial approach to texts on 'brothering'. *Qualitative Research, 10,* 511-531.

Shaw, S.N. (2002). Shifting conversations on girls' and women's self-injury: An analysis of the clinical literature in historical context. *Feminism & Psychology, 12*, 191-219.

Sher, L., & Stanley, B. (2009). Biological models of nonsuicidal self-injury. In M.K. Nock (Ed.), *Understanding nonsuicidal self-injury: Origins, Assessment, and Treatment* (pp.99-118). Washington, DC: American Psychological Association.

Shoppmann, S., Schröck, R., Schnepp, W., & Büscher, A. (2007). 'Then I just showed her my arms…' Bodily sensations in moments of alienation related to self-injurious behaviour. A hermeneutic phenomenological study. *Journal of Psychiatric and Mental Health Nursing, 14*, 587-597.

Sinclair, J., & Green, J. (2005). Understanding resolution of deliberate self harm: Qualitative interview study of patients' experiences. *British Medical Journal, 330,* 1-9.

Smith, B., & Sparkes, A.C. (2006). Narrative inquiry in psychology: Exploring the tensions within. *Qualitative Research in Psychology, 3*, 169-192.

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: Sage.

Smith, J.A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to methods* (2nd ed.). London: Sage.

Sutton, J. (2007). *Healing the hurt within: Understand self-injury and self-harm, and heal the emotional wounds*. Oxford: How To Books.

Suyemoto, K.L. (1998). The functions of self-mutilation. *Clinical Psychology Review, 18,* 531-554.

Svirko, E., & Hawton, K. (2007). Self-injurious behaviour and eating disorders: The extent and nature of the association. *Suicide and Life Threatening Behavior, 37*(4), 409-421.

Turp, M. (1999). Encountering self-harm in psychotherapy and counselling practice. *British Journal of Psychotherapy, 15*(3), 306-321.

Turp, M. (2002). The many faces of self-harm. *Psychodynamic Practice, 8*(2), 197-217.

van den Bosh, L.M.C., Koeter, M.W.J., Stijnen, T., Verheul, R., & van den Brink, W. (2005). Sustained efficacy of dialectical behaviour therapy for borderline personality disorder. *Behaviour Research and Therapy, 43*, 1231-1241.

Van Vliet, K.J, & Kalnins, G.R. (2011). A compassion-focused approach to nonsuicidal self-injury. *Journal of Mental Health Counseling, 33*/4, 295-311.

Verheul, R., van den Bosch, L.M.C., Koeter, M.W.J., de Ridder, M.A.J., Stijnen, T., van den Brink, W. (2003). Dialectical behaviour therapy for women with borderline personality disorder: 12-month, randomized clinical trial in the Netherlands. *British Journal of Psychiatry, 182*, 135-140.

Walker, T. (2009). 'Seeing beyond the battled body' – An insight into selfhood and identity from women's accounts who self-harm with a diagnosis of borderline personality disorder. *Counselling and Psychotherapy Research, 9*(2), 122-128.

Walsh, B. (2007). Clinical assessment of self-injury: A practical guide. *Journal of Clinical Psychology: In Session, 63*(11), 1057-1068.

Walsh, B.W., & Rosen, P.M. (1988). *Self-mutilation: Theory, research, and treatment*. New York: Guilford Press.

Whitlock, J.L., Eckenrode, J.E. & Silverman, D. (2006). The epidemiology of self-injurious behavior in a college population. *Pediatrics, 117*(6).

Whitlock, J., Purington, A., & Gershkovich, M. (2009). Media, the internet, and nonsuicidal self-injury. In M.K. Nock (Ed.), *Understanding nonsuicidal self-injury: Origins, assessment, and treatment* (pp.157-180). Washington, DC: American Psychological Association.

Williams, E.N., & Morrow, S.L. (2009). Achieving trustworthiness in qualitative research: A pan-paradigmatic perspective. *Psychotherapy Research, 19*(4/5): 576-582.

Willig, C. (2008). Introducing qualitative research in psychology. Maidenhead: McGraw-Hill Open University Press.

Willig, C. (2012). *Qualitative interpretation and analysis in psychology*. Maidenhead: McGraw-Hill Open University Press.

Yates, T.M. (2009). Developmental pathways from child maltreatment to nonsuicidal self-injury. In M.K. Nock (Ed.), *Understanding nonsuicidal self-injury: Origins, assessment, and treatment* (pp.117-137). Washington, DC: American Psychological Association.

Appendices

Appendix A: Ethics release form

Appendix B: Recruitment flyer

Have you been self-injuring for several years?

Are you aged 18 or over?

Then I would really like to hear your story

For my doctoral research as a Trainee Counselling Psychologist at City University, London, I am exploring what it means to self-injure, and I am looking for someone willing to share his or her experience with me.

I am hoping that this project will contribute to a better understanding of self-harm, and therefore better support for those seeking help.

All the information collected will be made anonymous and kept confidential.

If you are interested in participating, please call **Daphne Josselin** on **07722 243 549** or email daphne.josselin.1@city.ac.uk for more information.

This research is supervised by Professor Carla Willig (C.Willig@city.ac.uk), at City University

Appendix C: Information sheet

Information for participants

Thank you for considering taking part in this research project. This information sheet provides some details about the project and what your participation would involve.

My research is exploring the meaning of self-injury for the person who is self-harming. I am hoping that it will contribute to a better understanding of self-injury by those offering psychological help, and therefore better support for those seeking it.

Your participation will involve two, possibly three interviews with me, each lasting between one hour and one hour and a half. The interviews will take place in London, at a private and convenient location, with date and time to be arranged; however it is important for you to commit to both interviews. The areas I will be looking at are your experience of self-injury, and the meaning you may attach to it. You will be compensated for your travel expenses, and you will receive a £15 M&S voucher as a small token of appreciation.

I will record the interviews so that I can transcribe and analyse them later. I will need your consent to do this, and I have a form that I will ask you to sign when we meet for the first interview. In this form you will also be asked to agree to the possible publication of extracts from the transcripts, provided your anonymity is fully preserved. This is so I can use the research to raise awareness of the meaning of self-injury among members of the health professions.

I am well aware of the sensitivity of this subject, and the interviews will be conducted respectfully in a non-judgmental manner. You will be free to refuse to answer any question. At the end of each interview I will ask you how you found it to participate, and I will provide information regarding sources of support should any difficulty arise for you as a result of discussing your experience.

All data gathered during this study will be held securely and anonymously. You will also retain the right to withdraw from the study at any point, in which case I will destroy any recordings or data related to you.

If you would like to take part in this study, or if you have any question, please contact me using the details below.
Daphne Josselin
Trainee Counselling Psychologist
City University
Tel: 07722 243 549
Email: daphne.josselin.1@city.ac.uk

I thank you in advance for giving participation serious thought: research into self-injury is still in its infancy and developing a better understanding of the behaviour ‘from within’ would be a significant step forward.

This research is being supervised by Professor Carla Willig (C.Willig@city.ac.uk) and has received ethical clearance from City University.

Appendix D: Interview schedule

First interview

1. In your first email you wrote that you had self-injured 'on countless occasions'. Can you tell me more about that?

2. Can you recall a recent episode when you self-injured? Can you tell me what happened?

3. Do you remember the first time you self-injured? How old were you? Can you tell me more about that?

4. How does it feel to be discussing your self-injuring with me?

5. I have no further question for you today. Is there anything else you would like to mention before we finish the interview?

Second interview

1. How did you feel after our last interview?

2. Is there anything that you thought you should have told me then and did not? Can you tell me more about that today?

4. If a friend asked you to try and explain why you self-injure, what would you say?

5. Last week you told me that when you self-injure, you also mean to communicate something to others. Is it always the case? What might that be?

6. Do you feel that you can be open about your self-injuring? Who with? Why is that?

7. What do your family or friends think about your self-injuring? How do you feel about that?

8. How does it feel to be discussing your self-injuring with me for the second time?

9. I have no further question for you. Is there anything else you would like to mention before we finish the interview?

Third interview

1. How did you feel after our last interview?

2. Is there anything that you thought you should have told me then and did not? Can you tell me more about that today?

3. Can you tell me more about your experience growing up?

4. Looking back on your life so far, can you think of any event that may be relevant to your self-injuring? How so? Can you think of anything else?

5. Can you think of any relationship, past or current, that may be relevant to your self-injuring? How so? Any other relationship?

6. Do you feel that your self-injuring has changed in the time that you have been doing it. Could you tell me more about that?

7. How does it feel to be discussing your self-injuring with me for the third time? For the last time?

8. I have no further question for you. Is there anything else you would like to mention before we finish the interview?

Appendix E: Consent form

Participant's consent to record and participate

Thank you for agreeing to take part in my doctoral research on the meaning of self-injury. Before we begin the first interview, it is important that you give signed consent to show that you fully agree to participate and understand what is involved. As part of my research it is necessary that I record the interviews for later transcription and analysis. The transcripts of the interviews will be completely anonymous and confidential. Any names used in the final piece of work will be pseudonyms to protect your identity. In case this work is later published in whole or in part, the same guarantees of confidentiality will apply.

In the interviews I will be looking at your experience of self-injury, and at the meaning you may attach to it. The first interview will last around one hour and a quarter, and subsequent interviews will last around one hour. You will be free to refuse to answer any question. You can also withdraw your consent to participate at any stage, without giving a reason.

This consent form will be stored securely, separately from the written transcripts.

****

I understand what will be required of me in the research project on the meaning of self-injury. I agree to participate in the research, and that the interviews are recorded for later analysis. I also agree to the publication of extracts from the transcripts, on the condition that anonymity is fully preserved.

Participant's name……..
Participant's signature…….. Date……

Interviewer's name……..
Interviewer's signature…… Date……

Appendix F: Resource sheet

Resource sheet

Please find below a number of resources and telephone numbers which you may find helpful if you feel you are experiencing any difficulties after the interview. The following numbers and websites all provide help and support for people who are self-harming.

Bristol Crisis Service for Women (email and text support for girls and women in emotional distress, particularly those who harm themselves)
www.selfinjurysupport.org.uk

Harmless (postal and email support for people who self-harm) - www.harmless.org.uk

National Self-Harm Network (confidential support, advice and helpline for individuals who self-harm) – www.nshn.co.uk 0800 622 6000 (opening hours –Thursday-Saturday 7pm-11pm, Sunday 6.30pm-10.30pm, including public holidays)

Samaritans (24h emergency helpline) – www.samaritans.org.uk 08457 90 90 90

Support Line (confidential emotional support for children, young adults and adults by telephone, email and post) **–** www.supportline.org.uk 01708 765 200
info@supportline.co.uk

The Site (information, advice and support for young people)
http://www.thesite.org/healthandwellbeing/mentalhealth/selfharm

If you wish to see someone privately to discuss any problem, the following organisations have lists of qualified therapists and counsellors which can be accessed under the 'Find a therapist/psychologist' section.

www.bacp.co.uk (British Association for Counselling and Psychotherapy) 01455 883316

www.psychotherapy.org.uk (UK Council for Psychotherapy – UKCP) 020 7014 9955

www.bps.org.uk (British Psychological Society) 0116 254 9568

www.babcp.org.uk (British Association for Behavioural and Cognitive Psychotherapies)

Appendix H: Superordinate themes and themes for each interview

Superordinate themes and themes from the first interview

Themes	Page/line	Key words/sentences
Self-harm as a way of managing life		
Always there	1/9-10	as far back as I can remember
Different types	6/13-14	some of the self-harm that I do, I don't remember doing
	12/21-23	the times when I had to have surgery were the times where the self-harm, um, was completely premeditated
Lots of little things	21/24-25	it's usually lots of little things that build up
A clandestine obsession	13/6-9	you get on with your normal day to day things, um, as if there is absolutely nothing wrong with you, but in the background you've got this'
Having control	13/13-15	it's like I've got control over something, that's something I can control
This awesome sort of rush	30/8	I just feel this awesome sort of rush
Touching the void	33/7	I was thinking: this is what it's like to die
Punishment	20/24	some of it is about punishment
Communicating distress	39/23-25	bad enough that people would realise how…how much pain I'm in, emotionally
What's underneath: the fragile self		
Flicking	24/5-7	I actually put my head between the pillows in bed and just as I flick I'm trying to hold my thoughts in
Two separate me	26/20-22	it's like there's two separate me
Confused	23/8-11	I often find myself debating things in my head: you know: should I, shouldn't I? You know: why did this happen, or…
Self-judgment	18/18-19	I still have quite a lot of judgment about myself

It's not me	27/24-28	if I'm cutting my arm it's all… it's like, well I know it's my arm, but it feels like, or it looks like it's not mine
Hidden	24/16-19	I can often be having a conversation with someone and it's like, other stuff's going on there at the back of my head as well

What's underneath: experiences of the other

The judging other	21/10-11	I worry that people are judging me as well
Alone	38/31-32	I felt really powerless then… and really alone
The controlling other	38/27-29	then I felt like, then everybody else had control, that I didn't have any say into what happened
The supportive other	7/27-28	I've got support now, I've got people like that, if I ring, they'll understand

Developing a new understanding of self and self-harm

Clueless	43/15-16	I did not have a clue what they were talking about
Having the words	16/23-28	now, probably in the last couple of years […], I actually have the words for things.
Saying it	5/19-22	when I say it all in one thing long, you know, when I say that out loud, it kind of makes me realise how far I've come
The scientific way	17/15-16	the way that I've come about understanding it is, you know, I kind of look at it in a scientific way
New options	4/25-28	now that I have that sort of knowledge, now that, I, that helps me think of other options
Understanding vs feeling	18/15-17	I can understand it on an intellectual level but feeling it and, me, um, applying it to me, that's quite difficult
Helping others understand	50/19-21	it's quite important for me, for people to see that it's not what it's about

Superordinate themes and themes from the second interview

Themes	Page/line	Key words/sentences
Self-harm as a way of managing life		
An addictive feeling	31/18-19	there's almost this addictive element to it
Having control	4/13-15	it's the only thing I can control, the only thing that I can, you know… have any say in
Communicating distress	9/18-21	so maybe just to communicate how bad you feel you self-harm again
Hospitals make it worse	2/24-25	hospital admissions make my self-harm a lot worse
What's underneath: the fragile self		
Flashbacks from the past	11/9-10	sometimes I get, um… images in my head that are like flashbacks from the past
Sucked underground	11/12-14	the distress itself… that almost feels like you're being sucked underground
No room in my head	11/21-24	these thoughts, like they're being… pushed into my head, um… and it's almost like there's so much going in there, um… that there isn't any room left
Empty	16/13-15	that numbness kind of feels like kind of empty, like an empty shell or something
I'm not me	15/5-7	I'm not me in a way, like I'm not, like, uh… It's almost like I'm looking at me
That powerful feeling	17/23-26	there's some force around me – I know it sounds weird – that, you know, that is acting for me
Confused	17/19-21	even at the time I know, there's something telling me that this isn't quite right
Nosedive	19/2-4	way up there and then, this massive nosedive, um, where this rush of everything just comes in
Out of control	20/21-23	it feels like you're out of control, like you've got no…like someone else is at the steering wheel

Why can't I do that?	12/18-20	So there's that kind of anger at myself that, you know, I can do this, so why can't I do that?
Hiding	27/11-14	there's other days when I'm feeling a bit… not so good and… I don't feel like I can manage people staring at me

What's underneath: experiences of the other

Horrible comments	8/18-20	I've had lots of really horrible comments to me
Making it worse	9/17-18	hearing that, this was like: I just feel even worse now
They're judging me	26/4-5	they're judging me before they even know me
They don't get it	6/14-17	that may come across to some people like manipulative, or like you're seeking attention or… but… you know it's not really about that, for me
Those who understand	8/6-8	there's people that can really grasp, that can understand the reasons you're doing it

What's underneath: experiences of the family

My parents are part of it	29/27-29	If I'm honest my parents are like, part of the reason why I am the way I am, um… part of why I self-harm
Invasion	33/10-11	it's almost like they're invading my space here, and this is my safe place

Developing a new understanding of self and self-harm

A new awareness	2/4-6	I have a lot better understanding of myself and how, and you know, why I self-harm
What others do	21/14-17	I'm often thinking about why other people do things, and how they manage to be around other people, and I kind of file it in my head
Using the word	23/14-16	Maybe in my head I knew the word, but I wouldn't have used it, because I thought that I would be judged
Saying it loud	42/9-10	sometimes when you say it out loud, it doesn't sound so bad

So much to say	1/19-20	I was quite surprised at the end that I'd so much to say

Superordinate themes and themes from the third interview

Themes	Page/line	Key words
Self-harm as a way of managing life		
Always there	8/17-19	I've self-harmed so much over, like, for as long as I can remember
Punishment	52/4-6	it would have been to punish yourself, cause I was this bad… I was this little bad person
Irrepressible	12/14-16	it's almost like I'm fighting so hard not to do it that maybe it's coming out another way
Communicating distress	11/10-11	I'm using it to communicate cause I'm feeling this way
Blocking things off	53/12-15	you can block everything else that's going on outside but also you could divert your attention from how you're feeling
It works	54/5-6	you know that it will work, at least for the short term
What's underneath: the fragile self		
All those things	16/26	All those things going on in my head
Stuck in time	54/19-21	you can't see past the next few seconds or minutes, because it feels like forever
Confused	25/19-21	my self-harm got so bad because I just got so confused about how I was supposed to feel
Out of control	55/8-9	I don't know when I'm gonna feel completely overwhelmed again
Frustration	16/9-11	there's that sort of shame and, that feeling about, you know, doing it and… a frustration with yourself
Hiding the self	18/14-15	until somebody really properly knows me, they won't actually see that in me

What's underneath: experiences of the other

Internalising the critiques	3/5-7	you kind of internalize all that and you say those things to yourself as well, and believe them yourself

What's underneath: experiences in the family

The abuse	22/6-10	my dad abused me, as I was growing up, me and my older sister C, and… So… part of what, um, triggers self-harm for me is like I get lots of flashbacks
Away from them	28/17-19	a big massive part of why my self-harm is reduced is because I moved here, and I'm away from them
Denial	25/3-5	I had to… deny outwardly you know, kind of like… sweep everything under the carpet, you know, everything's fine
Trapped	49/6-8	it's a bit like the times I've been in hospital, how hospital has felt like to me, like feeling trapped
Still under control	27/30-28/2	for me to be able to see my sisters and my brother, and my nieces and my nephews, I have to have contact with my parents, and pretend that everything is ok

Developing a new understanding of self and self-harm

Clueless	8/21-24	for something to be such a big part of your life and to, for so long not really understand it, or even… even know that you need to understand it
New understanding	8/6-9	having the awareness of how self-harm, what it means for me and that… you now… how it affects me and… you know, my reasons for doing it
Actual physical things	56/11-14	now that I'm doing biological psychology and knowing that there's actual physical things happening
Understanding to managing	11/5-6	understanding that actually helps me reduce doing it
Understanding vs believing	15/14-15	Sometimes you can understand but not necessarily believe it and, you know, inside

Having the words	6/16-18	It takes people so long to get to know how things affect me because I can't express myself
Talking about self-harm	10/14-16	there are constructive ways of talking about it and not so helpful ways of talking about it
So much to say	59/7-9	I didn't think I was gonna be able to talk so much, but… I have done

Appendix I: Master table of themes across the three interviews

Master table of themes across the three interviews

Themes	*Page/line*
1. Self-harm as a way of managing life	
Always there	
Interview 1: 'as far back as I can remember'	1/9-10
Interview 3: I've self-harmed so much over, like, for as long as I can remember, from doing little things right up to doing massive things'	8/18-21
Lots of little things	
Interview 1: 'it's usually lots of little things that build up'	21/24-25
In the background	
Interview 1: 'you get on with your normal day to day things, um, as if there is absolutely nothing wrong with you, but in the background you've got this'	13/6-9
Having control	
Interview 1: 'it's like I've got control over something, and that's something I can control'	13/13-15
Interview 2: 'it's the only thing I can control'	4-13-15
Interview 3: 'you can block everything else'	53-12-15
This awesome sort of rush	
Interview 1:'I just feel this awesome sort of rush'	30/8
Interview 2: 'there's almost this addictive element to it'	31/18-19
Punishment	
Interview 1: 'some of it is about punishment'	20/24
Interview 3: 'it would be to punish yourself cause I was this bad… I was this bad little person	52/4-6
Irrepressible	
Interview 3: 'it's almost like I'm fighting so hard not to do it that maybe it's coming out another way'	12/14-16
Touching the void	
Interview 1: 'I was thinking: this is what it's like to die'	33/7
Communicating distress	
Interview 1: 'bad enough that people would realise how… how much pain I'm in, emotionally'	39/23-25
Interview 2: 'so maybe just to communicate how bad you feel you self-harm again'	9/18-21
Interview 3: 'I'm using it to communicate cause I'm feeling this way'	11/10-11
Hospitals make it worse	
Interview 2: 'hospital admissions make my self-harm a lot worse'	2/24-25

It works
Interview 3: ‘you know that it will work, at least for the short term’ 54/5-6

2. What’s underneath: the fragile self

Flashbacks from the past
Interview 2: ‘images in my head that are like flashbacks from the past’ 11/9-10

Sucked underground
Interview 2: ‘the distress itself… that almost feels like you’re being sucked underground’ 11/12-14

Overwhelmed
Interview 1: ‘just as I flick I’m trying to hold my thoughts in’ 24/5-7
Interview 2: ‘these thoughts, like they’re being… pushed into my head’ 11/21-24
Interview 3: ‘all those things going on in my head’ 16/26

I’m not me
Interview 1: ‘I know it’s my arm, but it feels like, or it looks like it’s not mine’ 27/24-28
Interview 2: ‘I’m not me in a way, like I’m not, like, uh… It’s almost like I’m looking at me’ 15/5-7

That powerful feeling
Interview 2: ‘there’s some force around me – I know it sounds weird – that, you know, that is acting for me’ 17/23-26

Stuck in time
Interview 3: ‘you can’t see past the next few seconds or minutes, because it feels like forever’ 54/19-21

Nosedive
Interview 2: ‘way up there and then, this massive nosedive, um, where this rush of everything just comes in’ 19/2-4

Out of control
Interview 2: ‘it feels like you’re out of control, like you’ve got no… like someone else is at the steering wheel’ 20/21-23
Interview 3: ‘I don’t know when I’m gonna feel completely overwhelmed again’ 55/8-9

Divided and confused
Interview 1: ‘it’s like there’s two separate me’ 26/1
Interview 2: ‘even at the time I know, there’s something telling me that this isn’t quite right’ 17/19-21

Why can't I?

Interview 1: I say 'why can't you just ask? Why are you being so stupid about that?' 16/5-6

Interview 2: 'So there's that kind of anger at myself that, you know, I can do this, so why can't I do that?' 12/18-20

Interview 3: 'there's that sort of shame and, that feeling about, you know, doing it and… a frustration with yourself' 16/9-11

Hiding the self

Interview 1: 'it's like, other stuff's going on there at the back of my head' 24/18-9

Interview 2: 'I don't feel like I can manage people staring at me' 27/12-14

Interview 3: 'until somebody properly knows me, they won't actually see that in me' 18/14-15

3. What's underneath: experiences of the other

Horrible comments

Interview 2: 'I've had lots of really horrible comments to me' 8/18-20

They're judging me

Interview 1: 'I worry that people are judging me as well' 21/10-11

Interview 2: 'they're judging me before they even know me' 26/4-5

The controlling other

Interview 1: 'then I felt like, then everybody else had control, that I didn't have any say into what happened ' 38/27-29

They don't get it

Interview 2: 'that may come across to some people like manipulative, or like you're seeking attention or… but… you know it's not really about that, for me' 6/14-17

They make it worse

Interview 2: 'hearing that, this was like: I just feel even worse now' 9/17-18

Interview 3: 'you kind of internalize all that and you say those things to yourself as well, and believe them yourself' 3/5-7

Alone

Interview 1: 'I felt really powerless then… and really alone' 38/31-32

Those who understand

Interview 1: 'I've got support now, I've got people like that, if I ring, they'll understand' 7/27-28

Interview 2: 'there's people that can really grasp, that can understand the reasons you're doing it' 8/6-8

4. What's underneath: experiences of the family

My parents are part of it

Interview 2: 'If I'm honest my parents are like, part of the reason why I am the way I am, um… part of why I self-harm' 29/27-29

The abuse

Interview 3: 'my dad abused me, as I was growing up, me and my older sister C, and… So… part of what, um, triggers self-harm for me is like I get lots of flashbacks '	22/6-10

Invasion

Interview 2: 'it's almost like they're invading my space here, and this is my safe place'	33/10-11
Interview 3: 'It's hard sometimes when that space feels invaded by the odd text, or the odd phone call'	28/24-26

Denial

Interview 3: 'I had to… deny outwardly you know, kind of like… sweep everything under the carpet, you know, everything's fine'	25/3-5

Trapped

Interview 3: 'it's a bit like the times I've been in hospital, how hospital has felt like to me, like feeling trapped'	49/6-8

Still under control

Interview 3: 'for me to be able to see my sisters and my brother, and my nieces and my nephews, I have to have contact with my parents, and pretend that everything is ok'	27/30-28/2

5. Developing a new understanding of self and self-harm

Clueless

Interview 1: 'I did not have a clue what they were talking about'	43/15-16
Interview 3: 'for something to be such a big part of your life and to, for so long not really understand it, or even… even know that you need to understand it'	8/21-24

A new awareness

Interview 2: 'I have a lot better understanding of myself and how, and you know, why I self-harm'	2/4-6
Interview 3: 'having the awareness of how self-harm, what it means for me and that… you now… how it affects me and… you know, my reasons for doing it'	8/6-9

What others do

Interview 2: 'I'm often thinking about why other people do things, and how they manage to be around other people, and I kind of file it in my head'	21/14-17

The scientific way

Interview 1: 'the way that I've come about understanding it is, you know, I kind of look at it in a scientific way'	17/15-16
Interview 3: 'now that I'm doing biological psychology and knowing that there's actual physical things happening'	56/11-14

Having the words

Interview 1: 'now, probably in the last couple of years […], I actually have the words for things'	16/23-28
Interview 2: 'Maybe in my head I knew the word, but I wouldn't have used it, because I thought that I would be judged '	23/14-16
Interview 3: 'It takes people so long to get to know how things affect me because I can't express myself'	6/16-18

Saying it loud

Interview 1: 'when I say it all in one thing long, you know, when I say that out loud, it kind of makes me realise how far I've come'	5/19-22

So much to say

Interview 2: 'I was quite surprised at the end that I'd so much to say'	1/19-20
Interview 3: 'I didn't think I was gonna be able to talk so much, but… I have done'	59/7-9

New options

Interview 1: 'now that I have that sort of knowledge, now that, I, that helps me think of other options'	4/25-28
Interview 3: 'understanding that actually helps me reduce doing it'	11/5-6

Talking about self-harm

Interview 1: 'it's quite important for me, for people to see that it's not what it's about'	50/19-21
Interview 3: 'there are constructive ways of talking about it and not so helpful ways of talking about it'	10/14-16

Understanding is not enough

Interview 1: 'I can understand it on an intellectual level but feeling it and, me, um, applying it to me, that's quite difficult'	18/15-17
Interview 3: 'Sometimes you can understand but not necessarily believe it and, you know, inside'	15/14-15