Context and Complexity:

Counselling Psychology,

Deliberate Self-Harm

and Substance Misuse

Portfolio for Professional Doctorate

in Counselling Psychology

(DPsych)

Luke Shobbrook

City University

Department of Psychology

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City University Declaration

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Introduction to portfolio

The following portfolio comprises four separate pieces of written work that were completed during my three years as a trainee counselling psychologist at City University. The first is an original research study focusing on the experiences of eight young adult men in managing their deliberate self-harm. The second and third are pieces of client work from my clinical placement that explore some of the difficulties and complexities of working therapeutically as a counselling psychologist with clients misusing alcohol or other substances. The fourth is a critical literature review that explores the phenomenon of deliberate self-harm among adolescents and the effectiveness of the various treatment options that have been developed to prevent repetition of the behaviour.

The research that forms the first section of the portfolio targeted young adult men who self-harm and aimed to explore their experiences in managing or recovering from the behaviour. Eight young men aged 18-26 were recruited to take part in the study, five through online self-harm communities and three from an advertisement in the local newspaper. All of them had avoided self-harm for at least three months. Data were collected using semi-structured interviews and analysed using the qualitative methodology of interpretative phenomenological analysis (IPA). The experiences of participants appeared to represent a journey from negative self-evaluation and an invalidated self to validation and self-acceptance. Self-harm initially appeared to provide participants with a coping mechanism for dealing with difficult or overwhelming emotions and a means of punishing the self. They also appeared to find the behaviour shameful, however, and went to great lengths to keep it hidden from others. Despite the secretive nature of their behaviour participants nevertheless expressed a desire to share how they felt and to be listened to and understood as people. The research highlighted the role of close relationships of empathy and support and the importance of validation and acceptance in the management of participants' deliberate self-harm.

The second section of the portfolio consists of two distinct pieces of client work that I completed as part of a clinical placement with the local health service's community drug team. This section aims to demonstrate my own knowledge of psychological theory and its application to clinical practice as a counselling psychologist. The first part

of this section features a case study of a client with co-morbid social anxiety and alcohol misuse and explores some of the difficulties and dilemmas I faced in establishing an effective therapeutic relationship. The second part features a process report focusing on a client whose substance misuse was accompanied by obsessive thoughts and anxiety symptoms. Both cases demonstrate the complexities of substance misuse work and represent an attempt to identify and work with some of these complexities within a cognitive behavioural model.

The third and final section of the portfolio presents a critical literature review that explores the phenomenon of deliberate self-harm and the various treatments that have been developed to prevent its repetition among adolescents. Deliberate self-harm is a contentious issue and the review outlines some of the problems in defining exactly what constitutes self-harming behaviour and in estimating its prevalence. The failure of clinical interventions to prevent the repetition of the behaviour in young people highlights the need for different approaches that take account of the person behind the behaviour, a view endorsed by qualitative studies involving young people who self-harm. Counselling psychologists seem well placed to offer this kind of support provided they are adequately prepared to deal with what can be a distressing experience.

The thread that links the various pieces of work contained within the portfolio is the recognition of the complexities of human experience and behaviour and the relative strength of counselling psychology in accommodating these complexities. People often act in ways which seem strange to others but make sense to them given their personal, social and cultural context. I believe that it is only by seeing the person as a whole and attempting to understand this context that we can come to understand their motivations. In clinical terms, I believe this is what distinguishes counselling psychology from other approaches to the treatment of psychological problems as its focus on subjective experience and personal meanings represent an opportunity to recognise and work with this complexity.

The critical literature review addresses the complex issue of deliberate self-harm among adolescents and the various treatments that have been developed to prevent its repetition. Despite a growing interest in the phenomenon among professionals and the wider public the behaviour is still not well understood. The literature review represented my first attempt to explore the issue and has transformed my own thinking on the

subject. I approached the review with the same morbid fascination with which many others view the phenomenon, informed more by sensationalist stories in the media than by any personal experience. I have since learned however that as a counselling psychologist I already possess the necessary skills to deal effectively with clients who deliberately self-harm as the effective treatment of the behaviour appears to depend more upon being able to build an effective and validating therapeutic relationship rather than any special skills or techniques. My deeper understanding of the issue has since increased my confidence that I will be able to deal with it more effectively when it arises in my own practice by being less focused on the behaviour and more attentive to the person behind it instead.

The two pieces of client work I have included in the portfolio both reflect some of the complexities of working with a difficult client group. I have learned through my practice that like deliberate self-harm, drug and alcohol problems are often symptomatic of underlying issues. The use of alcohol or other substances is often functional and clients who come for treatment are often ambivalent about change. Through my clinical practice I have developed ways of working with clients to address this ambivalence and enhance motivation within a cognitive behavioural approach. As my knowledge and skills have developed I have learned that the cognitive behavioural model, which at first appeared simplistic and mechanistic, provides a useful framework within which I can develop respectful, empathic working relationships with clients. As I have become more experienced in its application I believe I have learned to rely less on an expert role and work more collaboratively with clients to develop idiosyncratic case conceptualisations that reflect the complexity of their individual social and cultural context.

The doctoral research provided the opportunity to revisit the issue of deliberate self-harm and explore the experiences of young adult men in managing or resolving the behaviour. I was particularly interested in how participants had learned to manage their behaviour for themselves and how these experiences might help inform the practice of counselling psychology. While participants' individual experiences were unique, reflecting the complexity of the phenomenon, the research nevertheless found that each participant described a parallel journey from negative self-evaluation and an invalidated self to acceptance of themselves and their behaviour. The process of conducting the research was itself riddled with complexity and I found myself going through a parallel process of self-doubt and emotional turmoil. By conducting the research I believe I have

gained valuable knowledge and experience of the research process and feel much better equipped to perform and critically evaluate other qualitative studies in the future.

The three different sections of the portfolio each represent different aspects of my own journey reflecting the uniqueness and complexity of my own experiences during what has been a time of considerable learning and personal transformation. Together they provide evidence of my own personal and professional development over the last three years and in particular the acquisition of the knowledge and skills necessary to make the transition from student and trainee to chartered counselling psychologist.

Part One

Research

The Management and Resolution of Deliberate Self-Harm Among Young Adult Males: An Interpretative Phenomenological Analysis

Abstract

This study aimed to explore the lived experience of the hidden population of young adult males in managing their deliberate self-harm. Semi-structured interviews were conducted either face-to-face (n=5) or online (n=3) with male participants aged between 18 and 26 years old recruited from self-harm message boards online and a newspaper advertisement. Transcripts of the interviews were subjected to an interpretative phenomenological analysis which revealed four superordinate themes reflecting a journey from negative self-evaluation to self-acceptance: the invalidated self, the struggle for control, validation of the self by others and learning to live with a new self. Participants' experiences reflected the use of deliberate self-harm as a means of emotional regulation, however the management of deliberate self-harm appeared problematic from the outset. Despite the behaviour's subjective benefits it also served to increase participants' emotional distress and increase the likelihood of further self-harm. While gender was not an explicit concern participants nevertheless appeared to make an effort to maintain an illusion of self-control to conform to a male stereotype. Their struggle to manage their own behaviour met with limited success however and it was not until they were able to seek help and support from others that most were able to manage it more effectively. Despite the hidden nature of the behaviour empathic and validating relationships of support and especially reciprocal relationships were a core feature of all accounts. Even after abstinence from the behaviour was achieved participants appeared reluctant to abandon the behaviour altogether and keen to maintain self-harm as a last resort if necessary. Participants' experiences appear to reflect the tension between professional priorities and the needs of those who self-harm for autonomy and responsibility for their own behaviour. The study provides a unique insight into the lived experience of young men in managing self-harming behaviour that may help inform counselling psychologists who encounter male self-harm in their practice.

Introduction

The phenomenon of intentional self-inflicted injury, referred to hereafter as deliberate self-harm, remains a highly sensitive and controversial topic that has garnered a great deal of attention in recent years among clinicians, researchers, the mainstream media and also the general public. Despite a growing awareness of the issue, the behaviour still evokes both fascination and disgust in many people who find the idea of deliberate self-harm disturbing. While in some cultures deliberate self-harm forms an important part of socially sanctioned rituals and practices, self-inflicted injuries represent a challenge to the values of contemporary Western society which place a greater emphasis on the sanctity of the body and its integrity. The existence of hard hats, safety belts and shaving creams all demonstrate the lengths that people in Western society go to on a daily basis to avoid pain and injury. Nevertheless a minority of people still persist in deliberately harming themselves and many of them will at one time or another seek the help of others in managing or resolving their behaviour and the underlying emotional distress that accompanies it.

Deliberate self-harm is considered a largely female phenomenon. Men who self-harm seem less likely to seek help than women and appear particularly vulnerable to the perceived judgements of others because of societal expectations about how men should behave. A greater understanding of the experiences of men who self-harm may be of benefit to counselling psychologists and their male clients who self-harm as it could help to improve the quality of the therapeutic relationship by preventing misunderstandings and promoting a more open dialogue about the behaviour and the emotional distress that underlies it.

What is deliberate self harm?

Although deliberate self-harm has only recently become the focus of media interest and clinical research the phenomenon itself is nothing new. Acts of self-mutilation were recorded as early as the 5th century B.C. by the Greek writer Herodotus and also appeared in the Gospel of Mark (Clarke and Whittaker, 1998). Deliberate self-harm as a form of asceticism or adornment continued throughout the centuries and some forms of

body modification, such as facial scarring among African tribeswomen, are still practiced today (Favazza, 1998). In contemporary Western society various body-focused practices previously considered deviant, such as tattooing and body piercing, are becoming increasingly common. Other more socially acceptable behaviours such as alcohol use, cigarette smoking and long working hours are known to be hazardous to health and yet many people willingly indulge in them. All of these behaviours could conceivably be included within a broad definition of deliberate self-harm.

One of the earliest references to deliberate self-harm in formal clinical research was in a case study by Emerson in 1913 (cited in Simpson, 2006). The first clinician to attempt to classify self-harming behaviour was Karl Menninger in 1938 (cited in Favazza, 1998). Both of these studies importantly represented self-harm as a phenomenon in its own right, distinct from suicidal behaviour both in its meaning and its intent. These early explorations proved well ahead of their time as little further interest was shown in deliberate self-harm until there was a marked increase in its prevalence, most noticeably amongst young women, in the United Kingdom, the United States and Australia during the 1960s and 1970s (Hawton, 1998). Following this perceived epidemic of self-harm and attendant media interest there was a corresponding increase in other forms of body-focused behaviours during the 1980s as part of what Favazza (1998) identifies as a 'Modern Primitivism' movement. Practices once viewed as deviant such as tattooing, body piercing and cosmetic surgery have all since become gradually more common and more socially acceptable and an increasing number of people do not consider these body modification practices to be particularly harmful. Nevertheless Favazza and Rosenthal (1993) maintain that some of the more extreme forms of body modification are still classifiable as self-mutilation as they involve the wilful destruction of body tissue. It has been suggested that the attraction of such behaviours, whether deviant or not, is the sense of control they provide for the individual over his or her own body (Clarke and Whittaker, 1998) and as such there are clear parallels with other forms of deliberate self-harm. While the dividing line between body modification and deliberate self-harm is sometimes perilously thin a distinction may nevertheless be made between the two behaviours. Body modifications or decorations are often a source of pride and are flaunted by their owners while the majority of those who deliberately self-harm experience shame and go to great lengths to keep their scars hidden from others (Sutton, 2007). While both behaviours represent a deliberate transgression of the same social taboo the milder forms of body modification such as tattooing and body piercing appear

to be more socially acceptable and less damaging to an individual's sense of self than self-injurious behaviours such as cutting or burning.

Problems with defining exactly what constitutes self-harm are confounded further by the sheer variety of terms used to describe it which have included 'attempted suicide', 'parasuicide' and 'self mutilation' (Allen, 2007). Many of these terms have been criticised as overly emotive and some for the association they create between deliberate self-harm and suicidal behaviour (McAllister, 2003). Self-harm and suicide are now recognised as distinct phenomena differing both in their epidemiology (Favazza, 1998) and the meanings ascribed to them (Simpson, 2006). While the intention of suicidal behaviour is to end life, self-harm is believed to be a mechanism for regaining control or for managing psychological distress (Adams *et al.*, 2005; McAllister, 2003). While a number of different models have been proposed and several separate functions identified (Babiker and Arnold, 1997; Klonsky, 2007), the regulation of affect appears to be the most commonly reported function of deliberate self-harm (Adams *et al.*, 2005; Gratz, 2007; Klonsky, 2007). Far from being a self-destructive behaviour deliberate self-harm appears to represent an attempt to preserve life, while suicidal behaviour is by its very nature an attempt to end it. Attempted suicide has its own particular etiology and treatment and is distinct from self-harm in this respect (Simpson, 2006; Muehlenkamp, 2005). However the relationship between the two phenomena is complex as they share some common psychosocial risk factors and although the majority of those who deliberately self-harm do not experience suicidal ideation (Klonsky and Muehlenkamp, 2007) a significant proportion have attempted suicide at least once (Klonsky, 2007). The distinction between attempted suicide and deliberate self-harm appears highly nuanced but is nevertheless fundamental to a better understanding of the phenomenon.

It has been argued that a further distinction should be made within the broader definition of self-harm itself and specifically between self-harm and self-injury (McAllister, 2003). Any act that causes psychological or physical harm to the self without suicidal intent may be classified as self-harm whether intentional or not. Self-injury on the other hand may be seen as a specific sub-category of self-harm that involves a visible injury to the body, most commonly from cutting or burning. Some of the recent literature has begun to refer to 'non-suicidal self-injury' or NSSI (Muehlenkamp, 2006; Klonsky, 2007) rather than self-harm to make this distinction clear. Even these terms are

challenged however by a growing number of self-help materials and autobiographical survivor accounts that attempt to avoid the negative connotations of much of the existing terminology. They employ terms such as 'self-soothing' (Strong, 2000) instead as such terms recognise the motivation behind the behaviour and its function as a coping mechanism. McAllister (2003) suggests that this use of a more positive label for the behaviour also represents an act of resistance that challenges the dominant discourse on self-harm in an attempt to reduce the stigma attached to the behaviour and address the harmful effects of negative labelling.

In the absence of a consensus within the existing literature on the appropriate terminology to describe self-harming behaviour the term 'deliberate self harm' was chosen for this study as it appeared to be the most widely used and understood in the UK literature at the time. This term describes a wide range of direct, body-focused behaviours outside normal convention that are non-suicidal, intentional in nature and cause injury through the *"destruction or alteration of body tissue"* (Favazza, 1998). This usually means cutting or burning but can also include other ways of injuring the body such as biting, scratching, head banging or skin picking (Simpson, 2006). This definition is synonymous with that of self-injury and participants in the study appeared to use the two terms interchangeably.

The prevalence of deliberate self-harm in the UK

The recent report from the national enquiry into deliberate self-harm by young people identified it as a growing problem in the United Kingdom, particularly among adolescents and young adults (Brophi, 2006). Estimating the number of people who engage in the behaviour is problematic however as there are no official statistics. Evidence comes instead from a number of sources including hospital admissions (Sinclair and Green, 2005) and community based studies such as school surveys (Hawton *et al.*, 2002). The secretive nature of self-harming behaviour means that much of it occurs behind closed doors and many of those who injure themselves are assumed to nurse their own wounds (Sutton, 2007). They are less likely to attend hospital than those who poison themselves and therefore less likely to show up in hospital statistics. Furthermore, many of those who do seek medical attention attempt to convince hospital staff that their injuries are the result of an accident or a fight and their injuries may not

be recorded as deliberate self-harm. It is assumed therefore that many episodes go either unreported or undetected (Sutton, 2007). This helps to explain why there is considerable variation between the figures generated by attempts to estimate the prevalence of deliberate self-harm in the UK. Despite these discrepancies figures from various studies consistently indicate that the numbers of people deliberately harming themselves have risen in recent years. One comparison of two recent estimates suggests that between 1996 and 2005 the number of people deliberately harming themselves in the UK rose from approximately 87,000 to 170,000, an increase of 93 per cent (Sutton, 2007). Comparing these prevalence figures with those from other countries suggests that the UK has one of the highest rates of deliberate self-harm in Europe (Brophi, 2006; Fox and Hawton, 2000). The pan-European Child and Adolescent Self-Harm in Europe (CASE) study (Hawton and Rodham, 2000) provided one such comparison of English schoolchildren with five other European countries and also Australia. The use of a standard measure allowed researchers to compare findings and provided a reliable estimate of the relative rates of deliberate self-harm in the countries studied. The lifetime prevalence among young women in England was higher than in any of the other five European countries at 16.9 per cent. The lifetime prevalence among young men in England was found to be 4.9 per cent, second only to Belgium whose rate was 6.8 per cent. Rates were consistently higher for females than for males in all of the countries represented in the study.

Deliberate self-harm rates revealed in clinical studies have also been consistently higher in females than in males (Hawton *et al.,* 1998). The gender difference appears most marked during adolescence but even in adulthood females appear to outnumber males by two to one (Hawton *et al.,* 2002). It has been suggested that men are more likely to convert difficult emotions into aggression or other forms of self-harm such as substance misuse (Clarke and Whittaker, 1988) and even self-wounding is more likely to be recorded as an accident if the person involved is male (Clarke and Whittaker, 1998). Recent studies of non-clinical populations in the US (Gratz, 2001; Klonsky *et al.*, 2003), however, have revealed equivalent rates of self-harm among males and females. A further study (Gratz and Chapman, 2007) has focused exclusively on young male undergraduates in an attempt to identify the risk factors associated with the development and maintenance of the behaviour among this population. The results of these studies support the notion that hospital presentations represent the tip of the iceberg (Hawton

and Rodham, 2006) and suggest that deliberate self-harm among the non-clinical male population may be more common than was previously thought.

Self-harming behaviour typically begins in adolescence (Muelhenkamp, 2005; Klonsky, 2007) and can continue for many years well into adulthood (Bywaters and Rolfe, 2002; Hawton *et al.*, 1997). Between 15 and 25 percent of those who deliberately harm themselves repeat the behaviour within a year (Hawton *et al.*, 1998). One reason for the continuing interest in deliberate self-harm among clinicians is that the repetition of deliberate self-harm is considered a particular risk factor for eventual suicide. Of those who attend hospital after an episode of deliberate self-harm, 1 per cent commit suicide within a year and 3 to 5 per cent do so within five years (Hawton *et al.*, 1998).This focus on suicidal intent does little to help those who deliberately self-harm, however, as the majority of them have no intention of ending their lives.

Despite attempts to establish a separate clinical 'syndrome' for deliberate self harm (Muehlenkamp, 2005; Tantam and Whittaker, 1992), its complex etiology has defied classification and its only appearance in the American Psychiatric Association's DSM-IV-TR diagnostic manual (APA, 2000) to date has been as a symptom of borderline personality disorder. Deliberate self-harm has nevertheless been identified as occurring across a range of diagnoses and also among non-clinical populations (Gratz and Chapman, 2007; Hawton *et al.*, 2002; Klonsky *et al.*, 2003). The occurrence of deliberate self-harm in the absence of any identified disorder has been identified as a neglected area of research (Clarke and Whittaker, 1998).

Until comparatively recently, the majority of existing literature on deliberate self-harm appears to have reflected professional priorities and largely ignored the needs of those who self-harm to be understood and valued as people with their own thoughts, feelings and reasons for their behaviour. It seems to have focused instead on the classification of self-harm as a mental disorder in its own right (Muehlenkamp, 2005) or on identifying the most effective forms of treatment using the traditional hypothetico-deductive method (Hawton *et al.*, 1998). There have been few randomised controlled trials however and the results of those that there have been are inconclusive. One comprehensive and systematic review of treatment approaches revealed *"promising results"* (Hawton *et al.*, 1998) for problem solving therapy and dialectical behaviour therapy but failed to reach any firm conclusions about effective treatment approaches

even when the results of previous studies were synthesised in a meta-analysis. The trials studied were criticised for their small sample sizes and their failure to specify the standard care that many control groups received.

The most commonly chosen outcome measure for clinical studies exploring the efficacy of treatment is the repetition of deliberate self-harm. This repetition is generally measured in terms of further hospital attendances although there is no standard measure, which itself makes comparisons between different treatment approaches difficult (Hawton *et al.*, 1998). Studies in which interviews with patients were used to measure outcomes revealed further episodes of self-harm that were not reported (Hawton *et al.*, 2002). These results suggest that relying on hospital data alone to measure repetition is unreliable as it does not measure the full extent of the problem. It would appear that a wider research focus employing different criteria is necessary to reach a more comprehensive understanding of the management and resolution of deliberate self-harm.

The management of deliberate self harm in clinical settings

The management of deliberate self-harm in clinical settings is problematic and presents a number of challenges both for those who self-harm and those providing treatment. Deliberate self-harm has traditionally been seen as difficult to treat (Clarke and Whittaker, 1998) and was often managed by hospitalisation. In these environments it can be difficult for staff to balance their own duty of care with the needs of those who deliberately self-harm for autonomy and responsibility (Babiker and Arnold, 1997). Attempts to address the behaviour through coercive techniques or excessive restrictions are seldom effective however and hospitalisation has been found to make the behaviour worse (Crowe and Bunclark, 2000) as it takes away control and leaves people feeling powerless. Tantam and Whittaker (1992) recommend that hospitalisation be used only as a last resort when a patient is in crisis as it removes responsibility from the patient and reinforces the perception that they are ill.

Labelling the client who self-harms with a medical disorder may also be counterproductive as it encourages clinical staff to see the disorder rather than the person behind the behaviour. The existence of deliberate self-harm as a criterion of borderline personality disorder (BPD) within the American Psychiatric Association's

DSM-IV-TR (APA, 2000) has meant that many people who deliberately self-harm are given a BPD diagnosis regardless of whether they display any of its other symptoms or not (McAllister, 2003). Such labelling has been criticised as it pathologises the behaviour, blunts the normal compassionate response and creates the expectation that patients will be difficult (Tantam and Whittaker, 1992).

Doctors and psychiatrists often respond to patients who deliberately self-harm by prescribing medication and many different drugs including amphetamines have been used at one time or another in the treatment of deliberate self-harm. The negative affect and low self-esteem that often accompanies the behaviour indicates that the use of antidepressant drugs may be therapeutic, especially for those who also complain of other depressive symptoms such as weight loss or sleep disturbance (Tantam and Whittaker, 1992). While there is some evidence that serotonergic drugs such as fluoxetine can lead to a reduction in deliberate self-harming behaviour, Tantam and Whittaker (1992) warn against the use of antidepressants unless there is also evidence of a marked change in social functioning or of endogenous depression as the evidence of their effectiveness in reducing deliberate self-harm is inconclusive. Lithium has been used successfully in the treatment of deliberate self-harm in people with a learning disability and may be appropriate where mood swings, manic episodes or bipolar disorder are indicated (Sutton, 1997). Pharmacological therapies may offer those who deliberately self-harm a way of managing their behaviour but they can also induce side effects such as feelings of unreality or an inability to cope which increase the likelihood of deliberate self-harm (Babiker and Arnold, 1997). While some drugs appear effective at tackling some of the symptoms that underlie the behaviour, critics of the pharmacological approach claim that deliberate self-harm can only be fully resolved by addressing the psychological and emotional turmoil that maintain the behaviour (Babiker and Arnold, 1997; Sutton, 2007).

A number of different psychological treatments have been developed for deliberate self-harm but to date most have met with limited success (Hawton *et al.*, 1998). The ethical and legal problems of studying the behaviour appear to have limited the number of large scale treatment studies (Muehlenkamp, 2007), but from the evidence available cognitive-behavioural approaches appear to offer the greatest potential for helping those who deliberately self-harm manage their behaviour. Two treatments that have shown particular promise are problem solving therapy and dialectical behaviour therapy or

DBT (Hawton *et al.*, 1998; Muehlenkamp, 2007). With problem solving therapy most of the studies that have demonstrated a long-term reduction in deliberate self-harm appear to have been multi-modal, incorporating cognitive, behavioural and interpersonal elements along with problem solving (Muehlenkamp, 2007). While these results suggest that multi-component programmes may be effective in the management or resolution of deliberate self-harm in clinical settings it is not clear whether the problem solving element is the principal mechanism for change. Nevertheless Muehlenkamp (2007) concludes that problem solving therapies show promise in the treatment of deliberate self-harm especially when combined with other cognitive or behavioural interventions.

Dialectical behaviour therapy (Linehan, 1993) was originally developed as a specific treatment for borderline personality disorder and incorporates elements of Zen Buddhist practice with cognitive-behavioural interventions, problem solving and skills training (Lynch *et al.*, 2005). At its heart is a recognition that an acute dialectical tension exists between acceptance and change which necessitates the incorporation of both strategies. This is based on the assumption that validation alone fails to produce any change in behaviour while a purely change-based approach will prove too invalidating for the borderline individual. DBT does not focus exclusively on deliberate self-harm or any particular disorder but treats the person as a whole in keeping with the ontological principles of dialectical philosophy (Lynch *et al.*, 2006). Nevertheless numerous empirical studies including four randomised controlled trials have found that DBT is effective in reducing self-harming behaviour in individuals with BPD (Muehlenkamp, 2006). There appears to be a lack of evidence concerning which elements of DBT are responsible for its success but small scale studies with between 4 and 24 individuals indicate that the therapeutic alliance is emerging as one of its key components. In one study (Shearin and Linehan, 1992) self-harming behaviour decreased when therapists were rated as nurturing and providing autonomy to the client during the previous week. These results seem to suggest that an empathic relationship is central to the success of DBT for deliberate self-harm and that without it treatment is less likely to be successful.

The management of self-harming behaviour in clinical settings can prove problematic both for those who harm themselves and those who provide treatment. Deliberate self-harm appears to provide subjective benefits for those who engage in the behaviour such as relief from overwhelming emotional pressure (Gratz, 2003; Klonsky, 2007). However, while some of the behaviour's consequences are negatively reinforcing

(Gratz, 2003), they may also inadvertently serve to increase the emotional burden that fuels the behaviour. Deliberate self-harm is a social taboo and arouses strong reactions in others including horror and disgust (Favazza, 1998; Clarke and Whittaker, 1998). The response that self-harming behaviour invokes in others may therefore also serve to increase an individual's sense of isolation and further exacerbate his or her emotional distress. This sensitivity of those who deliberately self-harm to the reactions of others appears to make the management of deliberate self-harm in clinical settings and particularly in emergency provision especially problematic. Accident and emergency staff are a popular target for criticism in qualitative studies and autobiographical accounts of self-harm experiences (Bywaters and Rolfe, 2002; Pembroke, 1994), which accuse them of being particularly unsympathetic or judgemental. Deiter *et al.* (2000) suggest a number of reasons why this may be so. A lack of context means that those providing treatment in emergency settings may not know the individual being treated and the reasons for their underlying emotional distress. They may see the same person several times presenting in crisis but not see him or her coping or making progress in between these times. Not knowing about the individual's background or the resources available to them is more likely to lead to an unsatisfactory outcome for both parties and result in feelings of anger and frustration all round. Those who present for treatment are also likely to be fearful and mistrustful of those providing it making the establishment of a rapport with those who deliberately self-harm especially difficult. Qualitative studies of patient experiences suggest that the attitudes of professionals may exert a considerable influence on those who engage in deliberate self-harm. While some people found the help they received following an episode of deliberate self-harm to be invaluable, many appear to have encountered unhelpful and judgemental attitudes (Bywaters and Rolfe, 2002; Mackay and Barrowclough, 2005; Sinclair and Green, 2005). These have included being stereotyped as manipulative or attention seeking, even by medical or nursing staff. People who cut themselves are recognised as being treated particularly badly. Worse still, the repetition of deliberate self-harm is associated with a reduction in helping behaviour (MacKay and Barrowclough, 2005), suggesting that those that seem most in need of help and support may be the least likely to receive it.

The difficulties in managing deliberate self-harm in clinical settings do not appear to have gone unnoticed, however, as recommendations have been made to try and improve provision. The National Institute for Clinical Excellence (NICE, 2004) has produced

guidelines on the management of deliberate self-harm in primary and secondary care. These guidelines recommend that those who self-harm should be treated with care and respect, be involved in making clinical decisions about their care and informed about the range of treatment options available. The guidelines also recommend that advice on the self-management of injuries and harm minimisation be given to those who repeatedly injure themselves.

A growing recognition that the attitudes of those providing treatment influence its outcome has led to an increasing focus within the literature on the role of the therapeutic relationship in providing treatment for deliberate self-harm. A number of papers have highlighted the effects that deliberate self-harm can have on those providing treatment in clinical settings and the influence that this may have on its outcome. Nathan (2006) claims that deliberate self-harm is often interpreted as an act of violence rather than one of self-preservation and can encourage a powerful countertransference reaction in those providing treatment. In a review of empirically supported treatments Muehlenkamp (2006) draws on evidence from empirical and theoretical work on dealing with suicidal behaviour to suggest ways of improving treatment for those who deliberately self-harm. Drawing on this literature Muehlenkamp warns against adopting an expert position and recommends instead an approach where therapist and client work together collaboratively as a team. Muehlenkamp asserts that the formation of a strong therapeutic alliance is an essential prerequisite to tackling self-harming behaviour and suggests that one way to do this is to acknowledge both the pain the client is experiencing and the function of his or her self-harming behaviour. Acknowledging the behaviour as a coping mechanism and helping clients explore how it helps them to self-soothe promotes empathy and helps the client to feel understood. Muehlenkamp suggests that this facilitates a strong therapeutic alliance and a collaborative working relationship within which the less adaptive elements of the behaviour can be discussed and later addressed. In dealing with those who deliberately self-harm Walsh (2007) recommends adopting a *"low key, dispassionate demeanour"* as they are likely to be emotionally distressed and will not respond well to being judged or reprimanded for their behaviour. Nathan (2006), on the other hand, encourages an active emotional engagement with the client which he claims models tolerance and flexibility and encourages change. At the heart of this engagement is an acceptance of the behaviour as there is evidence that acceptance and validation can help those who deliberately self-harm with the management of their behaviour (Lynch *et al.*, 2006). At the same time

however Nathan (2006) recognises that those providing treatment must be able to challenge self-harming behaviour as validation alone is unlikely to bring about behavioural change. Nathan claims that the therapeutic relationship is of paramount importance in addressing this dialectical tension and facilitating change.

Although accident and emergency staff are particularly vilified by those who deliberately self-harm other health professionals including psychologists are by no means immune to the distressing effects of having to deal with the behaviour. In a survey of 117 licenced psychologists in the United States (Gamble *et al.*, cited in Deiter *et al.*, 2000) self-harm was rated the single most distressing client behaviour and the most traumatising to encounter professionally. To help those who deliberately self-harm manage their behaviour effectively, Deiter *et al.* (2000) echo recommendations found elsewhere (e.g. Sutton, 2007) by suggesting that treatment providers make regular and effective use of training, supervision and consultation. They further recommend that they attend to their personal needs by maintaining an adequate balance between work, play and rest.

The management of deliberate self-harm in non-clinical settings

Given the limited success of the available treatment (Hawton *et al.*, 1998) it is not surprising that many of those who deliberately self-harm and men in particular do not appear to seek treatment for their behaviour. That is not to say that they do not seek help elsewhere, however, as there are a number of alternative sources of help and support available. Knowledge of how these resources are used to manage the behaviour and to what extent they are helpful does not appear to have been extensively studied.

Self-help literature on the subject of deliberate self-harm is being published with increasing frequency (Bateman 2004), reflecting the growing interest in the phenomeonon in recent years. Some of this literature has been written by professionals and recommends a variety of self-help strategies aimed at helping those who deliberately self-harm (Sutton, 2007) while others are written from the perspective of those who engage in the behaviour and offer a more subjective account of their experiences to raise awareness of the phenomenon (Pembroke, 1996; Strong, 1999). Some of these accounts offer a perspective on deliberate self-harm that represent it as a

positive coping response and represent an important challenge to more clinical approaches. Babiker and Arnold (1997) voice their concern however that such accounts may fail to sufficiently acknowledge the problems associated with the behaviour and the emotional distress behind it. They stress that it is important to look beyond the self-harm to promote acceptance and validation of the person behind the behaviour so that they are accepted for who they are and not simply for what they do.

One particular source of help and support that appears to be gaining in popularity among those who deliberately self-harm is the internet (Whitlock *et al.*, 2007; Bateman, 2004). As well as providing information on the phenomenon a growing number of websites now feature message boards where people who deliberately self-harm can share information and experiences with each other online. The anonymity and the degree of control offered by online exchanges may particularly appeal to those who deliberately self-harm who often struggle with feelings of shame and social isolation as a result of their behaviour. The number of online communities dedicated to the issue of deliberate self-harm appears to testify both to the extent of the behaviour and the utility of the internet in its management as one study identified over 400 self-injury message boards dedicated to the issue (Whitlock *et al.*, 2006). Users of the message boards studied had a mean age of 18 and eighty percent of members declared themselves to be aged between 14 and 20. Female members were more likely than males to be registered and participate actively in discussions. Message board users appeared to use online exchanges to do the same kinds of things that trusted friends do in everyday conversation such as sharing ideas, offering support and recounting their personal experiences. The results of a self-report survey of message board users (Murray and Fox, 2006) found that this kind of online support can also help some of those who self-harm to manage their behaviour more effectively. The survey evaluated the impact of online discussion groups and 37 per cent of respondents claimed that the support they received had encouraged self-acceptance and helped them manage their behaviour better. Only 7 per cent claimed that their involvement had made their self-harming behaviour worse. Whitlock *et al.* (2007) suggest that the internet serves an important social function for adolescents and young adults whose emotional and social development depends upon their ability to establish and maintain meaningful relationships, be accepted socially and achieve intimacy. They propose that it can provide those who feel socially isolated or especially vulnerable with an opportunity for friendship and social support at a time when they feel most isolated or distressed. In a

separate paper Whitlock *et al.* (2006) sound a note of caution, however, as their study also discovered a correlation between sharing techniques for self-injury and discouraging disclosure. While the internet appears to offer those who deliberately self-harm valuable support and practical advice in managing their behaviour it appears that for some it may also inadvertently make their behaviour worse. Exposure to a large community of others who deliberately self-harm may serve to reinforce the behaviour by providing those who do it with a justification for their self-harm that prevents them from developing alternative coping strategies.

The views of those who deliberately self-harm

The existing approach to the management and resolution of self-harming behaviour among clinical services may be characterised by a focus on the harm at the expense of the self (Adams *et al.*, 2005). They appear to neglect the uniqueness of the individual and concentrate instead on identifying and eliminating the various factors contributing to his or her mental distress. Conversely, a growing number of qualitative studies reveal that what the person who self-harms wants is to be treated as an individual, with dignity and respect, and to have his or her views listened to and understood (Adams *et al.*, 2005; Bywaters and Rolfe, 2002; Simpson, 2004; Sinclair and Green, 2005) . From their perspective, it would appear that the effective management and resolution of self-harming behaviour requires more focus on the self rather than on the harm. These accounts support the idea of deliberate self-harm as functional behaviour and suggest that to try to stop it altogether may be counterproductive. Participants in one qualitative study (Bywaters and Rolfe, 2002) revealed that they found it difficult to stop their self-harming behaviour because it made them feel so much better than they would without it. Half of those interviewed felt that these benefits had diminished over time, however, as their behaviour became a habit which some likened to addiction. Some expressed the fear they felt on discovering that their self-harming behaviour was no longer under their control, although most seem to have regained some degree of control eventually. Most interviewees had managed to reduce the frequency of their self-harming behaviour and some had abstained for a year or more, although most were reluctant to say they would never do it again. A number of factors were reported as playing their part in reducing their deliberate self-harm. These included personal changes such as 'growing up',

increased self-esteem and improved communication skills, lifestyle changes such as leaving care or having children and alternative strategies such as alcohol or drugs, distraction techniques or creative activities.

Another qualitative study focused exclusively on patients' experiences of recovery, selecting 20 participants from a cohort of 150 patients with a history of deliberate self harm (Sinclair and Green, 2006). Of the 20 participants, 12 were female and 8 were male. All 20 had deliberately poisoned themselves. The aim of the study was to use personal accounts of the resolution of self-harm to inform the future development of more appropriate services. Three key themes emerged from the data that were collected. These were the resolution of adolescent chaos, alcohol as a factor in self-harm and an understanding of self-harm as a symptom of unrecognised or untreated illness. The help different participants felt they received varied, depending on the degree to which they felt listened to and understood. This itself appeared to be influenced by the reasons for their self-harming behaviour and who they approached for help. Those describing adolescent chaos said they found it most helpful to share their problems with people they already had a relationship with, such as their general practioner. They found their encounters with other professionals following their admission to hospital much less helpful. By contrast, those reporting an undiagnosed illness described their frustration with doctors who failed to identify their symptoms and their relief upon admission to hospital as it facilitated access to professional help and support. Participants' differing motivations for self-harm appear to have affected their experience of treatment and suggest that the effective management and resolution of harm depends on an understanding of the meaning behind the behaviour. While this study is useful in highlighting people's differing motivations and experiences of help seeking it focused exclusively on hospital presentations following self-poisoning. Its results may not be generalisable to the wider population of those who deliberately self-harm.

Rationale for study

The emphasis in the current research study was on the personal experiences of young men and employed a qualitative methodology using interpretative phenomenological analysis (IPA). This methodology is informed by phenomenology, a branch of philosophy concerned with knowledge derived from the study of consciousness and

individual experience (Willig, 2001), the very essence of the self. The idiographic approach of interpretive phenomenological analysis and its emphasis on personal meanings rather than objective facts make it ideal for this particular study.

Within the existing literature on deliberate self-harm men appear somewhat marginalised as the majority of studies focus on the experiences of women (Babiker and Arnold, 1997). Even self-help materials and survivor accounts attempting to give those who deliberately self-harm a voice are mostly written by women (Bateman, 2004; Pembroke, 1996). Men appear less likely than women to access services for support (Thom, 2003) and more likely to believe that they can cope on their own (Fortune *et al.*, 2003). The true extent of deliberate self-harm among young men is unknown and attempts to quantify it are confounded by a number of factors. The reluctance of men to seek help for their behaviour means that they are likely to be underrepresented in statistics that rely on hospital data alone. Furthermore, young women are more likely than men to use methods such as self-poisoning or cutting that are easily identified and classified as deliberate self-harm (Hawton and Rodham, 2006). Men on the other hand may cut themselves but also engage in a variety of other behaviours that are less easily categorised such as self-battery or substance abuse. While the motivation behind these behaviours may be the same as for other forms of deliberate self-harm they are less likely to be recognised as such. Even when men do attend hospital to be treated they appear more likely than women to be misdiagnosed and their injuries recorded as an accident rather than an act of deliberate self-harm (Clarke and Whittaker,1998).

The way men and women are socialised may also have an effect on their behaviour by encouraging differences in the way emotions are expressed (McAllister, 2003; Sutton, 2007). It has been suggested that men are more able to express their anger and behave aggressively towards others while women are more likely to turn their aggression inwards towards themselves (Babiker and Arnold, 1997). As societal attitudes change however some of these traditional gender differences are becoming less pronounced. Favazza (1998) suggests that men are becoming more emotionally literate and society less accepting of what Clarke and Whittaker (1998) refer to as acting out behaviours such as verbal or physical abuse. As outward displays of aggression are increasingly frowned upon men may be forced to seek out other ways to express their anger and some may turn their aggression inward towards themselves.

Given that the majority of self-harming behaviour begins in adolescence and continues into adulthood (Favazza,1998), research into the experiences of young men in managing and resolving their deliberate self-harm is essential to gain a better understanding of their particular needs and the appropriate professional response in relation to their self-harming behaviour. If young men are not accessing services and continue to harm themselves, there is a danger that the behaviour could escalate and that they could seriously injure themselves. Conversely, if they have managed to reduce the severity or frequency of their self-harm, or even stop altogether, then there is still a great deal to learn from their experiences, as they have succeeded on their own where most available treatment options appear to have failed.

Despite increased professional interest in the phenomenon (Favazza, 1998) there is still no definitive treatment for deliberate self-harm (Klonsky *et al.*, 2003) and while a consensus appears to be emerging definitions of self-harm and the terminology used still vary. To complicate matters further, medical staff (Huband and Tantham, 2000) and therapists (Klonsky *et al.*, 2003) are often themselves disturbed by self-harm and have to manage their own emotions while simultaneously attempting to address their client's behaviour. Klonsky *et al.* (2003) suggest that increasing knowledge of self-harm is central to improving clinical practice. The increased knowledge of the experiences of young men in managing or resolving their deliberate self-harm could benefit counselling psychologists in a number of ways. Firstly, an increased understanding of the phenomenon could help therapists to address the emotions they themselves experience when faced with male clients who self-harm. Secondly, any increase in knowledge is also likely to improve empathy and increase the quality and depth of the therapeutic relationship as a result. Numerous studies have shown that the quality of this relationship between therapist and client is an important influence on therapeutic outcome (Nathan, 2006) so this increased knowledge is likely to benefit the client as well as the therapist. Thirdly, improved knowledge and understanding of male deliberate self-harm could improve the ability of the counselling psychologist to respond appropriately by concentrating on the person behind the behaviour instead. This is precisely what those who deliberately self-harm want from treatment according to a number of qualitative studies that have explored the phenomenon (Adams *et al.*, 2005; Bywaters and Rolfe, 2002; Sinclair and Green, 2005).

A survey of 6,000 schoolchildren by Hawton *et al.* (2002) revealed that deliberate self-harm may be considerably more common than previously thought, especially amongst young males. Furthermore, research suggests that young men who self-harm are more likely to use methods such as cutting that do not usually require medical attention (Hawton *et al.*, 2002) and are also less likely to seek help for their injuries than young women (Lee and Owens, 2002). As deliberate self-harm commonly begins during adolescence and continues into adulthood it seems reasonable to assume that there is a hidden population of young males who continue to self-harm into adulthood and do not receive professional help or support with managing their behaviour. For counselling psychologists working with young men, an encounter with those who self-harm is likely because of its association with a range of common mental health problems. Deliberate self-harm has been identified as occurring in combination with substance misuse (Muehlenkamp, 2005), eating disorders (Muehlenkamp, 2005), childhood neglect or abuse (Bywaters and Rolfe, 2002), depression, anxiety and hopelessness (Hawton and Rodham, 2006). To be able to respond effectively to the needs of male clients who deliberately self-harm counselling psychologists need to be both vigilant for signs of the behaviour and able to respond appropriately to it when it occurs.

Aim of study

The aim of this particular study was to target a few individuals from the hidden population of young adult males who deliberately self-harm and explore the lived experience of managing, or resolving the behaviour. It was hoped that an in-depth study of young men who may not have accessed services might help to inform and enhance the future practice of counselling psychology. It was acknowledged that those who self-harm might conceptualise the terms management and resolution in different ways and also that their priorities might differ from those in the helping professions seeking to address their self-harming behaviour. It was further hoped therefore that the study might provide a clearer understanding of what these terms represented to participants and their own position in relation to each of them..

The question the current study aimed to address is:

> **How do young men who have repeatedly harmed themselves in the past and attempted to manage or resolve their behaviour make sense of their experiences?**

Personal reflexivity

This section provides some background information into the decisions I made in choosing this particular topic and my own position in relation to the research with the aim of increasing transparency (Yardley, 2000). It has been written in the first person to address the reader directly and to distinguish my own perspective on the research from the shared account that emerged through the process of analysis. While IPA is a qualitative research method and does not lay any claim to objectivity, the third person has nevertheless been used in the remainder of the report as a way of enhancing validity by allowing the reader to distinguish between my own subjective experiences and the shared account that forms the bulk of the report. I have also included some first person self-reflection within the analysis where appropriate to make my own role within the process even more explicit.

Approaching the issue of deliberate self-harm as a research topic was a simultaneously fascinating and daunting prospect for me. I had no previous experience of the behaviour either personally or professionally and did not know what to expect from the process of researching it. Like many other people my limited knowledge of the subject had been gained largely from media coverage and on reflection I found that I shared the same mixture of fascination and disgust with which the general public seemed to view the behaviour. While I considered my comparative ignorance of the phenomenon an advantage as it allowed me to enter the research process with a relatively open mind, I found that my assumptions nevertheless impacted on the interview process with participants because of my own feelings and prejudices about self-harming behaviour.

I was conscious that whatever subject I chose for my doctoral research would have to be of sufficient personal interest to keep me motivated throughout the research process and considered that the best way to do this was to find something that would address a gap

in my own knowledge and help improve my future practice. Having qualified as a youth and community worker in 1996 and spent some years working with adolescents and young adults I was interested in researching an area pertinent to this age group with which I was already familiar. At around this time I was approached by a local youth and community worker who knew that I was training as a counselling psychologist and asked if I would like to become involved in setting up a self-help group for young people who self-harm. My immediate reaction was one of fear and I refused on the grounds that I did not know enough about the phenomenon to get involved. Reflecting on this experience prompted me to consider self-harm as a research topic firstly because it offered the opportunity to address my own fear and ignorance and secondly because I considered it likely to be something that I would later encounter in my practice as a counselling psychologist.

I did not consider myself to have had any personal experience of deliberate self-harm and my own assumptions about the behaviour were largely derived from media coverage which tended to focus on self-injury, particularly cutting, among young women and ignore other forms of deliberate self-harm. This safely positioned the behaviour as something outside of my own experience that only ever happens to other people. In reality, however, self-injury is merely one of a number of behaviours using the body as a means of expressing distress (Babiker and Arnold, 1997) and as I learned more about the issue I realised that my own experience was actually much closer to deliberate self-harm than I previously thought. Although I did not suffer the childhood trauma many assume to be the cause of self-harming behaviour a road accident I was involved in at the age of fourteen had left me sensitised to the sight of blood and even today I wince at the sight of injury. I was therefore unlikely to self-injure but became a heavy drinker and recreational drug user during my late teens and throughout my twenties. At the time my behaviour was encouraged and therefore reinforced by my peer group and I did not consider it abnormal or deviant. While socially acceptable, especially for a young male, my heavy drinking and drug use was nevertheless harmful and occasionally self-destructive. I have since effectively managed the more self-destructive aspects of this behaviour by giving up smoking, moderating my alcohol consumption and taking up cycling and running as a way of combating stress. In retrospect I believe the more extreme aspects of my earlier behaviour could be considered related to other forms of bodily harm. This revelation prompted me to consider how other men might manage difficult emotions or self-destructive behaviour

and encouraged me to investigate the phenomenon of deliberate self-harm among young adult males.

While adolescence is acknowledged as a time of particular emotional upheaval, once young people reach the age of 18 they are considered adults and legally responsible for themselves. Young adulthood is itself a period of transition, however, when many young people experience profound changes such as starting paid employment or learning to live independently for the first time (Pugh, McHugh and McKinstrie, 2006). I myself left home at 18 and moved to a town 30 miles away where I began my first full-time job. My interest in this period of transition is perhaps influenced by my own experiences of social isolation, family breakdown and a lack of guidance and support as a young adult. I believe that these experiences were instrumental in my decision to focus on this population.

Male self-harm is not a well researched area and very little literature exists on the specific experiences of young men in managing their behaviour. My own assumptions at the beginning of the research process were that the men I interviewed would experience unique difficulties because of societal expectations about their gender and that 'being a man' would be central to their experiences of deliberate self-harm. Furthermore, I also assumed that my participants would feel an additional burden of shame that women do not experience that might confound their efforts to manage their behaviour.

Method

Study Design

As the aim of the study was to explore the lived experience of participants in managing or resolving deliberate self-harm, a qualitative approach using semi-structured interviews was considered most appropriate. Most qualitative methods acknowledge the importance of language in the representation and interpretation of experience (Smith and Dunworth, 2003) and focus on the analysis of verbal accounts and written reports rather than numerical data. These accounts provide a rich source of data that can provide valuable insight into a participant's private world of thoughts and feelings.

A growing interest in the use of qualitative research within psychology in recent years has led to the establishment of a number of distinct approaches that differ in terms of their epistemological standpoint, their methodological emphasis and their theoretical stance (Smith, 2004). The emphasis in this study is on the personal experiences of young men and it employs a qualitative methodology using Interpretative Phenomenological Analysis, commonly referred to as IPA (Smith, 1996). This methodology is informed by phenomenology, a branch of philosophy that has also developed into an approach to research in the social sciences and psychology. Phenomenology is concerned with the knowledge derived from the study of consciousness and individual experience (Willig, 2001), the very essence of the self. There are differing schools of thought within phenomenological philosophy and each emphases different principles. Transcendental phenomenologists influenced by Husserl assert that it is possible to suspend preconceptions and assumptions and describe the essence of a phenomenon as it appears in consciousness (Willig, 2001). Hermeneutic phenomenologists influenced by Heidegger (1978), on the other hand, are less essentialist and emphasise reflexive and existential concerns instead (Finlay, 2003). The methodological recommendations of phenomenological philosophy have provided researchers in the social sciences and psychology with an epistemological framework that takes as its focus the content of consciousness and the subjective experience of participants. Phenomenological psychology recognises that people perceive reality differently and stresses the importance of individual accounts of lived experience (Smith and Dunworth, 2003).

The idiographic approach of Interpretative Phenomenological Analysis represents an approach to psychological research and a variation on the hermeneutic tradition that emphasises individual, personal meanings (Smith and Osborn, 2003). IPA is phenomenological in that it is more concerned with these individual perceptions of phenomena than with making objective statements or establishing universal truths. At the same time it acknowledges that direct access to a participant's experiences is impossible. The final analysis produced by the researcher in IPA is viewed as an interpretation and a partial account of these experiences rather than a literal representation (Willig, 2001).

Smith and Osborn (2003) describe IPA as a two-stage process of interpretation or a double hermeneutic, simultaneously concerned with the way the participant makes sense of the world and also the way the researcher makes sense of the participant's sense-making. This two-stage analysis is thought to lead to a richer account that remains faithful to the participant's experience while also drawing on a wider body of theoretical and psychological knowledge that provides a richer description of the phenomenon in question.

While IPA acknowledges the importance of the researcher's own preconceptions based on his or her own experiences there is no prescribed method for incorporating them into the research process (Willig, 2001). This study was conducted by a 39 year old male researcher without personal experience of self-harm whose own attitudes and experience of early adulthood were nevertheless considered to be an important influence on the choice of research topic. In IPA it is considered vital to attempt to separate the researcher's own thoughts, feelings and ideas from those of participants. This was achieved through the use of summary notes for each interview and a reflective journal throughout the research process to help make the interpretive role of the researcher explicit.

A combination of face-to-face and online interviews was used to gather data for the study. This increased the geographical diversity of the sample, encouraged disclosure by providing a degree of anonymity where required and offered participants more control over the interview process.

Participants

Inclusion criteria for the study were chosen with two considerations in mind. The first was to fulfil the methodological requirement for relative homogeneity of the research sample within IPA (Smith and Osborn, 2003) by narrowing the target population. The second was to ensure as far as possible that participants had truly resolved or learned to manage their self-harm. This second consideration provided a guarantee that the experiences of participants would be relevant to the study and some assurance that they had developed resilience and were therefore better able to manage their feelings. This was considered important because talking about their experiences was likely to prove stressful for participants as it could elicit painful memories for them and invoke some powerful emotions. The avoidance of emotional pain and the regulation of affect are both considered powerful motivators for self-harming behaviour so the risk of participation in the study triggering such behaviour was a real concern. It was thought that the risk would be lower for those who had already achieved a period of abstinence.

In the absence of any guidance about the exact time taken to recover from self-harming behaviour three months was decided on as a reasonable period. It was thought that this would allow participants to have achieved a reasonable period of abstinence but not so long that they would no longer be posting to the bulletin boards used in the study.

The following criteria for inclusion in the study were therefore decided upon:

- Participants must be male and aged between 18 and 30 years at the time of interview
- Participants must have a history of deliberate self-harm (as defined in the introduction)
- Participants must not have had any episodes of self-harming behaviour during the previous three months
- Participants must be resident in the United Kingdom

A small sample size of eight was decided upon, in keeping with the recommendations of Smith and Osborn (2003). This was considered necessary as the focus within IPA is on individual perceptions and their meaning rather than on broad generalisations (Smith, 1996) and such studies are said to derive more meaningful results from an in-depth analysis of a small number of cases (Smith and Osborn, 2003). A total of 8 young adult males were recruited as participants for the study. All fell within the target age range of 18 to 30 and all had a history of deliberate self-harm as defined in the introduction. Although the type of deliberate self-harm used was not specified in the inclusion criteria, all participants reported using cutting as their principal method and this served to strengthen the homogeneity of the sample.

Recruitment

While the use of the internet as a research tool is still in its infancy, it has already been identified and used as a valuable starting point for the exploration of self-harming behaviour (Adams *et al.,* 2005; Whitlock *et al.*, 2006). A number of internet sites exist for people who self-harm and many feature bulletin board facilities where visitors can post messages and interact with each other. One study discovered more than 400 such sites, many of which had been set up during the preceding five years (Whitlock *et al.*, 2006). These virtual communities represent instantly accessible, ready-made support networks for those who self-harm, regardless of geographical location, that have been found to provide visitors with valuable information, informal support and encouragement (Whitlock *et al.*,2006). Recruiting participants through these kinds of sites for this study was considered ideal as it represented the opportunity to target a hard to reach population directly. They provided a further benefit in terms of secure communication as each bulletin board featured a messaging facility whereby members could communicate with each other anonymously and securely.

Participants were initially recruited from internet bulletin boards on dedicated self-harm websites. The popular internet search engine Google (http://www.google.com) was used to identify sites that could potentially provide participants for the study. A search using the terms 'self harm forum' returned over 2000 responses. Websites were chosen on the basis of their search ranking, the number of subscribers to each site and their relevance to the UK context. Six websites were selected, three based in the UK and three based

elsewhere with a large number of UK members. The names of these six websites and their internet addresses are presented in Table 1 below.

Table 1 List of websites approached for participants

Website name	Website address (URL)	Used in study (Y/N)
Recover Your Life	http://www.recoveryourlife.com	Y
LifeSigns	http://www.lifesigns.org	N
National Self-Harm Network	http://www.nshn.co.uk	N
Bodies Under Seige	http://buslist.org/phpBB/	Y
Psyke.org	http://www.psyke.org	Y
Self Harmony	http://www.selfharmony.org	N

The researcher registered with each site using the same user name. An initial approach was then made via e-mail to the moderators of each site to explain the nature of the research and to request permission to recruit on their bulletin boards. If no reply was received within two weeks, an initial post was made on the bulletin board addressed to the moderator. Three site moderators eventually gave their permission and another refused permission to post on the site itself but promised to look out for potential participants. No reply was received from the other two sites so no further posts were made on their bulletin boards. On those sites where permission had been granted, an initial post was made to explain the purpose of the study and invite its members to participate. A number of replies were received to each of these posts, the majority of which were supportive, although only a minority of those who posted were potential participants who actually met the inclusion criteria. Those expressing an interest who did meet the inclusion criteria were referred to a separate post on each of the bulletin boards selected containing information about the purpose of the research. A copy of this information is included in Appendix B. Participants were asked to confirm that they had read and understood this information before any interview was arranged.

Despite repeated requests it proved impossible to recruit a sufficient number of participants from the websites whose moderators permitted the researcher to use them to recruit for the study. Further participants were sought through contact with two voluntary sector mental health projects in the UK and an article in the local newspaper

which carried information about the study and a photograph of the researcher. A copy of the newspaper article can be found in Appendix D. While neither of the organisations contacted were able to supply further participants, four young men did come forward after reading the newspaper article and face-to-face interviews were conducted with three of them who all met the criteria for inclusion in the study. A summary table of participant details may be found in Table 2 below.

Table 2 Characteristics of participants

Name*	Age	Location	Occupation	Ethnic Origin	Interview type	Age first episode	Time since last episode
Adam	21	Wales	Student	White British	FTF	4	12 months+
Bill	25	N England	Musician	White British	FTF	20	3-6 months
Jim	19	Midlands	Student	White British	OLI	14	3-6 months
Rob	25	S England	Technician	White British	OLI	22	6-12 months
Don	23	S England	Unemployed	White British	OLI	16	12 months+
Gary	25	S England	Engineer	White British	FTF	14	12 months+
Stuart	18	S England	IT reseller	White British	FTF	14	12 months+
Mike	26	S England	Entrepreneur	White British	FTF	16	3-6 months

**All participants' names and identifying information have been changed to preserve confidentiality*

Interview Procedures

The data for analysis were gathered from semi-structured one-to-one interviews, five of which were conducted face-to-face and three others online. Participants were given as much autonomy as possible in deciding how, when and where to be interviewed so that they felt as comfortable as possible and able to talk freely and openly about their experiences.

After agreeing to take part in the study, participants were offered a choice between an online or face-to-face interview and asked to sign the appropriate consent form in keeping with ethical guidelines (BPS, 2006a). Copies of these consent forms can be found in Appendix A. They were also asked to complete a separate demographics form giving some basic information about their background, their social status and their self-

harm. This provided the additional benefit of verifying the identity and age of online participants as they all opted to provide their real name. A copy of this form can be found in Appendix B.

No previous relationship existed between the author and any of the participants. The time and place of each interview was negotiated with each participant on an individual basis to engender a sense of ownership over the process while also giving due consideration to issues of comfort, privacy and confidentiality.

Participants doing face-to-face interviews were asked to identify a familiar location away from where they lived where they would feel relaxed and where the interview could take place without interruptions. People's homes were not considered a suitable location because the privacy of participants and the personal safety of the researcher could not be guaranteed. If the participant could not identify a suitable location, the researcher suggested contacting a local library or academic institution to find out whether a room could be booked for that purpose. Two interviews were carried out in libraries and three at the researcher's workplace where other staff would be present. After confirming that they understood the purpose of the study and were willing to take part, each participant was interviewed by the researcher for about an hour.

Participants who expressed a preference for being interviewed online were offered a choice of possible interview times. Once a suitable time was agreed, each interview was conducted using the author's personal computer and internet connection using the MSN Messenger instant messaging software. Online interviews proved far more time consuming than face-to-face interviews to conduct and the first one took nearly four hours to complete. There was a later benefit for the researcher in using this method however as the data from the interview were already in electronic form and there was no need to transcribe it. Subsequent participants were warned about the likely length of the interview and offered the opportunity to do it in two separate sessions, but only one participant took the researcher up on this offer.

The use of the internet as a research tool conferred both advantages and disadvantages. Compared with face-to-face interviews, those conducted online were much longer, taking up to four hours each, and each response tended to be more brief. While the final transcript of each online interview was taken directly from the computer and could be viewed as a verbatim account of what each participant actually said, their spontaneity

could be questioned as it was not known how much editing had gone on beforehand. The time delay between posting a question and receiving a reply sometimes led to conversations that were out of sync with replies being posted after the next question had been asked. It was always clear when this was happening however so it did not appear to interrupt the flow of conversation and was later accounted for and corrected during the transcription process. A further consideration was the lack of control that the researcher had over the interview process. With all face-to-face interviews both the interview process and the method of data collection were under the control of the researcher. With online interviews there was no control over the participant's environment and no way to gauge what their emotional responses were to the questions they were being asked. While it was impossible to control these potential sources of bias, the use of online interviews nevertheless conferred some advantages. Participants were able to express themselves more freely without fear of negative evaluation, for example, and online interviews also minimised or eliminated other potential sources of bias, such as the adaptation of responses to match the social characteristics or expectations of the interviewer (Anthony, 2000; James and Busher, 2006).

The lack of non-verbal communication and paralinguistic cues in online interviews occasionally proved frustrating for the researcher as it sometimes made it difficult to gauge the meaning of participant responses, although looking at the response in context and seeking occasional clarification from participants invariably addressed this issue. The physical absence of the researcher proved a benefit for some online participants who reported feeling more able to discuss their experiences without the researcher present. To compensate for the lack of non-verbal communication, participants were encouraged to use emoticons to express how they were feeling. These emoticons are small icons provided as part of instant messaging software that are meant to allow users to express how they feel but in practice few participants used them. Despite the limitations, the advantages of online interviewing were considered to outweigh the disadvantages not least because online interviewees would probably not have otherwise participated in the study. The anonymity offered by the internet was considered to be the major advantage of using this method for data collection. This anonymity has been shown to encourage disclosure through a process of disinhibition (Suler, 2004) that allows people online to be more honest about their feelings without fear of shame or embarrassment (Anthony, 2000). Participant anonymity was guaranteed because the researcher did not meet online participants at any point during the research process and

verified their identity solely by asking them to complete a demographics form which included their real name. Overall it was felt that the advantages of offering online interviews outweighed the disadvantages and provided an adequate means of data collection.

A list of questions provided a loose structure to the interview. These questions were chosen by the researcher and piloted with a participant who had volunteered to participate in the study but unfortunately met only two of the three inclusion criteria. The pilot interview was short and only lasted 45 minutes. As a result of this the initial interview schedule was revised. The wording of some questions was changed slightly to make their meaning clearer, some additional questions added to elicit further, more detailed information and some additional prompts added to help the researcher to probe further and lengthen the interview. A copy of the revised interview schedule can be found in Appendix C. This schedule formed the basis of all subsequent face-to-face and online interviews. It was based on a series of open-ended questions that provided a guide for the interview process and also allowed maximum flexibility. This flexibility was considered essential as the purpose of interviewing within IPA is to enter the participant's psychological and social world as fully as possible (Smith and Osborn, 2003). The IPA approach acknowledges that individual participants are the experts on their own experience (Smith and Osborn, 2003) and the role of the researcher in this study was therefore to try to encourage each participant to tell the story of his management or recovery from self-harm in his own words. Allowing flexibility within the interview process provided this as it gave participants the opportunity to guide the interview into areas that had not previously been considered by the researcher.

Each face-to-face interview was recorded on a digital voice recorder and transcribed using a word processing package. During this process all identifying information was changed but otherwise great care was taken to ensure that each transcript remained as faithful as possible to the original recording, including noting significant non-verbal exchanges. After transcription each original recording was downloaded onto a CD ROM disk and stored in a locked filing cabinet. There was no need to transcribe online interviews as they were downloaded directly onto the computer's hard drive, but the data from these interviews was anonymised and put into the same format as the transcriptions from the other interviews for ease of use. The transcripts from the face-

to-face and online interviews together formed the basis for later analysis of the data gathered during the interview process.

The role of the researcher in the interview process was not entirely passive. It was acknowledged that the interpretation of data by the researcher began during the interview process and this interpretation guided the kinds of questions asked. Occasional prompts and minimal probes were used during the interview as recommended by Smith and Osborn (2003) to allow for the exploration of areas of interest to the study without being overly directive. Both researcher and participant played an active role in constructing the account that emerged. The data collected through the interview process was complemented by the use of summary notes after each interview and reflective notes throughout the research process. These helped make the interpretative role of the researcher explicit to inform and encourage the interpretation of the data.

Ethics

The proposed research study was guided at all times by the ethical principles laid out in the British Psychological Society's Code of Conduct (BPS, 2006), those for conducting research with human participants (BPS, 2006a) and where appropriate those for conducting online research (BPS, 2007). As the research was conducted by a Counselling Psychologist in Training, the division's own ethical guidelines (BPS, 2005) also applied.

Participants recruited online were already registered and interacting with others on self-harm bulletin boards before volunteering to participate in the study. This indicated that they were very likely to be experienced in discussing their self-harm with others online and that their participation in the study would not expose them to any more risk than they would otherwise encounter in their daily lives. Care was taken to treat these participants' internet user names with the same care as other participants' real names, in keeping with BPS (2007) guidelines.

All interviews were arranged either through the instant messaging facilities of the websites used to recruit participants or by e-mailing participants directly. All e-mail

communication was stored in a separate folder from other messages. After each interview was conducted all communication with that participant was printed off and archived, all e-mails deleted and their details removed from the address book of the computer.

Prior to being interviewed, each participant was asked to read and sign a consent form to confirm his willingness to take part. Consent forms were e-mailed to participants in advance of their interview and also presented again at the start of each interview with a face-to-face participant. A copy of this consent form is included in Appendix A. Each participant was assured that his or her participation in the study was entirely voluntary and that they were free to withdraw at any time.

Following the interview, each participant was offered the opportunity to give feedback and to ask any further questions he may have about the nature and purpose of the research. It was acknowledged that discussing the private and personal issue of deliberate self-harm may have left some participants feeling distressed and in need of further support. Each participant was provided with an information sheet about support services for people who self-harm, including relevant internet addresses. A copy of this information sheet can be found in Appendix F. Participants were also invited to contact the researcher by telephone or e-mail at any time during the three months immediately following the interview should any issues arise as a result of their participation in the study. None of the participants took the researcher up on this offer.

Data Analysis

Not all researchers using IPA approach the analysis of data in the same way. Although a number of useful guides to the process of data analysis in IPA exist (Smith, 1996; Smith and Osborn, 2003; Willig, 2001), there is no prescribed methodology for it (Smith and Osborn, 2003). It has been argued that to provide one would not do justice to the idiographic and interpretative nature of the process in which the emphasis is on developing a personal account of a particular phenomenon (Brocki and Wearden, 2006).

Interpretative Phenomenological Analysis requires a sustained engagement with the data in a continuous, iterative process of interpretation and reinterpretation in order to

decipher the meaning of the text and accurately capture the lived experience of participants (Smith and Osborn, 2003). The opportunity for innovation in the analysis of the data was put aside and the method used was that recommended by Smith and Osborn (2003) as this study represented a first foray into IPA for the researcher and there was a concern that complicating it further would compromise the integrity of the study.

During the first stage, the text of each transcript was read and re-read, one at a time, to encourage familiarity and insight, noting any key themes which emerged. This initial interpretation of data was based purely on themes emerging from the transcript. It was intended wherever possible to avoid interpretations based on assumptions or hypotheses taken from the existing literature on deliberate self-harm.

The second stage involved the development of a further list of concise, higher level themes which retained the essence of the initial themes identified within each transcript, but were more abstract or psychological in nature and at the same time allowed for the connection of themes within and across cases. This stage generated a chronological list of themes arranged in the order they appear in the transcript.

During the third stage, this chronological list was arranged into clusters, with careful reference to the text to ensure that the interpretations being made accurately reflected what participants actually said. This iterative process of analysis produced a table of clustered themes, each with its own chosen title or superordinate theme, for each transcript. The themes that emerged from each transcript were used to inform the interpretation of subsequent transcripts and a final table of superordinate themes was created. A master table of superordinate themes can be found in Appendix G. At this stage, themes were not selected on the basis of prevalence alone as is sometimes the case with other forms of qualitative research. Attention was paid instead to the extent to which particular sections of the data exemplified a particular theme or how it was articulated before deciding whether it should be included in further analysis. The way in which different themes helped to illustrate various different aspects of the account was also considered. Closer attention was paid to those sections of the data which seemed particularly pertinent, as some parts of the text warranted a deeper level of interpretation than others.

The fourth and final stage of the analysis involved writing up the themes into a narrative account of participant responses where the key themes were presented. Care was taken during this stage to distinguish what participants actually said from the interpretations made by the researcher. The emergent themes are presented here supported by excerpts from participant interviews to lend validity to their interpretation and allow the reader to evaluate their reliability. A further section expands on these results by relating some of the main findings to the existing literature on the phenomenon of deliberate self-harm.

To help the reader source the extracts used as supporting evidence for data analysis excerpts from face-to-face interviews (FTF) and online interviews (OLI) have been labelled in parentheses alongside participants' identifiers. The page and line number where the extract occurs in the original transcript have also been included (e.g. Adam FTF 14.19).

Reliability and validity

Brocki and Weardon (2006) point out that the subjective nature of IPA as a research method means that two researchers both analysing the same data are unlikely to come up with exactly the same results. They furthermore suggest that this raises questions about the reliability and validity of IPA. Some previous studies appear to have used a team of researchers working independently and agreeing on a joint thematic framework to increase reliability, while others have had their analyses checked by fellow researchers or an independent observer. As the results of this study offered just one of many possible interpretations of its participants' experiences it was considered inappropriate to use inter-rater reliability as a way of validating the results. IPA was chosen as a methodology for this study because of its concern with subjective accounts rather than objective truths. The use of other researchers or independent observers within this approach was considered more likely to add yet another layer of subjective interpretation rather than offer any guarantee of objectivity (Yardley, 2000).

Other studies have sought the feedback of participants or others who meet eligibility criteria as a way of validating their preliminary interpretations and thereby increasing the reliability of their findings (Brocki and Weardon, 2006). These methods of respondent validation have been embraced by qualitative researchers looking for ways

to validate their findings and strengthen their arguments (Meyrick, 2006). The use of participant evaluation to validate research findings has been criticised as flawed, however, since each participant is likely to try to present a more socially acceptable self (Finlay, 2003) and can prove exploitative or distressing for participants depending on the topic under investigation (Barbour, 2001).

While traditional means of validation and especially those associated with positivist approaches may not be appropriate for qualitative research, some form of quality control is nevertheless still necessary. Yardley (2000) suggests four key dimensions by which qualitative methods can be assessed and these have been used as a guide in considering the validity of the current research study.

The first of these dimensions is sensitivity to context, both in theoretical and sociological terms. A thorough review of the literature encompassing both empirical research and autobiographical accounts ensured that the current study is relevant to the discipline of counselling psychology without distancing itself from the subjective experience of those who deliberately self-harm that provided the focus for the study. Sensitivity was also shown to participants' own context by giving them as much control as possible over the interview process. Participants were allowed to choose the location of the interview and whether it was conducted face-to-face or online. This was considered to help address the power imbalance that exists within the research process and to facilitate a more open dialogue between researcher and participant. The use of a semi-structured interview using open-ended questions was also considered to help encourage disclosure.

The second dimension is commitment and rigour. These refer to the degree of thoroughness in the process of data collection and analysis (Yardley, 2000). The method used in this study followed the guidelines recommended by Smith and Osborn (2003) which describe a four-stage process in the analysis of data. This process is described thoroughly in an earlier section of this report as is the process of recruiting participants and the procedures used to conduct interviews and collect data. Every effort has been made to engage with and represent the experiences of participants as fully as possible by focusing on a small number of participants (Smith and Osborn, 2003) and through a sustained engagement with the data during the process of analysis.

A third dimension is transparency and coherence. Smith (1996) himself suggests that internal coherence and the presentation of evidence are two important criteria to consider when determining the validity of qualitative research. Internal coherence refers to the extent to which a study is consistent in terms of the arguments it presents and whether they are truly representative of the data (Madill *et al.*, 2000). Again, every effort has been made to ensure that the arguments presented are coherent but the ultimate assessment of their merits lies with the reader. The presentation of evidence refers to the extent to which the researcher presents examples from the original data to support his or her arguments. While the independent assessment of IPA studies can be problematic because of its idiographic nature, data from participants' original accounts have been used extensively throughout the analysis to allow the reader to assess as far as is possible for him or herself the validity of the researcher's interpretations and how accurately they appear to describe the experiences of participants.

The fourth and final dimension is impact and importance. The intention of the current study was explicitly to target a population about whom very little is known and the use of IPA to research the lived experience of self-harm among this population has provided some insight into their experiences. It is hoped that this study may help to promote a greater awareness among counselling psychologists that will improve their ability to respond to male clients who self-harm.

Methodological reflexivity

Deliberate self-harm is an emotive subject and despite my best efforts to address my own assumptions and feelings about the behaviour beforehand I believe my initial discomfort and difficulty with the subject matter was evident in the way that I conducted the initial interviews for the research. This discomfort was borne of my ignorance about the behaviour and my view of deliberate self-harm and particularly self-injury as something irrational and alien to my own experience. I had assumed that participants would find it difficult or even painful to talk about their experiences and approached the first couple of interviews with trepidation. Although I was experienced in dealing with sensitive issues face-to-face my experience of interviewing for research purposes was limited.

I had been careful to try and put participants at ease by giving them as much control as possible over the interview process but with hindsight I believe I may not have been adequately prepared myself. While my ignorance of deliberate self-harm was in some ways a benefit it appeared to make me overcautious within interviews and it was initially more difficult for me to raise the issue than it was for participants to talk about it. I found participants to be surprisingly at ease with talking to a complete stranger about their behaviour and was taken aback by how little emotion was shown as they described their experiences of dealing with overwhelming emotional pressure. My failure to elicit a more emotional response and the apparent indifference of participants to the emotional impact of their experiences however left me uncertain about the data and wondering whether I had been asking the right questions. I was concerned that my own discomfort and relative inexperience at interviewing together with my worries about protecting participants may have prevented me from probing enough and had compromised my ability to collect meaningful data.

Although I had been careful to select open-ended and non-directive questions for the interview schedule (Willig, 2001), participants appeared to provide responses that gave a rather dry and factual account of their experience rather than the rich descriptions that are required for a thorough IPA analysis. While IPA acknowledges that direct access to a participant's lifeworld is impossible (Smith and Osborn, 2003), I was concerned that the partial glimpses that I was getting were insufficient. On reflection, however, I concluded that my inexperience as a researcher may not have been the sole factor involved. Participants' responses could have been a reflection of their gender, for example, as men are generally less at ease then women in talking about their feelings. It also occurred to me that attempting to hide their emotions from others was after all one of the issues many of them struggled with and that it may not have been possible to elicit more detail of their inner world of experience. Nevertheless given the opportunity to conduct the interviews again I would give more thought to the questions being asked and try to tease more out of participants, while remaining mindful of my ethical responsibilities towards them.

One of my principal concerns during the research process was about the quality of the data collected and in particular whether they provided enough rich descriptions to perform a nuanced analysis of participants' experiences. I was concerned that participants' accounts provided a rather dry, factual account of their experiences without

the use of metaphor or subtle errors that can provide a deeper level of interpretation. Although Smith (2004) warns against forcing any particular theory onto the reading of qualitative data in IPA, I found in this particular case that that it could not be helped. Not only was I immersed in the language of cognitive behavioural therapy (CBT) because of my training, but most participants had also picked up some of the terminology either directly through their own therapy or by proxy through the online support they received. Their accounts were peppered with CBT terms like 'negative thought' and 'maladaptive coping mechanism'. Also the second, higher level themes that emerged from the process of analysis are necessarily explicitly psychological in nature (Smith and Osborn, 2003) and thereby encourage the use of such jargon. It was no surprise therefore that these higher level themes, and the superordinate themes under which they were eventually organised, all reflected the way that both myself and my participants used such terminology to organise and make sense of their experiences. Furthermore, the use of such CBT terminology allowed me to look beyond the surface of participants' accounts and helped to provide a deeper level of interpretation that remained grounded in the data by utilising some of the CBT terms used by the participants themselves.

Online interviewing also brought a fresh set of challenges very different from conducting interviews face-to-face and I felt that instant messaging proved to have a number of limitations. While not being able to see interviewees prevented me from making judgements based on their appearance it also made communication more difficult, as without non-verbal cues there seemed to be more room for misinterpretation. Having to ask for clarification made a process that was already time consuming even more frustrating. I also had concerns again about the quality of the data as the responses online participants gave lacked the richness and spontaneity of the data from face-to-face interviews.

Although I had tried to approach the research with an open mind it became evident that I had made the prior assumption that the issue of masculinity and what it meant to be a man would be central to participants' lived experience of self-harm without any evidence that it would be the case. In reality gender issues were rarely mentioned and appeared to be of far less importance to participants than they were to me as a researcher. While gender issues were not explicitly mentioned in participants' accounts of their experiences, however, a deeper reading of their accounts revealed elements of

stereotypical male behaviour, such as the desire to be strong and to protect others, that seemed to encourage some participants to develop unrealistic expectations that increased their emotional distress and encouraged further deliberate self-harm.

One of the attractions of IPA as a methodology was its apparent simplicity and the fact that there were few if any restrictions on its application. In reality this produced a dilemma when it came to choosing which themes to focus on in the final write up and which should be discarded. While Smith and Osborn (2003) provide a reasonable guide to the process of analysing the data and acknowledge the challenge of prioritising and reducing the number of themes, there are no clear guidelines for this stage of the process. I found that by trying to approach the issue with an open mind I had been far too inclusive and ended up with far too many themes which then had to be revisited so that they could be whittled down again. This created extra work in rereading transcripts and merging different themes together which I feel could have been avoided had I been more ruthless in choosing which to focus on in the first place. Given the opportunity to perform the study again I would be far more selective and try to identify an area of focus much earlier on in the process.

The process of research and writing up at doctorate level while also juggling work and family has proved an intellectual and emotional challenge for me that stretched my capabilities to their limits. At times I have felt an overwhelming emotional pressure not dissimilar to that described by my research participants and to a certain extent I feel the process has represented its own unique form of deliberate self-harm. One participant revealed in his interview that he may never have begun to self-harm if it wasn't already in his head and this became something that haunted me as I wondered on several occasions whether I might in the longer term be doing myself some harm by having brought it into mine. It certainly felt at times that there was some kind of parallel process going on as I encountered some of the very problems that my participants described. My own self-imposed high standards dogged me throughout the research process as I worried constantly about whether my work was good enough and I also found myself mimicking the same kind of stoicism that some of my participants described to protect those around me from my emotional distress. At one stage I even ran a ruler across my arm and wondered what the release that participants were describing felt like. Unlike my participants, however, I had the benefit of their experiences which helped me realise that however curious I might be about the

behaviour the long-term costs far outweighed its short-term benefits. I also had the advantage of three years' training as a psychologist which allowed me to put into practice some of the alternative methods I had learned for regulating my own emotions and managing stress such as relaxation techniques, physical exercise and mindfulness meditation.

Results and Analysis

Overview

The analysis of transcripts from interviews with participants produced data which provided a rich description of their experiences of deliberate self-harm. In developing an interpretative account of these experiences priority was given to those themes which seemed most pertinent to the research question and to participants' experiences of managing their behaviour.

A number of themes describing these experiences of the management of their self-harming behaviour were identified during the process of analysis. The following section will present these themes grouped under four separate higher level themes: the invalidated self, the struggle for control, validation of the self by others and learning to live with a new self. What follows constitutes an interpretative account of participants' experiences and is by no means exhaustive but is intended to highlight some of the important issues which have arisen from this research study.

While the accounts of individual participants varied, reflecting the diverse nature of self-harming behaviour, they nevertheless all appeared to describe a similar journey. One particular shared concept that appeared to be important to all participants was the validation of the self or the extent to which they were able to maintain a sense of themselves as legitimate people of worth, acceptable both to themselves and to others. While self-harm was described as a very personal and private act the way other people responded to the behaviour seemed an important influence. Self-harming behaviour appeared to be associated in each case with experiences and perceptions that were invalidating and contributed to participants feeling worthless, judged or rejected. Conversely, the effective management of their behaviour was associated with validating experiences and relationships pof empathy and support where participants were accepted by others and thereby allowed to feel more accepting of themselves.

Superordinate theme one: The invalidated self

The first superordinate theme describes the beginning of the journey and some of the experiences that appeared to establish and maintain participants' self-harming behaviour. While self-harm appeared to provide them with welcome relief from unbearable emotional pressure, its management was nevertheless problematic from the outset. Both participants self-harming behaviour and the strategies they developed to manage it seemed to contribute to a vicious cycle of negative self-evaluation and negative affect that encouraged further self-harming behaviour.

Within this superordinate theme, four sub-themes were identified:

- **Negative evaluation of the self**
- **Unrealistic expectations of the self**
- **Fear of being judged by others**
- **Perception of the self as different to others**

Theme one: Negative evaluation of the self

While each participant had their own unique history the negative evaluation of the self appeared to play a central role in the establishment and maintenance of self-harming behaviour in each individual case. For some participants this appeared to be the result of invalidating experiences in childhood or adolescence such as bullying or neglect although this was not always the case as others claimed to have had a relatively happy upbringing. Nevertheless at some stage all participants appeared to have experienced negative self-evaluation and accompanying levels of emotional distress. Whatever the origins of participants' self-evaluations there appeared to be a direct relationship between these negative thoughts and feelings and self-harming behaviour. Many shared a tendency towards self-criticism and the negative evaluation of the self was often manifested as a belief that they were weak, inadequate or inferior to others in some way. The struggle to deal with these uncomfortable thoughts and feelings eventually resulted in self-harming behaviour that provided participants with temporary relief. This relief was then closely followed by feelings of guilt or remorse that contributed to further negative self-evaluation and self-harming behaviour.

Adam's account documented some of the key elements in the development of participants' negative self-evaluation and subsequent self-harming behaviour. He described a long history of self-criticism that had begun at an early age:

> *"With moving to a new school being the new person and being kind of fat I got picked on quite a lot so that didn't do much for my self-esteem. Erm I guess I just felt kind of inadequate because I couldn't get my mother's attention erm because it felt like everybody else was more important so I was somewhere deficient which obviously wasn't the case but you can't really reason about that when you are four years old." (Adam FTF 11.2)*

Seeking an explanation for the criticism and rejection he experienced both at home and at school Adam searched for the source of the problem and located it within himself by coming to the conclusion that he was *"somewhere deficient"*. His experience illustrated how negative experiences can become internalised and manifest as a negative evaluation of the self.

Adam turned to self-harm as a way of managing the emotions that accompanied his self-criticism. Although it provided relief from the way he was feeling at the time in the longer term it strengthened the belief that he was weak for having to resort to the behaviour in the first place:

> *"It used to be that this would feel like this is another way that I'm a freak and it's really weak of me that I have to do this you know so it used to feed into itself like I would feel that I was rubbish so I would self-harm and then I would think 'Oh my God I'm a self-harmer I'm crap' and just get all worse and worse." (Adam FTF 7.39)*

It appeared that it wasn't only Adam's self-harm that made him a *"freak"*. He had already decided that something about him was just not right and the self-harm was simply *"another way"* of proving it. Once caught up in a vicious cycle of self-criticism and self-harm however for Adam things could only get *"worse and worse"*.

The punishment of the self was another reason given by participants for their self-harming behaviour. This provided some of them with a means of justifying their behaviour to themselves that was congruent with their negative self-evaluation as they felt that they deserved the punishment and the pain that went with it. Stuart identified his own self-harm as a way of punishing himself for his perceived inability to manage his feelings better:

> *"It was like I wasn't normal kind of thing and it was like I couldn't express myself normally and it felt like a punishment because okay yeah doing it at the time was great and it really felt so much better but the pain afterwards when everything was healing up it was like a punishment sort of thing for doing it and like 'Why can't you just get rid of your emotions normally? This is what you get for turning to this. Even though it does make you feel better.'" (Stuart FTF 13.44)*

Stuart's internalisation of criticism and subsequent negative self-evaluation was manifest in this extract as an internal dialogue in which he criticised himself for not being able to *"get rid of"* his emotions. At the same time however this critical voice also appeared to be legitimising his behaviour by framing it as a punishment *("this is what you get")*. The existence of this critical voice hints at the possibility of a struggle between two separate selves within Stuart, one tough and uncompromising and the other more emotional.

Stuart's internal struggle appeared to manifest during our interview which he began in a jocular mood and later became far more intense and serious as he spoke about his self-harm. At the time I was suspicious of this behaviour and it led me to doubt the veracity of his account. It later made more sense to me however when I interpreted it as an outward manifestation of the struggle to make sense of his inner world of thoughts and feelings. This allowed me to put his humour down to an intial defensiveness and encouraged me to take his responses more seriously.

The degree of self-criticism experienced by different participants seemed to vary as did the resulting intensity of their negative affect. The persistent, regular and unchallenged negative interpretation of the self manifested for some as an intense self-loathing or self-hatred that increased their emotional distress and exacerbated their self-harming behaviour. Don provided perhaps the most extreme example. While many participants expressed a degree of self-loathing at its height it appeared to have overtaken him completely:

> *"When I thought of myself at all, I hated myself. A lot of the time I didn't really have a concept of myself. At one point I even believed that I was already dead. I can't remember how that made sense to me, but I remember feeling it!" (Don OLI 4.2)*

Don recognised the absurdity of thinking of himself as *"already dead"* but it did not appear to have prevented him from feeling it. His self-loathing was so overwhelming at

that stage that he literally wished himself out of existence, demonstrating the extremes to which self-criticism eroded some participants' sense of self.

Theme two: Unrealistic expectations of the self

One strategy adopted by some participants as a way of trying to compensate for their perceived inadequacies was to raise their expectations and set goals for themselves which would stretch their capabilities. Although intended to encourage extra effort and promote success this strategy caused participants to set impossibly high standards for themselves which they would then be unable to meet. The inevitable result was a failure to meet their goals which would lead to further self-criticism, making emotional regulation and the management of self-harm more difficult.

Jim neatly illustrated the dangers of this kind of strategy for anyone caught up in a vicious cycle of negative self-evaluation and self-harm:

> *"I do tend to have much higher standards/expectations of myself than I do others (sometimes so high that they're unachievable) [...] I think on many occasions it has led to me to setting myself up for failure which has resulted in me beating myself up because I haven't met my standards, which realistically weren't really achievable anyway." (Jim OLI 3.37)*

While it was likely that Jim actually was only speaking metaphorically about beating himself up the implication of his statement is clear. Anyone with a tendency towards negative self-evaluation and self-harming behaviour will not deal well with failure so setting such high standards was a counterproductive strategy. Jim appeared to have insight into the consequences of his behaviour but his use of the present tense here suggested that despite the effective management of his self-harm he appeared to have nevertheless maintained these high standards for himself.

Bill was also a self-proclaimed perfectionist who further illustrated the folly of setting such high standards for success:

> *" I feel that I can't live up to either what I'm trying to do or what other people not necessarily expect but maybe what other people are up to and I am trying to be and maybe on a good day I succeed but often it's like yeah yeah I've fallen a bit short." (Bill FTF 3.40)*

Starting from a position of perceived inadequacy Bill naturally wanted to set his goals high so that he would be able to feel better about himself. Setting his goals for success too high however meant that they were rarely achieved and even when they were would be attributed to luck ("*on a good day*") rather than any particular effort or skill on his part, preventing him from being able to take the credit for his own successes and reinforcing his perceived inadequacy.

Bill's high standards for himself were entirely self-imposed and led him to assume a lot of personal responsibility which at times he found hard to manage. Bill found sharing his problems with others difficult and tended to belittle his own difficulties as a way of justifying his reluctance to share them with others, preferring to suffer in silence:

> *"I was taking on a lot I was putting in sort of voluntarily putting myself under quite a lot of stress so all of that was on top of the work I had exams around the same time um and I suppose yeah I didn't like to sort of say to anyone 'I'm feeling under a lot of stress and suddenly it all feels a bit unmanageable' because really most practically most of the people I could have talked to I felt they were in the same boat and I didn't want to trouble them with it" (Bill FTF 6.11)*

Bill's high standards for himself combined with the desire to keep problems hidden from others to increase the amount of emotional pressure he experienced. In the absence of an alternative strategy for dealing with this pressure he turned to self-harm as a way of coping and keeping his problems hidden. Self-harm offered Bill a way of containing his feelings with a minimal amount of suffering that he found easier to endure than the thought of sharing his problems with other people:

> *"I spent a long time justifying it to myself by saying well if you know I did this it might hurt a bit it might be a bit dangerous but I can try and be careful but it ends up it's a scar that nobody can see and it saved me from having to pour out all my problems to someone else and upset them." (Bill FTF 6.48)*

Theme three: Fear of being judged by others

Participants' own negative evaluations and the invalidating responses they had already received from others led many to develop a fear of being judged for their behaviour. This fear caused participants to be cautious and secretive about their self-harming behaviour as they did not want to risk other people finding out about it:

> *"I didn't want to make a drama about it. It was more secretive, one of the things that I did when I was on my own and I made sure no-one could like walk in on me when I was doing it." (Stuart FTF 9.36)*

Keeping their behaviour hidden meant that participants initially had to manage their behaviour by themselves. Many avoided disclosing it to anyone for fear of being labelled while others appeared to try to pre-empt such judgment and legitimise their behaviour by labelling themselves.

Some participants had attempted to discuss their feelings or behaviour with others who did know how to react, leading to experiences which invalidated them further. These experiences led them to believe that their fear of judgement was justified and strengthened their resolve to keep their behaviour hidden from others. Adam had first attempted to talk about his behaviour to a friend at school whose stunned reaction was interpreted as a rebuke:

> *"With the cutting I tried to tell one of my friends um when I was at school and she was just like 'Oh' and wouldn't speak to me about it so then I just kind of hid it." (Adam FTF 11.48)*

Although Adam's friend's intentions did not seem malicious the effect of her lacklustre response nevertheless seemed to reinforce his existing feelings of inadequacy and his determination to keep his behaviour hidden from others. This experience left him reluctant to reveal his self-harm to anyone else and even more fearful of being judged for his behaviour:

> *"With the reaction from my mother about trich[otillomania] and then my friend being like that then I felt I'd better not tell anybody else cos they'll just tell me I'm a freak as well" (Adam FTF 12.42)*

Like other participants Gary viewed his self-harm as a private and deeply personal act. He attempted to hide his behaviour from other people because he was fearful of their reactions. His concerns reflected a common fear among participants that if his self-harm was discovered by others his behaviour would be misunderstood:

> *"I was kind of bothered about what they would say to others yeah um I didn't want people to think that I was some kind of attention seeker or something like that." (Gary FTF 11.32)*

Adam's experiences had led him to expect a judgemental response from others and he too expected to be labelled an attention seeker:

> *"I kind of felt that people were just negative so they'd just look at me like you know the 'emo' stereotype like attention seeking even though I like hid it for like ten years which isn't very attention seeking if you ask me" (Adam FTF 16.29)*

Participants' fears about being judged appeared to affect their ability to manage their self-harm by discouraging some of them from seeking help or support. Although most participants had at some point come into contact with professional support services the fear of being judged seemed to put Gary and Bill off the idea altogether. Bill's reluctance to share his problems with others was not only restricted to friends and family but appeared to extend to seeking help from professionals too:

> *"I thought that everyone else who did this had a good reason and I didn't and therefore I thought that if I did say if I went for counselling I thought the response I would get would be 'Grow up and stop wasting our time' which I realise now it probably wouldn't I just didn't want to go near anything professional." (Bill FTF 14.36)*

Bill's own perception of his self-harming behaviour was that it was unjustified and therefore unacceptable. His assumption appeared to be that others would necessarily share this view hence the expectation that he would be told to *"grow up and stop wasting our time"*.

To pre-empt or avoid this kind of judgemental response from others some participants sought to label themselves as a way of legitimising their behaviour and encouraging others to take their problems more seriously. Having already suffered perceived rejection from friends and family Adam's expectation seemed to be that the responses of others would continue to be negative unless he could find some way of legitimising his behaviour. On joining an online self-harm community his insurance policy against being judged was to attempt to validate himself by presenting as mentally ill:

> *"There was a very strong temptation to look up various mental disorders and see which fit me and in some ways try and make me fit them so that I could say 'Look I'm not crap I have an actual illness' you know erm to make people take it seriously [...] there was a tendency to validate myself by saying 'Oooh I'm mentally ill' um which I do see in other people." (Adam FTF 16.25)*

Stuart also seemed equally willing to label himself:

> *"I read something on the internet about bipolar where you get your moods up and down and you feel different every day and you have to sort of keep your lifestyle like in a happy environment like if you're happy with your friends you*

stay around your friends where you're happier. And I actually think I am like that more than depressed." (Stuart FTF 7.44)

Theme four: Perception of the self as different to others

Many participants were further invalidated by their perceptions of themselves as different to other people which reinforced their feelings of worthlessness. These perceptions of difference were evident in the language that participants used when describing themselves in relation to other people:

> *"Normally like normal people would do sort of thing they would do something to just chill out sort of thing but I couldn't do that so I would start self-harming to actually release those emotions" (Stuart FTF 13.20)*

Stuart distinguished himself from *"normal"* people while other participants used words such as *"weirdo"* (Bill FTF 12.13) or *"freak"* (Adam FTF 13.11) when describing themselves demonstrating just how far from the norm they too perceived themselves to be.

One of the ways in which many participants appeared to perceive themselves as different to others was their gender. When asked what being a man meant to them most participants found the question difficult to answer and some were unable to come up with a response at all. Many eventually identified a typical male stereotype of a strong, silent man who keeps his feelings to himself, takes responsibility and cares for others around him. This stereotype seemed to accurately describe how many participants themselves behaved by assuming responsibility for other people and trying to hide their feelings. Nevertheless most of the participants did not explicitly identify with this stereotype nor did most claim that this was something they themselves were trying to be or trying to live up to. Bill conceded that he might appear to be this way but that he did not personally identify with it:

> *"Kind of puts up with things and becomes a bit of a sort of you know emotional support in a crisis and concentrates on the you know like the outside if you're with me [...] I suppose I maybe I am a bit like that kind of externally but [...] because maybe I feel that there's a bit of effort going into keeping that up it's not, it's less genuine so that I don't feel that I really identify with that at all." (Bill FTF 3.22)*

Bill seemed to assume that being a man should come naturally and be effortless or it would not be real. The self he presented to others was *"a bit like that"* on the outside suggesting that this was the way he would prefer to be seen but the effort involved meant that he did not consider himself a real man.

Don shared this idea that being a man was all about strength and responsibility although again it was something he clearly did not identify with for himself:

> *"I suppose it means standing up to your problems, not hiding from them. Exactly the opposite of what I've been doing for the past few years." (Don OLI 2.7)*

Mike seemed a little more comfortable with being different to the stereotypical male but also seemed content to conform when it was required:

> *"I was more than happy to share my emotions with people and you know which I suppose isn't the accepted thing and what so I suppose er the general view of what a man should be is. But you see I was always more than happy to but I was also more than happy to sit in the pub with a beer and watch the football." (Mike FTF 3.48)*

These accounts suggest that although the typical male stereotype was something participants did not explicitly identify with they nevertheless made some effort to maintain this image in public.

Self-harm provided another way in which participants perceived themselves as different to others. Adam started self-harming at a young age and his initial ignorance of the behaviour reinforced the isolation he felt at the time:

> *"I thought it was just me I thought I was nuts I thought this was a completely stupid thing nobody else would do it because it was so stupid only I could be that stupid you know the world revolving around me again because I'm the most important person. Obviously I didn't know anybody else that did it and it was kind of isolating in a way" (P1 FTF)*

Other participants were already aware of the phenomenon and some were introduced to it by others but this awareness did not necessarily help to address this perceived difference. Don was unable to identify with other people who were doing it:

> *"Even though I knew it wasn't just me, it still felt very personal. It didn't help that I knew other people did it, because I could never feel any connection with what they were doing and what I was doing." (Don OLI 4.17)*

Being male also seemed to distinguish participants from the majority of others who self-harm and to reinforce participants' existing perceptions of themselves as different. Male self-harm is perceived as comparatively rare as those who do it do not generally seek help and support. When Rob tried to access what was available he found himself in the minority:

> *"In the last year it made me feel as though I was somehow regressing because every time I looked for support groups they were full of schoolgirls" (Rob OLI 5.21)*

Superordinate Theme Two: The struggle for control

The second superordinate theme described the next stage of the journey as participants struggled to control their self-harming behaviour. While self-harm had originally provided welcome relief from unbearable pressure, over time participants appeared to rely more and more on the behaviour or develop a tolerance to its effects. While control over the behaviour appeared important, a second consideration was the degree of control which participants felt they had when seeking professional help for their behaviour. They appeared to value their autonomy and to be wary of seeking help if it meant that they would have to surrender control of their self-harm.

Within this superordinate theme four sub-themes were identified:

- **Covering up**
- **Control over treatment**
- **Control over behaviour**
- **Taking responsibility for the self**

Theme one: Covering up

One of the principal ways in which participants attempted to manage their self-harming behaviour was to keep it hidden from other people by covering up their behaviour. Cutting and burning were the two methods most commonly used and left scars that would take some time to heal. These scars were perceived as shameful and to be kept hidden from others who might otherwise ask awkward questions about their origins. Participants used various strategies to keep their scars hidden from others so that they could continue to hide their behaviour.

Those whose principal method for self-harming was cutting their arms tried to cover up their scars by wearing long sleeves. While this kept them hidden from view the constant worry of their sleeves being pulled up by accident and the inconvenience of having to wear them all year round meant that this was still a source of discomfort for them. Mike described how this strategy could potentially bring unwelcome attention:

> *"A few summers ago I went to work in a shop at the height of summer with my shop t-shirt and a long sleeved t-shirt underneath and you can't complain it's hot because people would say well 'Why are you wearing that? You know so it just gets a bit er awkward'" (Mike FTF 18.1)*

Some participants had excuses prepared in case their scars were exposed by accident so that they could continue to cover up their behaviour. Gary for example was always careful to cut in a regular pattern so that if people saw his scars he could claim that they were simply another form of body adornment rather than self-harm:

> *"I've got big scars on my arms here (points to upper arm) and they've seen them and er I told them that it was a body modification kind of thing [...] I've got a line there and three lines going down so it's in a bit of a pattern because when I cut I always deliberately used I did the first three down um and as I said it's in a pattern so if someone sees it I can explain it away." (Gary FTF 12.24)*

Far from being out of control, Gary seemed to take great care when cutting to maintain this pattern and ensure that he would be able to justify the presence of his scars. Stuart also described practices which indicated that he too was taking care of himself while cutting:

> *"I never wanted that bad to literally screw myself over sort of thing. After I did it I always cleaned them out and if I didn't have any like antiseptic or anything like that I would just pour spirits on it just to burn away if there was any infection sort of thing, just use that to destroy the infection, stuff like that. And so I was looking after myself and stuff like that." (Stuart FTF 11.39)*

Although participants may have felt unable to cope without self-harm this did not seem to mean that they were completely unable to manage the behaviour. It appears that from the outset the behaviour and its consequences were carefully managed so that they could continue to conceal their behaviour from others.

Participants' scars were a visible sign that communicated something about their experiences and appeared to be of great significance to some. Gary's scars were a marker of his suffering and were worn almost like a badge of pride at the time. Each scar appeared to have personal significance for him and represented a milestone on his journey through life. As he later began to manage his behaviour however their meaning appeared to change and they all came to represent the same thing:

> *"I've got a load of scars now. And no I don't see them as like I don't like them much anymore. I always quite liked them because they were like tattoos you know um it shows a stage you were at on a journey [...] they are all just that was*

when I was unhappy, that was when I was unhappy, you know." (Gary FTF 13.14)

For Mike the avoidance of further scars was one of the principal reasons for his avoidance of further self-harm:

> *"The reason that I'll be honest with you that I haven't as much as I probably I haven't every time I have wanted to is that it leaves scars [...] that's the reason that people would notice and so the reason I don't do it is a sense of letting people down " (Mike FTF 7.34)*

The scars themselves did not appear to disturb Mike as much as other people's reactions to them. For the remainder of participants the avoidance of scars was not necessarily their main reason for attempting to manage their behaviour but nevertheless served as a useful deterrent when they were tempted to return to it. Gary described how the thought of further scars prevented him from succumbing to the urge to self-harm:

> *"It makes me feel or remember how I felt when I used to cut myself um which felt good as just a way of getting rid of the pressure but it also reminds me of the scars that I've got and that I don't want any more." (Gary FTF 15.19)*

Participants were unanimous in identifying the avoidance of further scars as one of the principal benefits of avoiding self-harm in the future. They seemed to have become weary of the guilt and shame associated with lying to others about their behaviour and the burden of responsibility they felt towards them. It seemed to be a relief to them that they no longer had to cover their arms up in public for fear of revealing their scars, even though this now meant that they would have to explain to other people why they had them:

> *"Since I stopped actively self-harming it was like I couldn't be bothered to wear the long sleeves all the time so obviously people see my scars they ask me about it" (Adam FTF 12.50)*

Despite the apparent significance of the scars as a outward symbol of inner distress I noted with interest that none of the participants offered to show them to me. The only evidence I seemed to have that their experiences were real at all were their words, yet I resisted the temptation to demand any further proof. I felt that asking to see them might be considered voyeuristic and may be potentially damaging if it led participants to think that I did not believe them as such invalidating experiences had been instrumental in the establishment and maintenance of their behaviour.

Theme two: Control over treatment

The degree of control or autonomy that participants perceived they would have over treatment appeared to influence their decisions about whether or not to seek help in managing their behaviour. For some participants, the thought of relinquishing control of their behaviour appeared to put them off the idea of seeking treatment. Gary was not prepared to relinquish the comfort and security it provided:

> *"I just didn't really want to start dealing with it. Didn't really want to talk about it you know [...] there's quite a nice safe feeling knowing that you've always got something like to release the pressure." (Gary FTF 17.41)*

Bill was concerned that if he sought professional help he would be required to stop immediately:

> *"I think I was worried that there would be kind of if you excuse the pun some cut-off point that I would just stop and then I would have to cope rather than being able to work myself up to stopping and thinking well I could but I'll allow it for a while but think about stopping and think about what I could be doing instead until I could actually sort of embark on that." (Bill FTF 14.52)*

Although Bill appeared motivated to change he was concerned about losing his autonomy by having the decision about exactly when to stop taken out of his control. He wanted time to prepare himself mentally, to *"think about stopping"* before changing his behaviour. His use of the word *"embark"* here invokes an image of the kind of long and arduous journey that would require just this kind of mental preparation beforehand.

Don's actual experience of treatment appeared to confirm Bill's worst fears:

> *"The first time I went to my GP and told him how I felt I was given antidepressants, which took the edge off slightly by making me feel less of anything. A little while after though I started to feel a lot worse, and was thinking of killing myself. I went to the GP again and he had me admitted to a psychiatric ward. That helped for a while by keeping me totally away from anything that could set me off, but after a few days I caught some virus and started to feel sick. I've always had a phobia of vomiting, and I panicked and had myself discharged as I was terrified of being sick away from home. I knew even then that I wasn't ready to leave. After that it was a few months until I managed to get help again, when I was put into Dialectical Behavioural Therapy, which I found useless. I was still self harming at the time, and the first thing you have to do in DBT is stop self harming. They don't tell you how, just that you have to. I was only given the group therapy part, although everyone else in the group was given individual too. I quit after a few weeks as I didn't think I was getting anything out of it." (Don OLI 7.36)*

This succession of treatment failures did not successfully address how Don felt nor did it seem to help him to manage his self-harming behaviour. Don believed that this was because he was not being offered what he felt he needed at the time:

> *"I think I needed to talk to someone about what I was going through. DBT seemed so impersonal and a bit patronising [...] I think it might have made a big difference if I'd been shown respect and talked to as an equal. It would have made me feel more like a person." (Don OLI 8.36)*

Don appeared to have a clear idea of what he wanted from treatment which was to be understood and validated as a person and treated with respect. The *"impersonal"* treatment he had received instead appeared to have the opposite effect however by invalidating him even further.

Jim's mixed experiences of treatment illustrated two contrasting approaches to the management of his behaviour:

> *"It was quite interesting that the majority of help I had came from my counsellor and not my NHS psychiatrist who just wanted to throw medications at me (nine in all until we found one that worked) and berate me for self-harming" (Jim OLI 9.22)*

Jim's preference for counselling over the approach of his psychiatrist suggested that like Don what he wanted from treatment was to be listened to and understood as a person and that he was lucky enough to find this with his counsellor. By contrast Jim's psychiatrist seemed to focus on addressing the behaviour with much less consideration for how Jim himself might feel.

As a counselling psychologist it was personally gratifying for me to hear Jim's apparent preference for counselling over the pharmacological approach offered by his psychiatrist, as it appeared to validate my own beliefs about the importance of relationships within the therapeutic encounter. At the same time however it introduced a source of potential bias in the form of my own prejudices against the medical model I believed was advocated and practiced by many psychiatrists. I realised that this bias could never be eliminated but the awareness of it nevertheless proved useful in the subsequent analysis of participants' accounts as I was able able to take account of these assumptions and accommodate them as far as possible within the research process.

Even when the treatment itself was unsuccessful or the professional response received was considered unhelpful at the time the outcome for participants was not always a sense of hopelessness and a return to self-harming behaviour. The realisation that no-one else was going to sort out their problems for them or the threat of having to continue treatment sometimes seemed to provide them with the necessary motivation to begin to manage their behaviour for themselves. Stuart for example appeared to strike a deal with his mother after a negative treatment experience so that she would not force him to go back again:

> *"My Mum knows I do that, used to the whole self-harming thing and stuff like that, she found out about that and she took me to the psychologist sort of thing that's where they put me on drugs. But she was I said to her instead of going back to them if I feel I am going to self harm or anything like that I will talk to her about it and either even if I don't talk to her properly about it then tell her that I'm feeling that way and that I just want some space." (Stuart FTF 8.14)*

The mixed experiences participants described in treatment reflected the difficulty in treating self-harming behaviour and the variety of professional responses to it. Participants appeared to value their autonomy and to respond best to treatment when they were treated as a person and with respect.

Theme three: Control over behaviour

The degree of control that most participants felt they had over their behaviour appeared to change over time. They initially felt that their behaviour was contained, well managed and under control and at that stage the positive benefits of the behaviour outweighed the costs. These perceptions gradually appeared to change however as the frequency or severity of the behaviour increased and the costs of maintaining the behaviour began to outweigh the benefits. As managing their behaviour became an increasingly attractive option participants tried out different ways of controlling their behaviour with mixed results.

Jim's first experience of self-harm was typical of other participants and described the relief it initially provided:

> *"I discovered it one evening when I was feeling particularly low and for some reason I was using a Stanley knife for something and I thought 'I wonder' and*

> *tried cutting myself and I found that it briefly lifted me from how crap I was feeling. It gave me an enormous feeling of calm and tranquillity almost a rush but not quite. It made me feel relaxed and chilled out and like I could cope with what was going on for a while." (Jim OLI 4.31)*

Jim's account is reminiscent of the experimental drug user whose curiosity gets the better of them and is peppered with the quasi-mystical terminology of drug use. His first experience of self-harm was a subjectively positive one in which he describes being *"lifted"*, reaching an almost transcendental state of bliss that was *"almost a rush"*. This provided a sharp contrast to the low that he had sunk into beforehand.

Most participants' self-harming behaviour increased in frequency or severity over time as they became accustomed to its effects. Rob used a more direct drug analogy to describe the way that his behaviour changed:

> *"I can't content myself to what I used to like the way a tolerance to alcohol or drugs builds up [...] say if you used cocaine you'd go from one line to three and so on, it was pretty much the same. I went from been [sic] content to cut with the blade light enough to draw blood to not been content until there was obvious scarring and a tear in the skin that was also deep." (Rob OLI 7.15).*

Don took things a stage further still and appeared to become entirely dependent upon self-harm:

> *"I actually felt better for quite a while after that first time, and it was a few weeks before I did it again, but then I found I got caught up in it. It wasn't long before the self harm became more important than the feelings that first caused it [...] I got to a stage where I couldn't leave the house without taking a knife with me. I started thinking about things that would make me upset or angry just so that I could cut" (Don OLI 4.2)*

Don's experience echoed that of the dependent drug user whose mind is completely preoccupied with his next fix of his chosen substance. Far from using self-harm as a means of staying in control the behaviour seemed to have completely taken him over and become completely unmanageable.

The inevitable escalation in the frequency or the severity of the behaviour as a tolerance developed presented a problem for participants in terms of managing their self-harm. As it escalated the behaviour lost many of its perceived benefits as its consequences became more difficult to manage and to hide from those around them. The potential costs of continuing to self-harm seemed to mount up just as its benefits diminished. Recognising the costs associated with their self-harm and then weighing them up

against the benefits appeared to help participants with the management of their behaviour as Adam demonstrated:

> *"By that time it had got worse to the extent that I was making a big mess when I did it and it was just like I would have to spend too long cleaning up and it would be really obvious to my family and I couldn't be bothered to deal with the hassle of going to my dad and my mother. So then it got to that point after about three months where I was thinking 'Well if I can go without it for this long then what's the point of going back to it?'" (Adam FTF 22.37)*

Participants described a variety of self-control strategies that they used to try and manage their behaviour. Bill attempted to fight the urge to self-harm through sheer determination with mixed results:

> *"Usually I would just try and do it by pure willpower you know if something had gone wrong and I want to cut I would er I would mainly be able to resist I mean would be able to resist I would like go sort of wandering around outside so that I wouldn't be able to pick up anything I could use. And then there's been a couple of times that's happened and then I've got back later that day and just you know this thing's lying there and I've used it for no good reason and I suppose that that did scare me that it could be that kind of out of control [..] it felt a bit like it was taking over." (Bill FTF 8.23)*

Bill's situation illustrated the futility of using willpower alone to fight the urge to self-harm as it led to him feeling that his behaviour was even more out of control. By contrast Mike recognised that trying to exercise willpower was not an effective response and rather than fighting the urge to self-harm used to try and distract his attention instead:

> *"I control myself more I know now where not to go and I know the best defence against it isn't always convincing myself not to it's watching something on the television it's taking my mind off it." (Mike FTF 17.9)*

Distraction also proved a popular and effective strategy with other participants for managing their behaviour:

> *"Just try to get something else to occupy your mind with, um well when you feel the pressure building up just try and find another way to release it you know" (Gary FTF 13.23)*

> *"I was so into my video games I could I would go and spend some of my wages at work on a video game and just sit there and play it for hours and hours and hours and hours on end just to get my mind off it" (Stuart FTF 21.25)*

Another influence on participants' control over their behaviour was their alcohol consumption. Participants ordinarily made an effort to keep themselves safe and manage their self-harming behaviour but under the influence of alcohol seemed more likely to relinquish control:

> *"There was an incident where I got drunk and self-harmed and then was um running around with no trousers on with blood pouring down my legs in my halls which wasn't very nice for my dorm mates" (Adam FTF 19.39)*

> *"I did do it on my wrists but I only did that once and that was because when I was drunk I did it I just literally ripped out a bit of beer can and went sort of thing I was that bad." (Stuart FTF11.25)*

Theme four: Taking responsibility for the self

A number of participants appeared to have had experiences either in treatment or in their everyday lives where they felt they had put their trust in other people to help them and been let down. These experiences nevertheless sometimes appeared to have a positive outcome for some who reported a sudden epiphany or realisation that if they could no longer rely on others then they had to start to take responsibility for themselves and their own behaviour. This epiphany appeared to represent a crucial turning point for these participants in the process of managing their self-harm and an important cognitive shift from a position of perceived weakness or inadequacy and dependence upon others to one of self-efficacy and a determination to change.

It was Don's dissatisfaction with his diagnosis and the treatment he received that ultimately encouraged him to take responsibility for himself:

> *"I used to think it was important what the doctors had written down but I don't feel that way anymore. It's just a name, not who I am. I've realised that doctors are just people and it doesn't really matter how they categorise me. Whatever they write down doesn't hurt me or help me. I used to rely on them to help me, which is why I was so upset by the diagnosis, but after a few disappointments with the therapies, I realised that it's me that has to do it." (Don OLI 9.20)*

Don appeared to rely upon doctors and the labels that they attached to him for validation which left him feeling dependent and vulnerable. His negative experiences of treatment however appeared to have subsequently made him more independent and determined to take responsibility for managing his behaviour by himself.

Adam had also sought medical help and was tried on a number of different medications, one of which he claimed had led to a suicide attempt. After that he too appeared to lose faith in medical professionals:

> *"That actually gave me schizophrenic tendencies and made me try and kill myself and um I went to a different doctor and she bitched at the first doctor for putting me on a dangerous medication. So when I came off all the medication I decided right they don't know what they are doing and this is something I'm going to have to do on my own because the doctor told me to grow up." (Adam FTF 17.21)*

For Jim, the adverse event that provided the catalyst for changing his behaviour was a problem at work:

> *"In the end I had the union involved with my ex-employer as my manager was being such a bitch and had so little understanding of my depression (only one person at work knew that I self-harmed - the friend who told me about her cutting the year or so before I started). After the meeting with the union I realised that things weren't going to change and that I had to get off my arse and do something." (Jim OLI 9.3)*

Jim claimed that it was a subsequent change of job that finally enabled him to manage his self-harm. He did not achieve this entirely on his own however as he had the support of an *"amazing counsellor" (Jim OLI 9.18)* and also a female friend. His acceptance of responsibility nevertheless appeared to be a powerful catalyst for change and mark a significant milestone on his journey towards the effective management of his behaviour.

Superordinate Theme 3: Validation of the self by others

The third superordinate theme describes participants' experiences of opening up to others about their behaviour and finally receiving validation through empathic and supportive relationships. Many participants appeared to particularly value reciprocal relationships of mutual support with others who engaged in deliberate self-harm as they offered the opportunity to offer help and support as well as receive it. These relationships also appeared to provide an alternative coping mechanism that allowed them to manage their deliberate self-harm more effectively.

Within this superordinate theme two sub-themes were identified:

- **Being accepted by others**
- **Mutual support**

Theme one: Being accepted by others

The acceptance of others appeared to provide participants with a form of validation which challenged their expectations that other people would judge them in the same way they were already judging themselves. Participants' own negative perceptions led them to assume that other people would necessarily feel the same way and this left them especially vulnerable to any perceived judgment or rejection by others. The establishment of formal or informal empathic relationships within which they felt validated and supported seemed to provide a powerful antidote to these negative perceptions that facilitated the effective management of participants' self-harming behaviour.

A number of participants identified one particular close friend or partner whose acceptance of their behaviour appeared to provide this validation and support them in the process of managing their self-harm. The nature of this support differed between participants although in the majority of cases the person offering it was female. In Don's case the mere offer of someone to talk to about his problems appeared to have a beneficial effect on his ability to manage his behaviour:

> *"She found out that I was doing it, and wrote me a note saying that she understood and that I could talk to her if I needed to. It was partially that that convinced me to stop. It certainly helped me stop once I tried." (Don OLI 4.21)*

Although this offer did not seem to constitute much by itself it contrasted starkly with the invalidating responses Don had received from other people who he claimed *"seemed to think it was a teenage phase and wasn't worth taking seriously"* (Don OLI 4.29) and the judgemental response of his family that appeared to have a negative impact on his feelings and behaviour at the time.

Bill had been very secretive about his behaviour and had avoided seeking any kind of help at all. Nevertheless he took things a step further than Don, eventually choosing to open up to his then girlfriend by telling her about his self-harming behaviour when she asked him about his scars:

> *"She just sort of asked 'What's that?' and I just felt 'Yeah I want to tell someone' and I just I suppose partly as an experiment because normally I had an excuse ready or I'd just pull something over it and just say you know 'Nothing' and I just thought 'Well maybe I'll tell her' and I did and she took it very well [...] that was also the longest time that I've been without it." (Bill FTF 9.4)*

Although this disclosure did not appear to be planned the key ingredients of autonomy *("I want to tell someone")* and control over disclosure *("maybe I'll tell her")* were both present in this account and appeared to have contributed to a positive outcome for Bill. The decision to finally open up to someone about his behaviour appeared to help him manage his self-harm more effectively as it was followed by a long period of abstinence.

In addition to the validation opening up to others provided it also seemed to offer an alternative coping strategy that allowed some participants to manage their behaviour better. After their initial disclosure some participants were encouraged to continue to share their feelings as a way of regulating their emotions without resorting to self-harm. Stuart acknowledged that even at the time of his interview he still experienced the thoughts and feelings that had previously triggered his self-harming behaviour but that he increasingly chose the talking option instead:

> *"It still happens now and then I have to admit it does I do get the feeling where 'Oh I'm just going to kill myself because I can't go out because there's no one out and I'm fed up and I can't be bothered with anything' sort of thing. When it does get to that point but then if it happens then I go and talk to my parents*

> *about it because my Mum knows I do that, used to the whole self-harming thing." (Stuart FTF 8.10)*

Stuart's exaggerated and dramatic response to being "*fed up*" suggested that his difficulty regulating his emotions had persisted even after he learned to manage his self-harming behaviour. Rather than trying to cope alone however he chose to talk to his mother instead as she already knew and understood about his self-harm. This strategy appeared to help Stuart to regulate his emotions and therefore manage his behaviour better.

It seemed important that participants could feel comfortable talking to others candidly about how they felt without having to worry about how they would react. Participants appeared most likely to want to share their feelings and receive the validation they needed from people they believed would not judge or reject them for their behaviour. Knowing the response they received would be non-judgemental seemed to encourage participants to be more open and able to share their feelings rather than trying to cover them up. It did not seem to matter whether the person they confided in was a friend, a family member or a professional but what did appear to matter was that the response they received validated them as a person. Jim described how the empathic relationship he developed with his counsellor had a positive effect on his behaviour:

> *"She was just really good, I told her things about myself that I'd never told another living soul and she was so understanding and non-judgemental. Plus she had a great sense of humour which made the process a lot easier. Without wanting to sound overly dramatic I think there were times when I was really low when she saved me from doing something regrettable." (Jim OLI 9.27)*

Jim's tendency to use euphemisms masks the gravity of his final statement as "*something regrettable*" undoubtedly refers to suicide. It appears that opening up to his counsellor and being accepted and validated by her in this way may literally have saved his life.

Although my own relationship with participants that of researcher and not a therapist, I was nevertheless aware that this role is not entirely passive and that my own attitude and training would undoubtedly have a bearing on the research process. I assumed that participants would be equally as sensitive to my reactions as they were to those of other people and I felt that it was essential that I use my training to demonstrate to participants that they were being listened to and understood during the interview

process. The significance of this was powerfully brought home to me when Jim revealed that simply having someone understand what he was going through may have saved his life. The realisation that the validation of participants' experiences could be so vital to their continued well-being made it doubly important for me to show throughout the research process that participants were being listened to and understood. I felt that the choice of a qualitative research method whose end product would be a subjective account of these experiences provided the best possible way of ensuring this.

Once participants had disclosed their behaviour to someone who they found was accepting of their behaviour it appeared to provide enormous relief and to some an alternative to the gratification they received from self-harm. Sometimes the person that they disclosed to was available to provide ongoing support and an alternative way of dealing with problems. Bill described how having opened up to his partner provided him with a kind of safety net that allowed him to manage his behaviour better. Although they only discussed the reasons for his scars on one occasion her initial acceptance of his behaviour appeared sufficient to give him the motivation to try and avoid self-harm safe in the knowledge that he could always count on her support again if needed:

> *"It was an odd feeling I'd got it out in the open and I thought 'Well she knows about it let me just try, really try as hard as I can not to do it at all if I did feel like there was a problem she knows that I could always ask her' but I never I never actually felt that I needed to ask her for help [...] she knew the scars were there I didn't have to hide them from her and I don't remember her paying much attention to them after that." (Bill FTF 9.22)*

Once he had taken the brave step of opening up about his behaviour Bill appeared to suddenly become more determined to avoid self-harm. The presence of an understanding and empathic partner seemed to provide him with an important ally in the struggle to manage his behaviour.

Mike also described an empathic relationship with a female friend who provided support when he felt his behaviour was getting out of control. This friend appeared to provide something more than just a comforting presence however and was more active in helping Mike to manage his behaviour:

> *"I think knowing that she wasn't going to judge me and that she was always there was kind of the sense I got from her [...] I did feel I could go to her and say 'I think I've done this too much'. Which again it was probably her response which probably allowed me to do that [...] when I did go to her when I had done*

it too deep I remember her saying 'That's too deep don't do it again' and I didn't. I made a conscious effort not to go so deep." (Mike FTF 14.4)

Theme two: Mutual support

While the acceptance of others offered participants the validation from a close friend or partner these relationships were often one-sided and participants did not appear to offer much in return. Some however did develop more reciprocal relationships of mutual support with others built on a shared experience of deliberate self-harm that helped them both with the management of their behaviour. Empathy was almost a given within these relationships as they were built on a shared understanding of each others' experience:

"The friend that I spoke about earlier helped a lot. Well actually we helped each other which was really beneficial as we both understood what the other person was going through. I think that was really important as I'm very much of the opinion that you can't really understand mental illness or self-harm unless you've experienced it first-hand." (Jim OLI 10.7)

I wondered at the time whether Jim's comment that mental health issues can only truly be understood by those who have experienced them was a thinly veiled criticism of my own voyeuristic interest and it initially put me on the defensive, although I did not feel this would have impacted significantly on our online interview. While Jim's assertion that personal experience can provide a deeper understanding of the issue rang true, I nevertheless felt that not having self-harmed personally was of benefit to the research process. While I acknowledged the existence of my own prejudices about the behaviour I do not feel they were as extreme as they may have been if I had personal experience of the behaviour.

Mutual support of the kind that Jim described appears to have helped participants with the management of their behaviour in two ways. Firstly, when successful it provided them with a valuable practical demonstration in the effective management of self-harming behaviour. Stuart for example did not have had much faith in his ability to manage his own emotions or behaviour but this did not prevent him from offering advice and support to his friends:

> *"I might not believe in myself sort of thing of helping myself but I can believe in myself in the way of helping others." (Stuart FTF 22.28)*

Where the strategies that participants suggested to others were seen to be effective it sometimes encouraged them to then try them for themselves as Gary revealed:

> *"I was going out with a girl and er she was she was quite badly self-harming she was just starting to stop though. Um she had scars all the way up and down both her arms [...] she didn't really know why she did it all that she knew was that she wanted to stop so I kind of suggested a few things for her and they happened to work for me as well [...] I think it was just instead of thinking about it in my head just coming out with it and speaking it just made things a lot clearer." (Gary FTF 15.55)*

Secondly, helping others also appeared to give participants a valuable boost to their own self-esteem that helped to combat the negative thoughts and feelings that contributed to their own behaviour. Stuart revealed how by helping others he was also helping himself too:

> *"I've given them ideas of how to help them out of situations or how they are feeling and stuff like that. That just makes me feel so much better." (Stuart FTF 22.43)*

This notion of mutual support also appeared to extend to virtual relationships developed online as well as those in the real world. Most participants were regular internet users registered with one or more bulletin boards dedicated to the issue of self-harm. The mutual support and the sharing of experiences offered by these online communities appeared to be one of their principal reasons for joining them:

> *"I wanted to kind of hear from other people who had been in that situation and they talked about the experiences that they had had you know either things that made them want to self-harm or things that they had done to help them overcome it and I thought well just a bit of solidarity really." (Bill FTF 14.13)*

> *"I think it was the sense of belonging and the sense of community really and that you know you weren't a freak and that you could meet all sorts of people from all stages of life and ages and careers and stuff who have the same problem so it was like less of a big deal [...] cos obviously I thought it was just me and it was 'Oh my God there's six thousand people just on this one site' kind of thing." (Adam FTF 15.24)*

The exposure to large numbers of other people all going through similar experiences provided participants with a validating experience that they would probably not have been able to receive elsewhere. For Adam, it appeared to be the diversity and sheer size

of the membership that provided him with validation that allowed him to feel less of a *"freak"*. By interacting with others online Bill was able to learn from many other people's experiences and develop ways of managing his own feelings and behaviour without resorting to self-harm:

> *"I picked up a lot of sort of practical hints like sort of bang a plastic bottle and things because it you know to get out the violent urge [...] everyone's got their own method they recommend and you end up hearing about hundreds of them and try them all to see what works." (Bill FTF 11.5)*

Adam developed a particularly close relationship with one friend through the message board that eventually proved to be instrumental in helping him manage his behaviour:

> *"That was one of the reasons why I stopped initially because I was seeing my friend who I met online she lives in Hungary [...] we kind of made a pact that we wouldn't have like fresh self-harm when we met each other because it would be kind of gross and horrible." (Adam FTF 22.22)*

While most participants appeared to find the internet a useful source of information and mutual support it did not appeal to all of them equally. Although Mike revealed that he had used the internet for information and as a distraction technique he was less effusive about online communities:

> *"I was looking through them and I'm quite wary of them but I think um there is almost the desire to identify yourself or define yourself through that and I sometimes think that maybe the websites reinforce that sense of identity er that was my overarching reaction when I kind of started looking at them um was that kind of 'I don't want to be one of these people' [...] I saw a person who said 'I have been a harmer for ...' I think I cringed but this is my kind of you know a superior attitude to such things." (Mike FTF 19.52)*

Superordinate Theme 4: Learning to live with a new self

The fourth superordinate theme describes the culmination of the journey and participants' experiences of managing without the behaviour. This appeared to represent a period of adjustment to new ways of being and relating to themselves and others, characterised by an increasing acceptance of self and also acceptance of their self-harming behaviour. While participants expressed relief at having managed their behaviour they did not rule out the possibility of further self-harm in the future, suggesting that for them the resolution of their behaviour may mean a life of managed self-harm rather than complete abstinence from the behaviour.

Within this superordinate theme five sub-themes were identified:

- Acceptance of self harm
- Acceptance of self
- Residual urge to self harm
- Growing strength and self confidence
- Discomfort with new self

Theme one: Acceptance of self-harm

When participants began to self-harm they appeared to consider their behaviour shameful and something to kept hidden from others although they still had to justify their behaviour to themselves. As they later learned to manage their behaviour however there appeared to be a shift in their perception of their own self-harm. At the time of interview for the study each participant had refrained from the behaviour for at least three months and some stated that they were determined not to do it again. Where self-harm had once been perceived as something they should feel bad about participants later came to accept the behaviour and view it as a coping mechanism that had helped them through a difficult time in their life.

Adam had previously attempted to legitimise his behaviour by labelling himself as mentally ill. His subsequent acceptance of his behaviour allowed him to reject this association between self-harm and being *"mental"*:

> *"I don't see it as anything to be ashamed of it's something that I used to cope and I don't anymore but that's all and it's nothing to be ashamed of it's not that you're mental or something because I mean some people will go out and just drink every night or something. That's their way of coping. Some people cut themselves." (Adam FTF 13.2)*

Jim was happy to accept that his depression was an illness and his self-harming behaviour a way of coping with its effects:

> *"I'd always had a very negative view of my depression (I saw it as a weakness, after all what did I have to be depressed about) and I think the self-harm was part and parcel of that. Once I accepted that the depression was an illness and that the self-harm was a way of coping (albeit not a particularly good way) it wasn't so much of an issue for me. It was something that would keep me going until I had the depression under control or could learn some better ways of coping." (Jim OLI 3.42)*

Some participants claimed that their self-harm had not only helped them to deal with the problems they were facing at the time but also represented an act of self-preservation that prevented them from losing control altogether or even committing suicide, as Don explained:

> *"I don't feel ashamed of turning to self harm, because it worked, and at the time I couldn't find anything else that did. If I hadn't started, I might never have been able to live with how I felt." (Don OLI 3.34)*

This acceptance of their self-harming behaviour seemed to provide participants with a way to break the vicious cycle of self-harm and negative self-evaluation that maintained their behaviour by demonstrating compassion for themselves. The role of this compassion for self is illustrated in the extract above. Rather than viewing his self-harm as a fundamental weakness Don reframed it as an understandable if maladaptive response to particular extreme circumstances *("it worked, and at the time I couldn't find anything else that did").*

Although participants expressed their determination to continue to avoid self-harm in the future they nevertheless also appeared to draw strength from the knowledge that having learned to manage it better it could still be maintained for use in an emergency if needed:

> *"I still find it a bit daunting to say that I'm never going to do it again. I still if you like it's there like as a last resort but it's something that I don't expect to have to use. But at the same time again it's a bit of doublethink. I could I always could but I'm not going to." (Bill FTF 13.7)*

This extract highlights the importance of autonomy for Bill in the management and resolution of his self-harming behaviour. Having the choice of whether to self-harm or not gave him the opportunity to demonstrate control over his behaviour *("I always could but I'm not going to")* while the thought of not having the option at all seemed to cause discomfort that could possibly trigger further self-harm.

It appeared that once self-harm had been adopted as a way of dealing with problems it complemented or enhanced a participant's existing repertoire of coping strategies and became difficult to let go of altogether. Mike likened this difficulty in fully resolving his behaviour to a smoker's craving for nicotine in that once started it becomes a habit that is all too easy to return to:

> *"In my head it's kind of like smoking I don't know if you smoke but erm it's much easier to go back to once you've started than it is to start for the first time so now if I get stressed or angry that is where my mind goes" (Mike FTF 7.16)*

Participants' changing perceptions of self-harm and the acceptance of their behaviour as a coping mechanism seem to have led those who claimed to have managed their self-harm to develop a more positive attitude towards the behaviour that allowed them to accept it as an integral part of themselves. At the time of interview participants were not actively harming themselves but most nevertheless maintained a perspective on the behaviour that acknowledged its benefits and appeared reluctant to give up on it altogether. There was even acceptance that the occasional lapse was excusable as long as there was a good reason for it and it did not lead to more regular or habitual self-harm:

> *"If it does get really really bad then once an excuse but don't make a habit of it sort of thing and don't just go running back to it as an excuse. Because I can do it doesn't mean I should do it, doesn't mean I need to do it" (Stuart FTF 9.3)*

This acceptance of lapses as inevitable appeared to be an important step for some participants in the process of managing their self-harming behaviour. It may have been Bill's self-confessed perfectionism that originally prevented him from seeing such lapses as anything other than complete failure but once he accepted that they would occur he seemed much more confident about a future without self-harm:

> *"I think that's possibly if I had to point at one thing that's made it that's really made me feel able to believe that I might succeed in stopping for good it's that. It's accepting that certainly in the early stages of it things will go wrong and*

sometimes I will let myself slip. And yeah it happens. You just move on and all that." (Bill FTF 15.47)

Bill appeared able to manage his behaviour much more effectively by relaxing his usual high standards and accepting that things would inevitably "*go wrong*". Accepting that the occasional slip was inevitable seemed to be what finally enabled Bill to break the vicious cycle that maintained his deliberate self-harm.

Theme two: Acceptance of self

The management and acceptance of self-harm also appeared to encourage the acceptance of other aspects of the self that participants had previously concealed from themselves and others. These perceived faults and weaknesses and the distress they caused had previously been held in check by self-harming behaviour. Without the behaviour to hold them back they were no longer able to conceal these hidden or denied parts of the self and had little choice but to acknowledge and accept them.

This acceptance of self did not represent a radical shift from self-derogation to unconditional self-acceptance. Simply having managed their self-harming behaviour did not mean that participants had suddenly become wholly content with themselves. However participants did seem prepared to acknowledge that the view they previously had of themselves was distorted and expressed a desire to develop a more balanced and integrated self-image:

"I think I would like to have a more realistic view of myself (particularly my weight/appearance - they're still very big issues for me) and not just base my self-worth on my achievements or things that I do but perhaps a balance between that and how I am as a person." (Jim OLI 4.8)

"I'm not 100% happy with who I am but I sort of have a rule in place now to save me from getting like I did last year which is that it's okay to be self-loathing but not self-doubting because when I was pitying myself and doubting my ability I couldn't get anything accomplished in pretty much everything." (Rob OLI 2.55)

Don and Adam both appeared to have become more accepting of themselves and their behaviour since managing their self-harm. They appeared to have become more willing to accept the faults in their character or behaviour and view them in their proper perspective. They no longer seemed to view these character flaws or mistakes as

catastrophic:

> *"I definitely have a more healthy self-image now than I did at school. There are still aspects of myself I don't like, but they're no longer all-consuming." (Don OLI 2.45)*

> *"It used to be if I [messed] up that it would be 'Oh no, it's the end of the world, no-one's ever going to accept me anymore because I'm so rubbish and stuff and now it's just like 'Yeah, whatever'" (Adam FTF 7.24)*

The acceptance of self seemed important to the continued management of participants' self-harming behaviour as it allowed them to develop a more realistic and balanced view of their perceived strengths and weaknesses. This more balanced view appeared to help avoid the vicious cycle of self-criticism and negative affect that had previously accompanied their evaluations of themselves and maintained their self-harming behaviour. These negative thoughts and feelings appeared to have become less overwhelming and more linked to particular situations or mood states. This offered them the opportunity to isolate and identify particular thoughts or situations that triggered their behaviour and take steps to avoid them if necessary. While these thoughts and feelings persisted participants appeared more able to resist them:

> *"It is in my head quite a lot but I don't fixate about it [...] I know what roads in my head not to go down" (Mike FTF 16.19)*

While the management of their self-harming behaviour appeared to allow some participants to achieve a more balanced view of themselves in others it seemed to reveal more deep-rooted distress that they had previously been using the behaviour to conceal from themselves and others. Adam had felt uncomfortable in his own skin from a young age because of confusion over his gender but having managed his self-harming behaviour had finally begun to take steps to address the issue :

> *"Now I'm actively going through gender reassignment that has helped me come to terms with my body and come to terms with who I am and maybe it's not so weird to not be specifically a girl or a boy. That's kind of helped with the self-acceptance and now I don't care whether or not I fit in with other people because other people are generally stupid anyway." (Adam FTF 13.34)*

Adam had used the word "*freak*" several times during his interview when describing himself and his self-harming behaviour initially seemed to reinforce this perception that he was indeed different to other people. The validation he received from others and the management of his deliberate self-harm however seemed to encourage him to accept

this difference, to feel more comfortable with himself and to believe that he was *"not so weird"* after all.

Gary revealed that he too had begun to face up to the confusion that he felt about his gender:

> *"Like with being or thinking I'm a transsexual. Like the last 18 months to two years I have started to come to terms with that a lot more and admit it to myself and to my friends." (Gary 18.38)*

For some participants the acceptance of self that seemed to accompany the management of their deliberate self-harm appears to have represented a stage on a journey towards self-acceptance rather than an end destination in itself. Facing up to their behaviour seems to have allowed these participants to confront and accept aspects of themselves that had been denied for some time and allow them to begin to reveal their true nature to themselves and others.

Theme three: Residual urge to self harm

Although all of the participants in the study had achieved a minimum of three months without resorting to self-harm and some had even managed twelve months or more without it most nevertheless reported some kind of residual urge to self-harm. This urge had once proved overwhelming and participants revealed that they had felt powerless to resist it in the past. Having learned over time to manage their behaviour however participants appeared to have developed a range of strategies to help them to deal with these urges. They appeared easier to dismiss the longer they had managed without the behaviour as this time factor itself seemed to provide an added incentive to avoid self-harm:

> *"Yeah I mean I still get urges to self harm when I've had a bad day or whatever but now it's just kind of like well I've gone without it for three years so what's the point?" (Adam FTF 21.30)*

The existence of this residual urge even after three years without self-harm suggests a powerful association between trigger situations and self-harming behaviour that persisted despite Adam's ability to manage his behaviour. Other participants also reported similar powerful triggers and the way they described them suggested that they

too had become accustomed to dealing with them. Where previously the urge to self-harm had been overwhelming and the response to it almost automatic it appears that participants later became able to recognise each trigger as a warning and deal with the urge to self-harm in a more rational and controlled way:

> *"I do find it quite strange using a scalpel / Stanley knife for anything other than self-harming. I do occasionally get that flutter in the pit of my stomach when I pick up a scalpel but I just chalk it down to past experience and dismiss it." (Jim OLI 11.20)*

The *"flutter"* that Jim described in the extract above revealed a kind of eager anticipation and suggests an almost romantic attachment to the behaviour. This involuntary response suggests a lingering desire to self-harm that persisted even after he had been able to manage his behaviour. Even the blades he had used to cut himself with seemed to have developed a new significance that made their everyday use seem *"strange"*.

I initially found the notion of a continuing attachment to self-harming behaviour disturbing as it challenged my own assumption that participants would be glad to put their self-harming behaviour behind them. The apparent fondness with which the behaviour seemed to be remembered by some participants particularly confounded my expectations. Their descriptions evoked bittersweet memories of lost love, something I could more readily identify with and which helped me to better understand their ambivalence towards a future without the behaviour.

Don's strategy for dealing with his urges was to remind himself of the consequences of self-harm:

> *"I don't think about it much except when I feel particularly upset, but even then I'm able to remember that it made things worse, so I don't feel the desire any more." (Don OLI 5.2)*

Jim and Don's responses suggest that they became more able to weigh up the costs and benefits before succumbing to the urge to self-harm as part of the process of managing their behaviour. Although the urge persisted it appears that their own response to it became less urgent and by taking time to consider these relative costs and benefits they were able to *"dismiss it"* or *"remember that it made things worse"*.

Participants' own evaluations of these residual urges were characterised by

ambivalence. The benefits of continuing to self-harm were not clear yet for many the urge to do it still remained. Mike was running his fingers over the scars on his lower arm as he gave the following confession:

> *"I miss doing it. I can't say specifically what. You know probably the blood aspect as always no idea why you know the life force symbolism type thing [...] I can still find myself going [touches lower arm] and just feeling it there and thinking 'Ooh' and I don't know what that is either sort of a wistful nostalgia I don't want to say I enjoyed doing it because I didn't but part of me wanted to do it part of me still wants to do it and I can't really tell you why." (Mike FTF 24.24)*

Although Mike claimed that he did not enjoy doing it he too appeared to have maintained a romantic attachment to self-harm that brought a *"wistful nostalgia"* each time he touched his remaining scars. To him self-harm appeared to represent a powerful symbolic ritual and the sight of blood a reminder of his *"life force"*.

It appears that a powerful residual urge to self harm remained even after participants had learned to manage their behaviour and still persisted for some time afterwards. By this time however participants appeared to have acquired a range of strategies to deal with such urges so they were able to manage their behaviour more effectively.

Theme four: Growing strength and self-confidence

Participants revealed that as they progressed towards the more effective management of their self-harming behaviour they developed a growing strength and self-confidence that appeared to challenge their negative perceptions about themselves and rendered further self-derogation or self-harm less likely. Participants' beliefs about their behaviour had previously fed their negative perceptions by providing them with confirmation that they were weak or inadequate for having to resort to self-harm. Developing alternative coping strategies and learning to manage the behaviour better appeared to have the opposite effect and provide them with a sense of achievement from which they could draw renewed strength:

> *"Whatever life throws at me I know I can come through the other side. I think that in a way the whole experience has made me a stronger person (not that I'd want to go through it all again given the choice though)." (Jim OLI 10.41)*

Participants' self-harming behaviour was a private act which they attempted to hide from others and manage for themselves. Although they received some help and support from others along the way ultimately the choice was theirs and any success in managing or resolving their behaviour was entirely their own. For Bill the ability to effectively manage trigger situations without resorting to self-harm appeared to be a source of personal pride:

> *"I can get a sense of achievement thinking that if I was in this situation a year or two years ago I'd probably have self-harmed now I'm not. Now I can think of any number of things that I could do if the urge hit me and I would come out of it safely." (Bill FTF 15.30)*

The strength and self-confidence that came with managing their self-harming behaviour also appeared to allow participants to develop the motivation and determination to deal with other problems too. Adam claimed that it gave him the strength and courage to face up to some of the feelings that his self-harm had been helping him to avoid:

> *"Now it's kind of look well I've defeated that it's another thing I've defeated in a way so it's kind of made me a stronger person it made me a stronger person while I was doing it because I had to deal with it but it's made me much stronger to get over it and to manage to cope without it to actually have to deal with the harder things that I was covering up like actually dealing with how I feel" (Adam FTF 23.52)*

Stuart also maintained that his self-harm had contributed to making him a stronger person and claimed that he now felt better equipped to face uncertainty as a result:

> *"I think most of it has brought more of me out and has helped me more than some people try to think like quite a few people think oh, self harming, they are just damaging themselves and destroying themselves and destroying their character but in my case it's actually brought out a lot in me and shown how strong I can be and how willing I am to move on with life and fight things that I may have no clue about and what how to solve but I'll pretty well try and do my best to try and solve it or get out on the way" (Stuart FTF 21.9)*

Although managing their self-harm appeared to have a large part to play in helping participants develop greater self-confidence and self-efficacy it was not the only thing that did so. Many participants were also going through a natural process of maturation at the same time that involved facing some of the ordinary challenges and upheavals of young adulthood such as getting work, living alone or going to university. These experiences also seemed to have contributed significantly to the development of

participants' self-confidence. By facing up to these challenges participants were given further opportunities to develop their self-confidence and enhance their coping skills.

Stuart revealed that he had recently entered the job market and this appeared to have increased his confidence in dealing with unfamiliar people and situations:

> *"I went onto temping sort of work, temporary contracts and stuff like that and that's kind of brought me out and got my confidence up more cos I'm meeting different people and working in different environments and stuff like that and working with customers it's just brought my confidence boost up so much" (Stuart FTF 1.49)*

Adam's self-doubt had previously led him to believe that he would not be able to cope with living independently but going to university forced him to face up to these fears:

> *"I think a lot of it was coming to University and because before I did I felt I couldn't cope with social situations, I couldn't deal with people, I couldn't deal with finding my way around a strange town, I couldn't deal with living away from home away from my parents and then I got thrown in the deep end and had to then I realised 'Actually this is pretty easy'. So yeah that helped quite a lot." (Adam FTF 14.22)*

Gary developed his own self-confidence by working abroad:

> *"Um I've always not had much confidence, especially when I was younger and that's something that has grown over time and that's something that going [abroad] helped me with as well just like before I left I was quite quiet um and not really sure of myself and then I went over there and I learned to live on my own in a different country." (Gary FTF 6.17)*

Stuart, Adam and Gary were all forced to face up to situations which challenged their perceived lack of confidence or coping skills. Their self-derogating nature meant that they previously did not have much faith in their ability to deal with such situations and would most likely have been motivated to avoid them. Having to face up to these challenges however proved easier than they previously thought. This forced exposure to feared situations appears to have allowed them the opportunity to challenge their negative expectations, develop more self-confidence and enhance their coping skills.

Theme five: Discomfort with new self

While learning to manage their behaviour was considered a major achievement and a source of personal pride for participants, the management of their deliberate self-harm appeared to bring with it a new set of challenges as they adjusted to a life in which it played less of a role. Without self-harm to help them cope participants appeared to struggle to regulate what others might see as normal emotions or behaviours that were unfamiliar to them because they had previously been able to avoid them. Living without deliberate self-harm meant that they now had to learn to accept and cope with these emotions and behaviours and some appeared to experience a degree of discomfort with at least some aspect of their new self.

Bill described how unusual it felt for him to talk to others about his feelings, as one of his principal reasons for self-harm had been to try and keep his problems away from others:

> *"I did feel especially in the first month or two when I was trying to stop well I succeeded in stopping but I did feel like it was it was making me very um very kind of self-indulgent and I don't know what's the best way of expressing this but so much of what I originally the original reasons why I did it were not wanting my problems to bother anyone else and one of the things was that I found that I couldn't just shut up about things that I did." (Bill FTF 16.15)*

While many people do not have a problem with talking about themselves it caused Bill considerable discomfort. Without self-harm he no longer felt able to conceal his problems from others and the new strategy he adopted for dealing with them was to talk about them with other people. Although talking about himself in this way made him feel *"self-indulgent"* it appears Bill nevertheless found it preferable to self-harm and it appeared from this account that after a couple of months it became less of a problem for him.

Don in particular appeared to struggle to manage his self-harm effectively and reported a flattening of his emotions as a result of the management of his behaviour. He seemed relieved to have broken the vicious cycle of negative emotions and self-harm but revealed that this had left him in a kind of emotional limbo:

> *"I'm still away from anything that could make me want to start again but also anything that could make me happy [...] I've stopped self-harming and I've*

stopped feeling bad but at the cost of stopping feeling really anything at all" (Don OLI 6.34)

Don had managed his self-harm by using anti-depressants and by avoiding emotional stress. His motivation for maintaining these changes seemed to be a fear of returning to how he had previously felt:

"I'm afraid of going back to how I was, and I'm not sure I could survive it again [...] I think anything would be better than going back to how I felt before. It was the closest thing I can imagine to hell." (Don OLI 7.12)

Don had a clear sense of what he was escaping from but appeared less sure about where he was heading to. His previous experiences provided a powerful motivator for maintaining the changes he had already made but he seemed unable to take the next step for fear of a relapse. Don's dilemma was that he couldn't be sure whether he had changed or simply learned to manage his self-harm with medication and by controlling his environment. He did not appear to trust himself enough to move forward for fear of going backwards, leaving him nowhere else to turn.

Rob found that the feelings he had been suppressing by self-harming resurfaced after stopping the behaviour leaving him with another, different problem to resolve as he did not yet appear to have developed an alternative strategy for managing his anger:

"I suppose on some level it's improved how I see myself, the main thing though has been that its actually made me more irritable and quick to anger [...] my girlfriend says go to therapy over it which I'll probably start doing in the new year [...] I think it's a symptom of the lack of mood regulation I have having stopped." (Rob OLI 9.4)

Rob's experience suggested that while the avoidance of self-harm promotes a more positive self-image in the absence of alternative coping strategies emotions that were being contained or suppressed by the behaviour might surface again.

While I had anticipated the kind of minor readjustment that Bill and Rob described, the possibility that the management of deliberate self-harm might ultimately have anything other than a positive outcome for participants in the longer term had not originally occurred to me. Don's account however represented a challenge to this assumption and I realised that I had been wrong to assume that the management of self-harm alone would be sufficient for him to put the rest of his life in order. This encouraged me to

acknowledge and further reflect on the continuing difficulties faced by those who learn to manage their deliberate self-harm.

While participants universally agreed that they were better off now that they were able to manage their self-harming behaviour there nevertheless appears to have been some initial discomfort for some as they adjusted to new behaviours, uncomfortable feelings and unfamiliar coping strategies for emotional regulation. It appeared that the journey which some participants had embarked upon in was far from complete and that managing their self-harm represented just another stage on their journey towards full recovery.

Discussion

The aim of the current study was to explore the experiences of young adult men who repeatedly harmed themselves with a particular focus on how they managed or resolved their self-harming behaviour. The discussion which follows takes each of the superordinate themes in turn and explores each one in relation to the extant literature on the phenomenon of deliberate self-harm.

The invalidated self

While the experiences that led to each participant's self-harming behaviour appeared to be different, a common thread running through many of their accounts was a sense of personal inadequacy and an intrinsic lack of self-worth. While each individual participant's history was unique, self-harming behaviour appeared to be established and maintained in each case by a vicious cycle of negative self-evaluation, negative affect and subsequent self-harm. Episodes of self-harm seemed to be interpreted by participants as either a well-deserved punishment or proof of their fundamental weakness. These negative interpretations of their own behaviour seemed to lead to further self-criticism with a corresponding increase in negative affect and self-harming behaviour. Participants' perceptions of themselves and interpretations of their behaviour appeared to be instrumental in maintaining this vicious cycle and making their deliberate self-harm more difficult to manage. In their review of existing research, Klonsky and Muehlenkamp (2007) identified three psychological characteristics that are associated with self-harming behaviour; negative emotionality, deficits in emotion skills and self-derogation. Individuals high in both negative emotionality and self-derogation are deemed to be particularly at risk of harming themselves. Although the way these two characteristics combine to increase the risk has not been identified by existing research, one possible explanation is the kind of vicious cycle described above. The increase in self-criticism and negative affect that seemed to be associated with participants' self-harming behaviour suggested that this combination of self-derogation and negative emotionality was indeed a confounding factor in the management of their deliberate self-harm.

Deliberate self-harm has been widely represented in the literature as a response to environmental influences and has been particularly linked to invalidating experiences in childhood especially abuse or neglect (Babiker and Arnold, 1997; Gratz, 2003).

However, only one participant in the present study reported being sexually abused as a child and some claimed to have had a happy upbringing. Although no generalisations can be made from such a small sample, it is nevertheless interesting to note that the majority of participants did not appear to have experienced significant childhood trauma, yet still turned to deliberate self-harm later on. The absence of what participants believed was a genuine reason for their behaviour appeared to be a particular problem for some whose emotional distress and reluctance to seek help were both reinforced by a belief that their self-harm was unjustified because they had not suffered childhood trauma. While the link between childhood abuse and adult self-harm cannot be disputed as empirical studies have established a link between the two even among men (Gratz and Chapman, 2007) this does not imply that it is the only cause of the behaviour. Other childhood experiences such as insecure attachment or separation from one or more caregivers have also been implicated in the development of self-harming behaviour but appear to have received less attention from researchers (Gratz, 2003). Furthermore, as stated in the introduction, significant rates of deliberate self-harm have been identified in studies of non-clinical populations (Gratz and Chapman, 2007; Klonsky *et al.*, 2003; Hawton *et al.*, 2002) suggesting that the behaviour may be more widespread than previously thought and not restricted to those with a psychiatric diagnosis or history of childhood trauma, as appears to have been assumed elsewhere. The assumption that all adults who self-harm must have been abused as children may simply be a popular and pervasive myth and a product of an inherent bias in the literature, as much of the existing research has been criticised for its focus on the study of female patients in clinical settings (Webb, 2002). The findings of these studies cannot be generalised to the wider population of adults who self-harm, many of whom do not come into contact with services, and certainly do not reflect the experiences of the male participants in the current study.

Regardless of the original causes of the behaviour, participants in the current study reported turning to self-harm as a way of coping with overwhelming emotional pressure. In their study of male undergraduates, Gratz and Chapman (2007) found that although environmental factors were important in the establishment of deliberate self-harm, individual factors were of greater significance in its maintenance. Of these individual factors the ability to regulate emotions and the intensity of negative affect were most strongly associated with the frequency of deliberate self-harm. Their findings

suggest that regardless of the causes of the behaviour the most significant influence on its later management is an individual's ability to regulate his own emotions. The effective management of deliberate self-harm among men may therefore be contingent upon individual coping skills and in particular the ability to deal with negative affect. In a comprehensive review of research findings, Klonsky and Muehlenkamp (2007) suggest that those who self-harm experience negative affect more frequently and more intensely than those who do not. They propose that an increased sensitivity to negative affect may even be the principal cause of the behaviour as emotional regulation is the most commonly reported function of deliberate self-harm. These findings appeared to be reflected in the accounts of participants in the current study which described overwhelming feelings or unbearable emotional pressure and the relief they experienced following an act of deliberate self-harm. Self-soothing has long been identified as one of the primary functions of deliberate self-harm, however the exact mechanisms by which it operates are unknown (Klonsky and Muehlenkamp, 2007). Despite these subjective benefits initially reported by participants the management of their behaviour appeared problematic from the start. Participants appeared to believe that their self-harm was further proof that they were weak or inadequate and experienced shame for having resorted to what they perceived was a deviant behaviour. While it provided an immediate and effective means of emotional regulation in the short term over a longer period it appeared to increase their emotional distress and make further self-harming behaviour more likely.

The vicious cycle of negative self-evaluation and negative affect that maintained self-harming behaviour also seemed to be exacerbated by other strategies that participants employed in defence of the self. Lacking an intrinsic sense of their own self-worth, some participants appeared to seek external validation through their achievements instead. These participants seemed to develop unrealistic expectations for themselves as a way of trying to compensate for their perceived inadequacies and intrinsic lack of self-worth. While high expectations are not always problematic when based upon a sense of personal inadequacy and applied inflexibly they can create problems because anything short of perfection is considered a failure. The problem with this approach for participants was that their self-worth became reliant upon a sense of accomplishment that could rarely if ever be achieved. Although designed to encourage success this strategy increased the likelihood of failure as it encouraged participants to develop

impossibly high standards for themselves which they would inevitably be unable to meet. This failure to meet self-imposed standards appeared to feed participants' negative self-evaluations and served to invalidate them further still. This in turn increased participants' negative affect and made them more likely to self-harm, either as a way of regulating this negative affect or punishing themselves for failure.

Participants' emotional distress also seemed to be increased by the fear of being judged by others for what was perceived as a shameful and taboo behaviour. Whether justified or not this fear appeared to make participants feel further invalidated and determined to keep their self-harm hidden from others. The fear of being labelled was a particular concern of participants in the current study that seemed to prevent them from discussing their behaviour with anyone else. This fear did not appear entirely without foundation, as despite growing awareness among professionals and the wider public, a number of myths and stereotypes about self-harming behaviour and about people who self-harm persist, as borne out by some of the studies already mentioned that have attempted to represent the views of those who deliberately self-harm (Brophy, 2006; Sutton, 2007). One of the most pervasive of these myths is that people self-harm to seek attention or to manipulate others. In his review of the evidence for the functions of self-injury Klonsky (2007) summarised the empirical evidence which indicated that a minority do harm themselves as a means of communicating distress or getting attention from others but the majority appear to do it for entirely different reasons. Nevertheless this popular myth persists, perhaps because those who self-harm for attention are by definition more public about their behaviour while those who do it for other reasons keep it hidden. Klonsky and Muehlenkamp (2007) suggest that those who self-harm to regulate their emotions or to punish themselves, the two principal reasons identified in the present study, are more likely to keep their behaviour hidden. Those who self-harm protest strongly that the attention-seeking label is a misrepresentation of their reasons for the behaviour, (Bywaters and Rolfe, 2002) as for most of them it is a very personal and private act. Klonsky's (2007) recent review of empirical research identified a number of studies investigating the role of interpersonal influence in deliberate self-harm but seemed to find little evidence in support of this function, as out of nine studies reviewed, only one provided strong evidence of interpersonal influence as a reason for self-harming behaviour. It is doubtful that interpersonal influence was high on the agenda of participants in the current study, who as mentioned already went to great

lengths to hide their behaviour from others. Some participants appeared to conceal their self-harm for months or even years before anyone else found out about it. Their fears about being labelled and thereby further invalidated appeared to initially discourage them from talking to others about their self-harm.

While most participants attempted to avoid negative labelling some sought to pre-empt judgemental attitudes by labelling themselves. Diagnostic labels in particular appeared to be welcomed by some participants as they provided external validation and proof that they were ill rather than mad. This seemed to provide them with a more comfortable and less stigmatising explanation for their behaviour that others might better understand and sympathise with. However in her criticial review of exisiting literature McAllister (2003) warns against the overuse of diagnostic labels, especially that of Borderline Personality Disorder (BPD), which she claims has been used inappropriately to diagnose those who self-harm even when they fail to exhibit any other signs or symptoms of the disorder. Self-harm may be interpreted as a manifestation of inner distress and for some it provides a way of accessing help and support for problems such as depressive symptoms that are otherwise ignored, as identified by participants in the aforementioned qualitiative study by Sinclair and Green (2005). For one participant in the current study, however, his diagnosis of BPD and subsequent experiences of treatment appeared to prove an invalidating experience. His perception of the label was that it was a kind of dumping ground, a view that McAllister (2003) claims is shared by professionals who can view the person with a BPD diagnosis as intractable and unlikely to change. These perceptions appeared to taint this participant's subsequent experiences of treatment, which he appeared to find impersonal and invalidating when what he wanted was to be treated as a person with dignity and respect. While diagnostic labels may have helped provide validation by legitimising participants' self-harm and also provided some with access to help and support, it is questionable whether such labels were helpful with the management of their behaviour in the longer term. Participants who labelled themselves used it as a means of legitimising behaviour which might otherwise be seen as unjustified, while those who were offered treatment on the basis of a clinical diagnosis appeared to find the experience impersonal, patronising and invalidating.

Participants' gender also appeared to invalidate participants further as it placed them in the minority even among those who self-harm. Its precise influence on their behaviour and its management was not immediately clear as most participants appeared to have difficulty in responding when asked what being a man meant to them. The failure of many participants to answer the question indicated that it may not have been something to which they had previously given a great deal of thought. Nevertheless gender is known to exert a powerful influence on people's perceptions of themselves and their bodies. Babiker and Arnold (1997) suggest that both men and women are subject to demands and expectations about what is acceptable behaviour for their gender and these are also likely in turn to influence the management of self-harming behaviour. These differing social influences are reflected in differences in the self-harming behaviour of men and women. Babiker and Arnold (1997) further state that within Western culture masculinity is associated with a rational rather than emotional outlook on life and that men are generally discouraged from showing signs of emotional weakness or vulnerability such as crying. One emotion they claim is more associated with men than with women is anger and this often manifests in more violent and bloody methods of self-harm such as punching walls. While the reasons participants in the current study gave for their self-harming behaviour did appear to reflect some of these societal expectations, most did not report violent outbursts and those few who did appeared to have been drunk at the time. These violent outbursts were presented as isolated incidents and seemed to be more related to participants' consumption of alcohol than their gender.

The principal reason participants gave for their self-harming behaviour was to regulate their own emotions, although by doing so, some claimed to be also trying to protect others at the same time. This behaviour reflects the expectations associated with the dominant stereotype in Western culture of the strong, silent male. Although no participant explicitly identified with this stereotype it was nevertheless something that they all seemed to endorse through their behaviour by trying to keep their feelings hidden and attempting to be strong to protect others. While deliberate self-harm helped preserve their masculinity in the public domain by keeping their emotions in check it was perceived by participants as fake because of the effort involved in maintaining it. Regardless of whether or not participants perceived themselves as masculine it appeared important to some of them that this was how they were perceived by others. However,

maintaining this public image required a sustained effort that seemed to increase their emotional distress and make the management of their self-harming behaviour even more difficult.

Societal expectations and prejudices about gender also appeared to be reflected in the way professionals responded to participants who sought treatment for their self-harm. Participants' concerns that they would be told to 'grow up' when they sought help for their behaviour appear to have been well founded in some cases as this was the response they claimed to have received. While participants' sensitivities to perceived rejection may have played some part in their interpretations there is nevertheless evidence to suggest that health professionals can be more judgemental of men who self-harm in comparison to women and treat them differently. It has already been suggested, for example, that one of the reasons why self-harm appears to be less common among men than among women is that male self-harm is more likely to be dismissed as typical male behaviour or recorded as an 'accident' (Clarke and Whittaker,1998).

The struggle for control

One of the principal concerns for participants in the management of their self-harming behaviour appeared to be covering up their behaviour and keeping it hidden from others. The principal methods of deliberate self-harm used by participants were cutting and burning and a common concern for all of them appeared to be the scars that were the inevitable result of their behaviour. While the behaviour itself could be kept a secret, the scars were less easy to conceal from others because they were a permanent reminder of their self-harm and could not be easily explained away. Participants attempted to cover them up either by wearing long sleeves or by having excuses prepared should someone see them.

Participants' descriptions of their behaviour indicated that they took great care to keep it hidden from others as much as possible and this appeared to include tending their wounds where necessary. Although this care of the self may seem antithetical to the popular perception of self-harm as a self-destructive behaviour, it makes sense in terms of the desire to conceal the behaviour from others as any infection would be likely to need medical attention. This kind of public exposure appeared to be the last thing that

participants wanted so it was in their interest to look after their wounds properly if they wanted to continue to cover up their behaviour. Tending one's own wounds in this way is also consistent with the concept of deliberate self-harm as 'self soothing' rather than self-destructive behaviour as it provides those who self-harm with an opportunity to demonstrate care for the self and experience some physical comfort by nursing their own wounds (Babiker and Arnold, 1997).

The growing number of qualitiative studies and self-help publications attempting to give those who self-harm a voice mentioned in the introduction (Sutton, 2007; Strong, 2000) also stress the significance of scars to those who self-harm. They suggest that these scars hold multiple meanings, representing shame or embarrassment to some while to others they are a proud reminder that the pain they have experienced is real or perhaps a testament to their ability to survive it. In the current study these individual differences not only varied between participants but also appeared to change for some individuals over time as they began to manage their behaviour differently. One participant described how previously he had always regarded his scars like tattoos as a kind of life history etched on his skin. Having managed his self-harming behaviour, however, these same scars appeared to become less benign and came to represent an unwelcome reminder of a time when he was particularly unhappy. This participant's experience reflects some of the complexities involved in deliberate self-harm and emphasises the importance of personal meanings in managing the behaviour. Given the many different meanings that scars appear to have for those who deliberately harm themselves it is small wonder that many people, therapists included, are unsure how to respond when confronted with them.

Participants' concerns about being judged by others appeared to persist to some extent even after they had managed their self-harming behaviour and seemed to provide an effective deterrent against further self-harm. They were unanimous in identifying the avoidance of further scars as one of the principal reasons for abstaining from self-harm in the future. Participants appeared particularly concerned about causing emotional distress to others and some participants continued to conceal the truth about their behaviour from their loved ones even after they had managed their self-harm. For participants in the current study the continued avoidance of scars appeared to be a powerful motivator for the continued avoidance of self-harm.

As already identified, men are generally less likely than women to seek professional help (Thom, 2003; Lee and Owens, 2002) and the current study sought specifically to target those who may not have been in contact with services. Most participants in the current study had nevertheless sought or received some kind of treatment at some stage during their struggle to manage their self-harming behaviour. They had consulted with a wide variety of professionals including doctors, psychiatrists, psychologists and counsellors and appeared to have been offered a variety of different kinds of treatment or support. While some participants claimed to have been happy with what they received, others appeared less content and two participants had avoided contact with professionals altogether.

The variety of professionals that participants consulted with and the differences in the responses they received reflect some of the complexities faced by those working in clinical or health care settings when dealing with deliberate self-harm. Its treatment is notoriously difficult because of the heterogeneous nature of the self-harming population which to date appears to have prevented the development of a single treatment that is effective in all cases. The systematic review of existing treatments by Hawton *et al* (1997) revealed that few approaches have met with any measurable success, leaving many health professionals feeling that they do not have much to offer those who deliberately self-harm other than symptomatic relief. Some participants in the current study prescribed medication by their doctor or psychiatrist found they slept better or that it alleviated their depressive symptoms, but its effects on their deliberate self-harm were unclear. Others claimed that the medication they were given made them feel worse.

The degree of autonomy which participants perceived they had over their treatment appeared to influence both their initial decision to seek professional help and its eventual outcome. The thought of losing control over their self-harming behaviour appeared to be too much to bear for two participants who avoided treatment altogether despite the negative consequences of their self-harming behaviour. These participants seemed particularly concerned that if they sought professional help they would be expected to stop immediately and have to cope without self-harm altogether. The loss of autonomy has been identified as a particular issue for those who self-harm as attempts to prevent the behaviour by controlling it can prove counterproductive. Clarke and Whittaker (1998) suggest that autonomy is the greatest ally of those who self-harm in managing their behaviour and that they should be given responsibility for their own

behaviour. As already mentioned, the need for those who deliberately harm themselves to have choices and to be fully involved in clinical decisions about treatment options has now been recognised and incorporated into the clinical guidelines developed by the National Collaborating Centre for Mental Health (NICE, 2004). Clarke and Whittaker (1998) also maintain that those who self-harm are particularly sensitised to hostile reactions from health care staff which serve to reinforce their existing feelings of inadequacy or self-loathing and make further self-harm even more likely.The experiences of participants in the current study appear to offer some hope as a few reported positive experiences of treatment, although the negative attitudes or judgemental responses encountered by others suggest that despite growing awareness of the phenomenon judgemental attitudes among professionals nevertheless persist.

Participants in the current study appeared to give a clear message that what they wanted from treatment was to be listened to and understood as people by discussing their feelings as well as their behaviour. Where this had occurred participants reported positive experiences of treatment that seemed to help with the management of their self-harming behaviour, while those who encountered health professionals who solely addressed their behaviour seemed to fare less well. Participants appeared to relate better to those with whom they already had an existing relationship or were able to spend time developing one, such as a family doctor or counsellor. Their responses appeared to provide a validating experience that helped to combat the self-criticism and negative affect that accompanied and contributed to participants' self-harming behaviour. Taking time to get to know the person behind the behaviour is a time consuming activity and is probably best delivered by someone who already has an existing relationship with the person who self-harms. Qualitative research of patient experiences (Bywaters and Rolfe, 2006; Sinclair and Green, 2005) has indicated that secondary services may only have a limited impact on people who self-harm because of the difficulties they have in engaging with unfamiliar staff. Participants in the qualitative study by Sinclair and Green (2005) stressed the importance of someone outside the family who was able to give them time to talk and to listen to their story. While their results must be treated with caution as their participants presented to hospital following an episode of self-poisoning, they are nevertheless useful as an indicator of the needs of those who deliberately self-harm. They suggest that when dealing with those who self-harm the quality of the therapeutic relationship is of greater importance than a professional's level of expertise in dealing with the phenomenon. The therapeutic relationship has

been found to be of prime importance to a successful outcome in all forms of therapy (Nathan, 2006). Counselling psychologists are well placed to provide this kind of support because of the primacy of the therapeutic relationship within their practice and the variety of settings within which its practitioners work.

One unexpected finding of the current study was that even unhelpful experiences in treatment sometimes produced a positive outcome for participants. While some avoided treatment altogether others relied on the help of professionals when they felt that their behaviour had got out of hand. Their lack of intrinsic self-worth meant that they had little faith in their own ability to manage their behaviour and participants appeared to delegate this responsibility to medical professionals, who were afforded elevated status. Putting such faith in medical professionals did not always seem to be well founded however as the outcome of treatment was not always a favourable one. When treatment failed to provide the outcome they hoped for participants appeared to perceive that the medical professionals in whom they had placed so much trust had let them down. Where treatment was perceived as having failed to address their deliberate self-harm it nevertheless appeared to provide some participants with the motivation to take responsibility for their own behaviour. The realisation that even the professionals could not be relied upon to help them seemed to encourage participants to make more of an effort to manage their behaviour for themselves.

While participants began self-harming as a way of regulating their emotions and staying in control, many encountered problems with the ongoing management of the behaviour itself. A number of them reported an escalation in the frequency or severity of their deliberate self-harm over time as they struggled to maintain control over their emotions and their behaviour. A number of participants used the language of drug use to describe these experiences and several parallels may be drawn between self-harm and drug using behaviour. Participants' initial experience was that self-harm provided a means of emotional regulation when nothing else seemed to work. Despite the negative consequences of their self-harming behaviour participants appeared to exaggerate the benefits and downplay the costs in justifying their behaviour to themselves, just as drug users do. The initial effects of self-harming behaviour also appeared to provide some participants with a drug-like 'high'.

While participants in the current study initially appeared to believe that self-harm gave them control over their feelings, a number of them reported that over time the behaviour escalated in frequency or severity so that they had to cut themselves more often or were having to cut deeper to get the same effect. Participants likened their increasing tolerance to the effects of self-harm to the way a drug user becomes accustomed to the effects of his or her chosen substance over time. One possible explanation for this increasing tolerance lies in the way the body is thought to respond to self-harming behaviour. Biological explanations of self-harm have proposed that the behaviour encourages the release of endogenous opioids within the body that have a soothing and analgesic effect (Brophy, 2006). There appear to be difficulties with this explanation, however, as the precise relationship between self-harm and the release of these chemicals is not well understood. It has been proposed, for example, that it is the emotional stress preceding self-harm that encourages their release rather than the act of self-harm itself (Babiker and Arnold, 1997). While there does not appear to be any evidence that those who self-harm become dependent upon these chemicals or their effects, addiction nevertheless appeared to provide a useful metaphor for participants in the current study when describing the struggle they had to maintain control of their behaviour. It has been proposed that as self-harming behaviour becomes more frequent or more severe the body becomes accustomed to receiving a higher level of endogenous opioids and that a greater level of harm may be needed to receive the intended effect (Brophy, 2006). This effect may help to explain the tolerance that participants claimed to have developed to the effects of self-harm and provide a possible explanation for some of the difficulties they experienced in managing their behaviour.

The metaphor of drug use is a convenient one for men who self-harm. It is more harmonious with concepts of masculinity than talk of emotional regulation as drug use itself and particularly notions of tolerance can be seen as a masculine activity while open displays of emotion are not. Although therapists seem reluctant to describe self-harming behaviour as an addiction (Strong, 2000), some nevertheless concede that it can be habit-forming as those who self-harm appear to experience strong cravings and withdrawal symptoms if they are unable to indulge in the behaviour. Babiker and Arnold (1997) warn against formulating self-harming behaviour as an addiction, however, because of the negative associations that such a label implies. They maintain that this kind of labelling pathologises self-harm and can lead to a simplistic response that is focused purely on tackling its symptoms. Focusing on the behaviour in this way

and ignoring the person behind it is likely to prove invalidating for those who self-harm and may make the behaviour worse, as some participants in the current study experienced when they sought help with their behaviour. Babiker and Arnold (1997) instead favour an open discussion focusing on how self-harm has addictive qualities but can nevertheless be interpreted as an understandable response to emotional pressure as it helps people to avoid unpleasant experiences or feelings such as anxiety. They argue that such explanations provide a validating experience which helps those who self-harm to understand their behaviour as a rational if maladaptive response rather than an addiction. This understanding is likely to have a beneficial effect on the management of their behaviour as it discourages negative labelling and encourages acceptance. Counselling psychologists working with those who self-harm are likely to have a good working knowledge of the mechanisms and effects of reinforcement from their studies. The utilisation of this knowledge may prove invaluable in helping clients to understand the influence of negative reinforcement on their self-harming behaviour.

One substance which did appear to directly influence the ability of participants in the current study to manage their self-harming behaviour was alcohol. It is suspected that one of the reasons why fewer men than women self-harm is that men are more likely to turn to alcohol or drugs rather than self-harm to try and block out or numb their emotions and some participants in the current study certainly reported doing so. However, while alcohol can prove effective in blunting emotions its disinhibiting effects unfortunately not only make self-harming behaviour more likely but also make those who do so more inclined to take risks (Thom, 2003). Although some participants in the current study reported using alcohol as a way of regulating their emotions a few also experienced episodes of deliberate self-harm after drinking. These participants appeared to be more reckless with their behaviour, taking less care of themselves while cutting under the influence of alcohol, and some reported bloodier or more violent methods of self-harm. Although alcohol consumption and binge drinking are both on the rise among women in the UK, men nevertheless continue to consume alcohol more often and in greater quantities than women do. The behaviour of participants in the current study while under the influence of alcohol suggests that given their higher levels of consumption alcohol is more likely to be an issue for men than for women in the management of their deliberate self-harm.

Validation of the self by others

Despite early attempts at disclosing to others which had often proved invalidating and strengthened participants' determination to hide their behaviour, many eventually seemed to develop close relationships with others who they trusted enough to be able to discuss their behaviour and received a more positive response. Many participants described one particular close relationship of empathy with another person that allowed them to manage their self-harming behaviour better. These relationships appeared fundamental to the effective management of their behaviour as they provided participants with the validation they desperately seemed to need and a vital challenge to the expectation that others would judge them in the same way that they judged themselves. In some cases the mere offer of support seemed enough to provide participants with the validation they needed or at least enough of an incentive to try and manage their self-harming behaviour differently. Participants described a variety of encounters with friends, family members or professionals that proved validating for them and helped with the management of their deliberate self-harm as they provided an alternative means of regulating their emotions.

Despite their fear of being judged or rejected it appeared that participants welcomed the opportunity to share some of their distress with someone who they felt was able to listen empathically to their concerns. Although self-harm is often characterised as a hidden and secretive behaviour, accounts drawing on the experiences of those who self-harm (Babiker and Arnold, 1997; Pembroke, 1994; Strong, 1990) recognise this need and have long advocated a more empathic approach to its treatment. In a paper considering the ability of mainstream services to provide meaningful care for those who self-harm, however, Simpson (2006) suggest that professional relationships based solely upon empathy may not be enough and can prove isolating for those who feel that their emotional burden is too much to bear on their own. Simpson stresses the need for increased understanding beyond the usual parameters of therapeutic working and suggests that those who self-harm have a need for companionship rather than mere empathy. This sentiment is echoed by Nathan (2006), who also stresses that being technically competent is not sufficient and that an active emotional engagement with the client is a vital component of effective therapy. In the current study participants did appear to receive both empathy and companionship but these came principally from personal rather than professional relationships. The success of these relationships in

helping participants to manage their self-harming behaviour nevertheless indicates that adopting an empathic approach in therapeutic relationships with men who deliberately self-harm may help to increase the likelihood of a satisfactory outcome for all concerned.

Many participants also described more reciprocal relationships of mutual support which helped with the management of their deliberate self-harm. Participants stated that they were generally reluctant to discuss their self-harming behaviour with others but appeared more willing to disclose information about themselves when they knew that the person they were talking to also had personal experience of self-harm. These relationships gave participants the opportunity to share their experiences with someone who understood what they were going through and would not judge them for their behaviour. Within these relationships of mutual support participants could be honest about their feelings and their self-harming behaviour without holding back for fear of being judged. They seemed to provide participants with the validation that they desperately wanted but had previously not been able to receive from others for fear of being judged.

Sharing experiences with others who self-harm in this way also provided participants with an opportunity to help themselves by helping others. Offering advice and support to others seemed to allow participants a rare opportunity to feel good about themselves and provided a much needed boost to their own self-esteem. Furthermore, when the advice they gave worked for others it sometimes helped them with the management of their own behaviour by encouraging them to adopt the same strategies for themselves. The self-efficacy theory originally proposed by Bandura (1977; 1994) offers a theoretical explanation for how this might occur. It suggests that the modelling of successful coping strategies provides a vicarious experience that strengthens an individual's own belief in his ability to cope in a similar situation. It also suggests that such modelling teaches the recipient effective skills and strategies that can further increase self-efficacy. Its impact depends on the recipient's perceived similarity to the person doing the modelling and the theory proposes that it is most effective when the degree of similarity between the two is greatest. The findings of the current study suggest that those who self-harm can increase their own self-efficacy and thereby improve their ability to manage their behaviour by learning effective coping strategies from others who self-harm.

Professionals such as counselling psychologists may be wary of bringing people who injure themselves together for fear that they will encourage each others' self-harming behaviour. However, Babiker and Arnold (1997) suggest that support groups can be helpful if they are well managed and support is offered at the right time. The experiences of participants in the current study also suggest there may be potential benefits to bringing those who self-harm together for mutual support. While groups specifically for men may offer the greatest potential for learning through vicarious experience because they will probably have more in common, most participants in the current study seemed to turn to a female friend with experience of self-harm for support, It appears that mutual support for those who self-harm may be effective irrespective of gender differences although one participant was dismayed to find himself the sole male in a self-help group that was full of teenage girls.

The internet provided participants in the current study with another valuable source of information and mutual support that seemed to help many with the management of their behaviour. The majority of participants in the study were recruited from message boards on the internet where they were already active members of an online community dedicated to the issue of self-harm. These message boards provide a safe and confidential environment within which their members are able to post information, share experiences and offer each other support and encouragement. They confer the advantage of anonymity and as mentioned in the introduction have been shown to facilitate trusting relationships and encourage disclosure (Whitlock *et al.*, 2006), allowing those suffering from shame, guilt or emotional distress to seek support and express themselves more easily. While the membership of self-harm message boards appears to be predominantly comprised of adolescent females (Whitlock *et al.*, 2006), the present study appears to indicate that despite being in the minority men can nevertheless benefit from membership as participants in the study reported receiving various kinds of help and support online. One particular benefit of internet message boards is that they are not restricted by geographical or social divisions, other than access to a computer with an internet connection and language considerations, so they can potentially attract people from all walks of life and from all over the world. The heterogeneous nature of these communities can provide reassurance to those who feel marginalised by helping them feel less isolated and stigmatised. At the same time however it appears there is a fine line to be trodden between such reassurance and the legitimisation of self-harming behaviour. Whitlock *et al.* (2007) warn against what they

have called narrative reinforcement which occurs when individuals receive subconscious justification for their self-harm by sharing similar histories and interpretations of their behaviour with others. This normalisation of self-harming behaviour was a concern for only one participant in the current study, however, and the majority of others found online support helpful in managing their behaviour. One participant who avoided treatment altogether appeared to rely principally on one particular self-harm message board for advice and support and seemed to have been successful in managing his behaviour. His experience suggests that provided adequate support is in place the effective management of deliberate self-harm can be achieved without any professional clinical intervention at all.

Findings from the present study appear to support those from existing research such as the self-report study mentioned in the introduction (Murray and Fox, 2006). These results indicate that internet message boards can provide valuable advice and support to help those who self-harm manage their behaviour more effectively. The internet is instantly accessible and available at any time of the day or night. Its global reach means that online communities can be active twenty-four hours a day and provide support for those who self-harm whenever they are in crisis. Internet support may prove particularly useful for men who self-harm as they are less likely than women to seek other kinds of help with managing their behaviour. Counselling psychologists working with young men who self-harm may therefore find that the internet provides a useful adjunct to therapy provided its use complements therapeutic goals. Whitlock *et al.* (2007) preach caution however and warn that involvement in shallow online exchanges may undermine these goals if used as a substitute for more intimate relationships in the real world.

Learning to live with a new self

The management of participants' self-harming behaviour brought with it an increasing acceptance of their self-harm that was in stark contrast to their original perceptions of their behaviour. While originally they had viewed their self-harming behaviour as shameful, deviant and a weakness, they later came to see it as a coping mechanism that had brought its own problems but had nevertheless helped them through a difficult period in their life. While participants were relieved to have managed their behaviour

and appeared reluctant to return to it in the future they did not rule out the possibility of further self-harm altogether. The behaviour had provided participants with what they perceived was an immediate and effective means of emotional regulation when nothing else had seemed to work. They seemed to feel reassured and comforted by the thought that the behaviour was still there as a last resort should they have need of it again and some found the prospect of a future without the behaviour daunting. This simple reappraisal and recognition of the behaviour as a useful if somewhat risky coping mechanism itself seemed to help participants to manage their behaviour better. This acceptance of their deliberate self-harm appeared to have allowed participants to become more forgiving of themselves and their behaviour, thereby removing one of the sources of their emotional distress and reducing the likelihood of further self-harm.

One surprising element of participants' acceptance of their self-harming behaviour, given the difficulties that it had caused for them in the past, was their reluctance to rule out the possibility of turning to it again in the future. Despite the struggles participants had reported in their attempts to manage their behaviour self-harm nevertheless appeared to maintain its hold over them as a promise of relief from unbearable emotional pressure. Participants' acceptance of the behaviour as an intrinsic part of the self seemed to have facilitated its integration with their existing repertoire of coping strategies. Rather than being seen as a deviant behaviour it had come to be viewed as a useful coping mechanism which participants did not intend to use but could nevertheless be drawn upon in an emergency if necessary. Despite the mounting costs attached to the behaviour and the negative consequences that had initially encouraged participants to attempt to manage their behaviour the majority seemed content with a life of managed self-harm rather than total abstinence. For participants in the current study the resolution of their behaviour appeared to mean accepting that self-harm was a part of who they were and having the power of choice over whether to use it or not. The apparent reluctance of those who deliberately self-harm to abandon the behaviour altogether has already been identified in some existing studies using qualitative methods. In one such study of adults aged 16-49 (Bywaters and Rolfe, 2002) only two out of twenty-four participants said they had stopped altogether even though the majority had avoided self-harm for months and some for a year or more. The notion of managed self-harm as opposed to complete abstinence appears to remain unpalatable to professionals, however, even though acceptance of the behaviour is increasingly promoted as a first step in tackling the behaviour (Lynch *et al.*, 2006; Nathan, 2006), particularly in DBT

which has the strongest empirical support for effectiveness. Deliberate self-harm is characterised within much of the clinical literature as a non-normative, dysfunctional behaviour. To those who self-harm, however, the behaviour is functional and represents a coping mechanism that provides relief from overwhelming emotional pressure (Gratz, 2007; Klonsky and Muehlenkamp, 2007). The report of the national enquiry into self-harm among young people (Brophy, 2006) recognises this tension that exists between the expectations of professionals and the reality of those who deliberately self-harm. The report states that many professionals equate recovery with the cessation of self-harm but points out that those who want to stop still find it a long and drawn out process whether they are in contact with services or not. Their immediate priority, the report claims, is achieving a sense of well-being which may initially involve some form of managed self-harm. While many participants in the current study stated their intention to continue to avoid self-harm in the future at the time of interview none of them appeared willing to rule it out completely. For them it appeared that managed self-harm was the reality and that the resolution of self-harm, in terms of complete abstinence from the behaviour, remained a distant and perhaps unattainable goal.

Participants' acceptance of the urge to self-harm rather than attempting to resist also appeared to help them to manage their behaviour more effectively. While many stated that distraction had proved an effective strategy in dealing with the urge to self-harm in the short-term, the use of willpower alone appeared to be somewhat less effective. The use of willpower may not have succeeded as thought suppression has been found to be an unsuccessful strategy for dealing with unwanted thoughts or emotions. Gratz (2007) describes how attempts to control thoughts by suppressing them have been shown to produce a paradoxical effect that increases their frequency, severity and accessibility and how the same effect has also subsequently been found for emotions, a potentially disastrous situation for those who have problems with regulating their emotions. Gratz (2007) suggests that successful emotional regulation be conceptualised as the ability to tolerate rather than avoid negative emotions and engage in goal-directed behaviours that perform a self-soothing function. The paradoxical effect of the attempted suppression of thoughts and emotions appeared to be borne out in the experiences of some participants in the current study, whose attempts to resist the urge to self-harm through pure willpower alone seemed to lead to further self-harming behaviour. Acceptance of the urge, on the other hand, acknowledged the desire to self-harm but also offered participants a choice. The exercise of autonomy in this way appeared to produce a

paradoxical effect of its own, as acknowledging the desire to self-harm seemed to alleviate or even remove the need for it altogether, as these participants experienced less emotional distress as a result.

Whether or not the choice to self-harm was eventually made depended not on willpower but an individual's sense of self-efficacy. Participants' urges to self-harm reflected an internal battle between the desire to remain in control and the temptation to succumb to the urge. According to Bandura's theory of self-efficacy (Bandura, 1977) this conflict demands an active coping response which helps explain why distraction seemed an effective strategy for many participants in managing their behaviour while thought suppression or willpower was not. Repeated success in coping with situations where the urge to self-harm was strong appeared to increase participants' self-efficacy and was reflected in their increasing confidence in their ability to manage their behaviour and resist the urge to self-harm over time.

Participants' management of their self-harming behaviour also appeared to force a confrontation with aspects of the self that they had previously denied to themselves and to others. While participants did not appear wholly happy with themselves even without the behaviour they nevertheless seemed to have achieved a more balanced view that allowed them to view their faults in their proper perspective. This acceptance of self appeared important to the continued management of self-harm as it seemed to address the negative self-evaluation that maintained the behaviour. Participants continued to experience the thoughts and feelings that had previously contributed to their self-harming behaviour but no longer seemed to be overwhelmed by them and did not seem to spiral into the same vicious cycle of negative self-evaluation and negative affect that they had previously experienced. Their negative thoughts and feelings appeared to more contextualised and less global and their explanations for their behaviour more linked to particular situations or mood states. Identifying and isolating these situations presented the opportunity for participants to develop specific strategies for dealing with these situations.

While all of the participants who took part in the current study had managed between three months and three years without resorting to self-harm, many of them reported a residual urge that persisted despite their efforts to manage their behaviour. Participants did not appear to have too much difficulty in dealing with these urges, however, and

appeared to have developed a range of cognitive and behavioural strategies for dealing with them. Nevertheless the existence of this residual urge to self-harm suggested that a powerful association had been formed between trigger situations and self-harming behaviour. What seemed to prevent participants from reacting automatically as they had done in the past were an awareness of the consequences of the behaviour and the ability to weigh up its costs and benefits before succumbing to the urge to self-harm.

The findings of the current study highlight the commitment and determination that was needed for participants in taking action to manage their deliberate self-harm. Their journey from negative self-evaluation to self-acceptance appeared to be a long and arduous process that took participants some time to achieve even when they were in contact with treatment services. For many participants self-harm had provided the only effective means of coping with difficult circumstances or overwhelming emotions and until they developed alternative coping strategies many were reluctant to abandon the behaviour. Even after managing for some time without deliberate self-harm participants appeared reluctant to abandon it altogether. For most the management of their deliberate self-harm appeared to mean accepting the behaviour as an intrinsic part of the self and one of a range of possible coping strategies that they could draw upon if necessary.

Counselling psychologists who come into contact with men who deliberately self-harm may need to address their own expectations about their clients' behaviour as any attempt to stop them from deliberately harming themselves may disrupt the therapeutic alliance and even lead to an increase in the client's emotional distress and self-harming behaviour. It appears instead that a more collaborative approach that validates the client's experiences, respects his autonomy and acknowledges the person behind the behaviour is more likely to lead to a mutually satisfactory therapeutic outcome.

Limitations of study

The present study concentrated on a small, self-selected sample of eight men within a fairly narrow age band and its results may not be generalised to the wider population of men who self-harm. The young men interviewed were all white and described themselves as British in origin. Their views and experiences cannot therefore be said to be representative of young men in general and certainly not those from other ethnic backgrounds. Existing studies have already revealed differences in the rates of

deliberate self-harm between young women from different ethnic backgrounds (Hawton and Rodham, 2004) and it is possible that their experiences of managing their self-harm were also different. Further studies involving young men from specific ethnic minorities or other groups might be helpful in identifying any similarities or differences in their own experiences of managing deliberate self-harm.

One limitation of using the internet to recruit participants was that only those with access to a computer and the skills to use them were able to participate in the study. Even participants recruited through a newspaper article needed to have access to a computer as they were asked to respond by e-mail. The results may therefore be biased towards the more well-educated and well-off and cannot be said to be representative of young adult men as a whole. The focus in this study however was the individual experience of its participants and no generalisations are being made from its results. While the use of the internet may have limited the numbers of potential participants it nevertheless facilitated access to a hidden population whose contact with services had been minimal.

Participants in the current study were deliberately given as much autonomy and control as possible over the interview process. This demonstrated a sensitivity to context by allowing participants to feel more comfortable and facilitate a relationship of trust within which they would feel more able to talk about shameful or distressing experiences. Participants were allowed to choose the location of face-to-face interviews and also given the option of doing an online interview should they prefer. While this was done deliberately with the intention of maximising participant autonomy it also reduced the degree of control the researcher had over the environment in which the interview took place and this may have had an impact on the quality of the data collected as a result.

While e-mail is an established method for data collection, the current study used instant messaging software for which there do not appear to be established protocols. This proved less effective than face-to-face interviewing in terms of the amount and the quality of data collected. Nevertheless feedback from online participants during the debrief was overwhelmingly positive and some said that they had revealed information that they had never told anyone else before. The use of online interviews was considered a necessary compromise because of both the difficulties in recruiting from

this hard to reach population and the responses of some prospective participants who stated that they would not participate in a face-to-face interview. While the use of online interviewing appears to have certain advantages in recruiting from this hard to reach population, future research in the area would need to consider changes in how participants were briefed and the interview conducted to maximise the quality of the data that are collected as a result.

Conclusions

Deliberate self-harm, defined as the destruction or alteration of body tissue without suicidal intent, is a complex phenomenon that is drawing increasing attention from clinicians, the media and the wider public alike. It was traditionally considered a largely female phenomenon because many existing studies focused on hospital presentations where the majority of cases were women. More recent studies involving non-clinical populations, however, have revealed equivalent rates of deliberate self-harm among males and females (e.g. Gratz, 2001; Klonsky *et al.*, 2003). Furthermore, many episodes of deliberate self-harm go unreported (Hawton and Rodham, 2004; Sutton, 2007), suggesting that hospital presentations are merely the tip of the iceberg and that male self-harm may be more common than previously thought. Its prevalence within the non-clinical population and its association with a wide range of common mental health problems make the issue a concern for counselling psychology as its practitioners are likely to encounter young men who deliberately self-harm.

Young men who deliberately self-harm appear particularly reluctant to seek help for their behaviour. As deliberate self-harm begins in adolescence and often carries on into adulthood it may be assumed that many learn to manage their behaviour for themselves. The present study aimed to explore how young men with a history of deliberate self-harm who had attempted to manage their behaviour made sense of their experiences. A qualitative methodology using interpretative phenomenological analysis (IPA) was considered the most appropriate way to achieve this aim. Its idiographic approach and focus on personal meanings offered the opportunity to access as far as possible the lived experience of this hidden population about whom very little is known and examine the implications for counselling psychology.

Much of the existing literature has reflected professional priorities by focusing on identifying and classifying the functions of deliberate self-harm (Klonsky, 2007) and its risk factors (Gratz, 2003) or the effectiveness of treatments in preventing the repetition of the behaviour (Hawton *et al.*, 1998). The current study represented an attempt to redress this imbalance by exploring the phenomenon from the perspective of men who deliberately self-harm. It adds to the limited research that focuses exclusively on male self-harm by providing an interpretative account of the experiences of eight young adult males in managing their behaviour. Although the experiences of each participant were unique there were nevertheless similarities and a number of important common themes emerged from the process of analysis. These illustrated how self-harming behaviour was established and maintained in each case by a sense of personal inadequacy or weakness and an intrinsic lack of self-worth. This invalidated sense of self contributed to a vicious cycle of negative self-evaluation and negative affect that fed and maintained their deliberate self-harming behaviour and confounded efforts to manage their behaviour. Despite providing temporary relief from overwhelming emotions and a form of punishment for their perceived weaknesses, deliberate self-harm also contributed to further negative self-evaluation and thereby increased participants' emotional distress in the longer term.

Although gender was an explicit focus of the study the issue of masculinity did not emerge as a distinct theme from the data. Nevertheless the influence of gender was evident in participants' accounts of their behaviour and in their stated desire to be strong to protect their friends and family. This effort involved in maintaining this illusion of strength and stoicism appeared to further confound participants' efforts to manage their deliberate self-harm by contributing to the emotional distress that fuelled the behaviour. This may be a particular issue for men who self-harm because of societal expectations about gender.

The journey from self-derogation to self-acceptance was not straightforward and involved many struggles to control their behaviour. Many participants found that their self-harm increased in frequency or severity over time and likened this experience to the tolerance that drug users experience. Experiences of treatment were also varied and

participants appeared to fare best when they were treated as a person and with respect while approaches focusing purely on their behaviour alone appeared less successful.

Despite the hidden and secretive nature of their deliberate self-harm the support of others nevertheless seemed fundamental to the effective management of participants' behaviour. Developing close relationships with others who understood and were non-judgemental about their behaviour appeared to provide participants with the validation they desperately needed and helped to combat their own intrinsic lack of self-worth. Relationships of mutual support appeared especially beneficial as they offered the opportunity to give help as well as receive it. Offering advice gave participants the opportunity to learn vicariously from the experiences of others and seemed to provide a valuable boost to their own self-efficacy and self-esteem.

The internet seemed to provide many participants with a particularly valuable source of information and support that helped with the management of their deliberate self-harm. The anonymity provided by the internet would seem to make it an ideal medium for men who self-harm as they are particularly reluctant to seek help for their behaviour. Counselling psychologists working with young men who self-harm may also find that the internet provides a useful adjunct to therapy provided its use complements therapeutic goals.

One important finding of the present study was that despite the negative consequences of their past self-harming behaviour none of the participants appeared willing to rule out the possibility of further self-harm in the future. Participants appeared to have accepted their self-harm as an intrinsic part of the self. The behaviour represented an effective coping strategy, albeit one with inevitable negative consequences, and participants were reluctant to abandon the behaviour altogether. While most expressed a desire to continue to avoid self-harm in the future their reality appeared to be one of managed self-harm rather than total abstinence from the behaviour and full recovery appeared remain a distant if not impossible goal. Counselling psychologists working with young men who self-harm may have to consider how their own expectations differ from their clients in terms of therapeutic goals as it is likely that they will be reluctant to give up a valued coping strategy, at least until a viable alternative is found.

Researching the phenomenon of deliberate self-harm represented a leap into the unknown and a considerable personal challenge for me as a trainee counselling psychologist. The need for the research was evident to me as the literature on male self-harm was almost non-existent and I considered some knowledge of it essential to my practice. It was nevertheless by far the biggest project I had undertaken and represented a subject I had little knowledge or personal experience of. It was inevitable that would I enter the process with anxieties of my own and essential that I learn to manage these effectively. I did not realise at the outset however just how much of a struggle this would turn out to be.

It had been my assumption that the most difficult part of the research process would be meeting participants and interviewing them about their experiences. As a trainee counselling psychologist and inexperienced researcher I expected to find the interviews uncomfortable and was full of trepidation that they might trigger uncomfortable memories or feelings for my participants. The interviews were in fact one of the most pleasurable parts of the research process as the histrionics I expected did not occur and participants proved able and willing to discuss their experiences openly without distress. I enjoyed the short time I spent with participants and felt that the interviews were more like conversations and played to my strengths as a counselling psychologist in forming relationships of trust. This positive view proved short lived however as I soon began to worry about the quality of the data collected. As participants had not responded as I expected, I interpreted the situation negatively and convinced myself that they had not given a rich enough account of their experiences, perhaps because it would have been too painful for them. I also worried about the relative quality of the data from the online interviews and sought the reassurance of my supervisor, then discounted her advice when it did not reflect my own perceptions. These doubts haunted me throughout the research process, just as my participants were haunted by their own negative appraisals of events in their lives. I found myself dogged by feelings of inadequacy and thoughts of not being good enough, demonstrating a curious similarity to the journey I was attempting to describe by documenting my participants' experiences.

Doing the research represented the single most significant milestone on my own personal journey, begun seven years earlier, towards the award of a practitioner doctorate and eventual employment as a Chartered Counselling Psychologist. My

personal investment in a successful outcome was therefore huge and the stakes very high indeed. As I progressed with the study there were inevitable difficulties, such as problems finding participants, and when things did not go according to plan I found it difficult on occasion to keep my own thoughts and emotions in check because the potential costs of failure were enormous. I turned to techniques learned during my training for relaxation and anxiety management and realised that without them as the pressure mounted I may have turned to less adaptive and more harmful ways of coping just as my participants had. I reflected that my age and my training may have been the only things to distinguish my own experience from theirs.

Although some of their experiences were similar, each participant had his own story to tell, his own reasons for self-harming behaviour and his own way of managing it. One assumption that I made was that participants would have a clear idea of what deliberate self-harm meant to them and of how they had learned to manage the behaviour. Despite my reservations about the quality of the data, the interview process itself appeared to be a way for participants to make sense of their experience as some of them revealed that I had asked them questions that they had never thought to ask of themselves. This was the first indication that although participants had managed their behaviour, their journey was far from over. This was later confirmed through the process of analysis which revealed that for participants deliberate self-harm was a choice, albeit an ultimately self-destructive one, and something which I found to my surprise that they were reluctant to turn their back on altogether.

The interpretative account of the experiences of the eight participants in the present study broadens the scope of the existing literature by focusing exclusively on the experiences of young men in managing their behaviour. Its results cannot be generalised to the wider population of men who self-harm as a whole but is hoped that they will nevertheless help inform the future practice of counselling psychology by raising awareness of the particular difficulties faced by these young men. Their accounts suggest that the effective management of their behaviour was contingent upon establishing empathic relationships of support within which they felt listened to and understood as people. The explicit focus within counselling psychology on subjective experience, the validity of personal meanings and its focus on the primacy of the

relationship within the therapeutic encounter together suggest that its practitioners may have much to offer young men who self-harm.

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Appendix A: Consent Forms

CONSENT FORM

'The management and resolution of deliberate self-harm in young adult males'

I consent to take part in the above titled research project conducted by Luke Shobbrook, a counselling psychologist in training with the Department of Psychology at City University, London and supervised by a member of staff at that department. The research will be conducted according to the Code of Conduct and Ethical Principles of the British Psychological Society (Available online at http://www.bps.org.uk).

The purpose of the study is to explore the experiences of young men in attempting to manage or resolve their self-harming behaviour. I understand that the only requirement will be for me to participate in an interview that will take about one hour of my time.

I understand that the interview will be recorded and that the results will be transcribed and coded in such a manner that my identity will not be attached to the information I contribute. The key listing my identity and code number will be kept secure and separate from the research data in a locked file and will be destroyed when the research is completed.

This research project is expected to provide further information on the experiences of young men in managing or resolving self-harming behaviour and will increase our understanding of the psychology of deliberate self-harm. I understand that its results may be published in psychological journals or otherwise reported to scientific bodies and that I will not be identified in any such publication or report.

I understand that my participation is voluntary, that it is my right to refuse to participate and that I may withdraw my consent at any time.

I understand that discussing the private and personal issue of deliberate self-harm could potentially cause some distress. I acknowledge that my participation in this study is not expected to involve any risks of harm greater than I encounter in everyday life, however, and that all possible safeguards will be taken to minimise potential risks.

If I have any questions about any procedure in this project I understand I can contact Luke Shobbrook via email lukeshobbrook@hotmail.com or by telephone on 07797 771984 at any time during the next three months.

Name (please print)	
Signature	Date

ONLINE INTERVIEW CONSENT FORM

'The management and resolution of deliberate self-harm in young adult males'

I consent to take part in the above titled research project conducted by Luke Shobbrook, a counselling psychologist in training with the Department of Psychology at City University, London and supervised by a member of staff at that department. The research will be conducted according to the Code of Conduct and Ethical Principles of the British Psychological Society (Available online at http://www.bps.org.uk).

The purpose of the study is to explore the experiences of young men in attempting to manage or resolve their self-harming behaviour. I understand that the only requirement will be for me to participate in an interview via instant messaging that will take up to four hours of my time.

I understand that the interview transcript will be saved and coded in such a manner that my identity will not be attached to the information I contribute. The key listing my identity and code number will be kept secure and separate from the research data in a locked file and will be destroyed when the research is completed.

This research project is expected to provide further information on the experiences of young men in managing or resolving self-harming behaviour and will increase our understanding of the psychology of deliberate self-harm. I understand that its results may be published in psychological journals or otherwise reported to scientific bodies and that I will not be identified in any such publication or report.

I understand that my participation is voluntary, that it is my right to refuse to participate and that I may withdraw my consent at any time.

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If I have any questions about any procedure in this project I understand I can contact Luke Shobbrook via email lukeshobbrook@hotmail.com or by telephone on 07797 771984 at any time during the next three months.

Name (please print)	
Signature	Date

Appendix B: Demographics Form

DEMOGRAPHICS FORM

1. ABOUT YOU

Name	
Age (years)	
Occupation	
Location	
Ethnic origin	
Place of Birth	
Nationality	

Marital Status (please tick one):

☐ Married Single Separated Divorced Widower

2. ABOUT YOUR SELF HARM

At what age did you begin to self-harm?	
What is the longest period you have avoided self-harm for in the past?	

How long has it been since you last harmed yourself?

Less than 3 months 3-6 months 6-12 months 12 months or more

Appendix C : Information posted to bulletin boards

INFORMATION FOR POTENTIAL PARTICIPANTS

First of all, let me introduce myself. I am a 39 year old postgraduate student studying Counselling Psychology at City University in London. This is a three year course leading to a practitioner doctorate and registration as a Chartered Counselling Psychologist.

As part of this doctorate programme I am conducting a research project on the experiences of young adult males aged 18-30 in managing and resolving self-harming behaviour. The purpose of the research is to explore the phenomenon of deliberate self-harm from the perspective of those who do it. I have chosen to focus on men who self-harm as the majority of existing research focuses on women.

I am particuarly interested in talking to men living in the United Kingdom who have had little or no contact with treatment services, so bulletin boards are the ideal place to find participants. By conducting this research I hope to gain a greater understanding of the lived experience of men who self-harm and their personal struggle to manage their behaviour. This will help inform my own work and potentially that of other Counselling Psychologists, as the study may eventually be published.

Although definitions of 'deliberate self-harm' vary, for this study I have defined it as an act that is outside normal convention that is non-suicidal, intentional in nature and causes the destruction or alteration of body tissue. This includes behaviours such as cutting, scratching, burning, bruising, skin picking or head banging and excludes tattooing, piercing and alcohol or drug use.

To volunteer for this research project you must:

- Be male and living in the UK (preferably England)
- Be aged between 18 and 30 at the time of interview
- Have a history of deliberate self-harm as defined above
- Have avoided deliberate self-harm for at least three months

Volunteers will be offfered a choice between an hour-long face-to-face interview or a longer online interview about their experiences. Face-to-face interviews will be held at a mutually convenient location in England. The interviews will be recorded and transcribed. These transcripts will be analysed and the main themes from each combined into a shared account that will form the basis of a final report.

The interview data will be kept strictly confidential and no names or identifying information will be used in the final report. If you are interested in taking part or would like to find out more please send me a private message or e-mail **lukeshobbrook@ hotmail.com**.

Self-harm study of young men

[redacted] asked to share their stories for research

MEN aged between 18 and 30 who have a history of self-harm are being asked to share their stories to help others.

Luke Shobbrook, who works for [redacted] is conducting research into men who self-harm as part of his studies for a doctorate in counselling psychology.

He is particularly interested in speaking to men who feel that they have learned to manage or resolve such behaviour, with or without professional help.

'Self-harm behaviour among men is not well understood,' he said. 'It is not known how much of an issue it is in [redacted] but this is a chance to find out. Anecdotally, youth workers and others are reporting that they are seeing increasing numbers of both genders self-harming.'

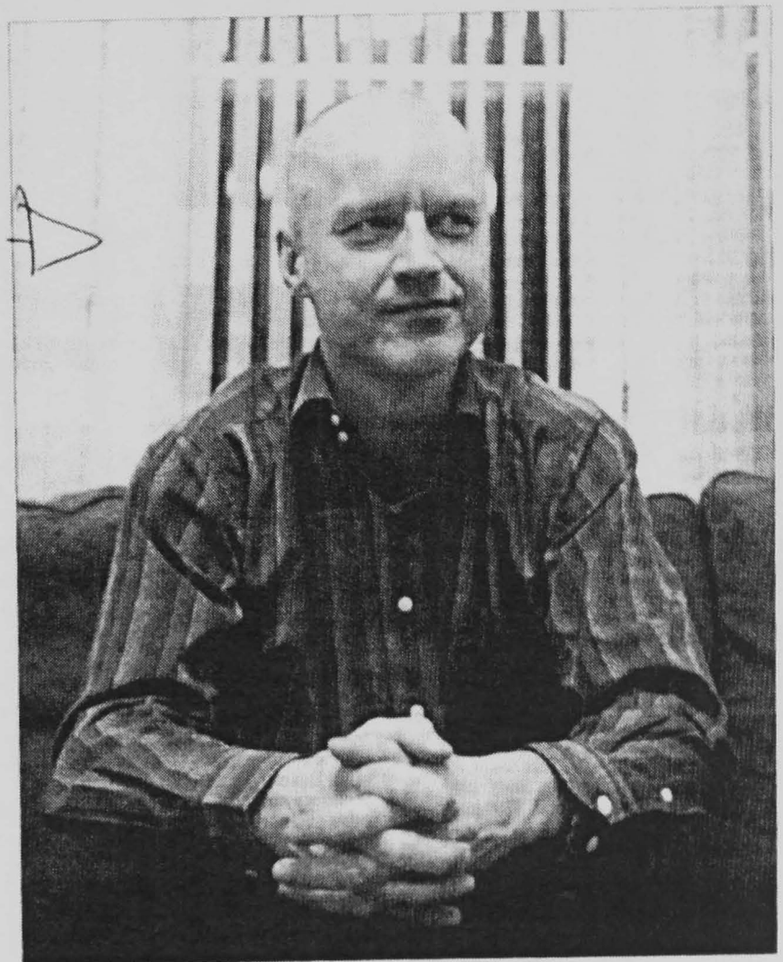
[redacted]

He added: 'The participation of [redacted] in this study will allow others to learn from their experiences and could contribute to the prevention of harm in the future.'

Mr Shobbrook explained that volunteers would be asked to participate in an interview that would last for up to two hours.

He stressed that all material would be kept strictly confidential and no identifying information would appear in the final report. The research has been approved by the City University, London, and is being supervised by a chartered counselling psychologist.

Anyone who would like to get in touch with Mr Shobbrook can contact him at lukeshobbrook@hotmail.com.



Luke Shobbrook, who is writing a thesis on self-harm Picture: RICHARD WAINWRIGHT (005354-38)

IN BRIEF

Appendix E : Interview Schedule

Warm-up questions

1. What did you have for breakfast this morning?

2. Apart from meeting me, what else do you have planned for today?

3. Who could you contact later on today if you felt that you needed someone to talk to?

Self

4. How would you describe yourself as a person?

   Prompt: *What are the qualities that make you unique?*

   What are your strengths and weaknesses?

5. If I asked your friends to describe you, how would their answers be different?

6. What does being a man mean to you?

   Prompt: *In what ways are you similar or different to other men?*

   How do you think men are expected to behave?

6. How do you feel about yourself?

   Prompt: *How happy are you with the way you are?*

   How do you find your own company?

7. How has your view of yourself changed over time?

8. In what ways has your self-harm affected your view of yourself?

9. What, if anything, about yourself would you still like to change?

Self and Self-Harm

10. Please describe the methods you have used in the past to harm yourself

    Prompt: *Cutting, burning, bruising, biting, scratching, skin picking*

11. Thinking back to when you began self-harming, what was going on for you at that time?

12. How did you feel about yourself when you began to self-harm?

13. What were your reasons for self-harming in the first place?

14. How did your reasons for self-harming change over time?

15. How did other people react when they found out about your self-harm?

16. What role, if any, does self-harm have in your life at the moment?

Management and Resolution

17. What has changed about you or your circumstances to allow you to feel that you are now managing your self-harm?

18. What resources have you found helpful in managing your behaviour?

Prompt: *Books, websites, self-help groups*

19. Was anyone else involved with helping you to change? If so, who?

20. What are your experiences of receiving professional help or support?

Prompt: *Nurse, doctor, counsellor, psychologist, psychiatrist etc.*

What was most helpful or unhelpful about it?

23. What are the benefits for you of avoiding self-harm?

Prompt: *Are there things you are more able to do now than before?*

24. What are the disadvantages or losses for you of avoiding it?

Prompt: *Is there anything you miss about it?*

Are there things you are less able do than you could before?

Ending / debrief

25. What are you most looking forward to in the future?

26. Before we finish, are there any questions you would like to ask me?

Appendix F: Self-Harm Support Services

SELF-HARM SUPPORT SERVICES

42nd Street
2nd floor, Swan Buildings
20 Swan Street
Manchester M4 5JW
Helpline: 0161 832 0169
WWW: www.fortysecondstreet.org.uk

Basement Project
PO Box 5, Aberavon, NGARY 5XW
Tel: 01783 856 524
WWW: www.basementproject.co.uk

Bodies Under Siege
WWW: http://buslist.org/phpBB/

LifeSigns
WWW: www.lifesigns.co.uk

MIND
Tel: 08457 660 163
WWW: www.mind.org.uk

National Childrens Bureau
WWW: www.selfharm.org.uk

National Self-Harm Network
WWW: www.nshn.co.uk

NHS Direct (24 hour)
Tel: 0845 4647
WWW: www.nhsdirect.co.uk

Psyke.org
WWW: www.psyke.org

Recover Your Life
WWW: www.recoveryourlife.com

Samaritans (24 hour)
Tel: 08457 90 90 90
Email: jo@samaritans.co.uk
WWW: www.samaritans.co.uk

Saneline
Tel: 0845 767 8000 (6-11pm)
Email: sanemail@sane.org.uk
WWW: www.sane.org.uk

SIARI
WWW: www.siari.co.uk

Sirius Project
WWW: www.siriusproject.org

YoungMinds
Tel: 0207 336 8445
WWW: www.youngminds.org.uk

APPENDIX G: Master table of themes

MASTER THEMES	P1	P2	P3	P4	P5	P6	P7	P8
Living with an undesirable self								
Negative evaluation of the self	2(1)	10(43)	2(30)	6(21)	4(8)	22(4)	10(28)	
Overattribution of responsibility	8(17)	6(17)	3(12)	8(36)	5(19)	12(19)	2(28)	7(40)
Perception of the self as weak or inadequate	7(40)	4(47)	3(42)	3(1)	3(21)	13(48)	6(51)	
Self-criticism and self-loathing	12(8)	3(32)	2(17)	3(1)	10(45)		8(31)	
Guilt			8(41)			12(15)	7(51)	
Unrealistic expectations of the self	14(15)	3(40)	3(37)		3(23)			
Being bullied or abused	10(3)		2(31)	3(45)	3(7)		8(38)	
Feeling judged by others	8(25)	14(39)	9(25)	6(50)	4(28)	16(31)		23(7)
Isolation and lack of support	18(18)	6(45)		5(46)		10(34)	14(26)	
Labelling the self	16(27)			6(29)	9(6)			
Perceived or feared rejection by others	19(26)	14(38)	6(13)	5(53)	4(28)	4(29)	11(37)	15(19)
Perception of the self as different to others	6(52)	3(2)		5(22)	4(17)		20(49)	3(51)
Self-regulation and self-control								
Alcohol	19(40)			6(14)		11(26)	3(30)	12(45)
Autonomy	6(45)	14(42)						17(44)
Avoidance of scars	21(38)		9(11)	8(56)			15(19)	7(34)
Opening up to others	13(8)	9(8)	6(8)		4(35)	8(14)	16(30)	23(33)
Distraction		8(24)		6(39)	6(21)	8(22)	13(23)	12(25)
Covering up	21(45)	6(48)	10(36)	1(50)	10(21)	14(10)	12(24)	18(51)
Control over treatment	17(8)	14(55)	9(22)		7(37)	8(17)	17(41)	22(2)
Loss of control over behaviour	22(38)	8(28)	5(4)	7(16)	3(47)	10(19)		19(11)
Motivation and determination	17(26)	9(23)	7(34)	7(47)	5(28)	9(23)	12(7)	17(10)
Releasing violent urge		11(7)				10(53)		
Separation of the self from self-harm	20(54)	6(37)	8(15)	5(14)				21(25)
Care of the self						11(30)		
Validation of the self by others								
Being accepted by others	15(41)	14(17)	9(48)	2(47)	8(41)	22(4)	11(18)	13(27)
Compassion							21(47)	23(1)
Empathic response	15(52)	9(10)	9(28)	8(15)	4(22)	10(5)		13(19)
Mutual support / reciprocity	15(39)	14(13)	10(7)	6(45)		22(14)	16(23)	20(2)
Reassurance		12(22)						
Being around other people						7(50)		

Re-evaluation of self-harm								
Acceptance of lapses as inevitable		15(50)	7(36)			9(3)		17(5)
Ambivalence towards behaviour	23(38)	8(16)	8(2)		3(32)		13(1)	24(31)
Diminishing benefits over time	23(21)	13(36)						
Increasing dependency on self-harm	23(22)	7(22)	8(45)		4(2)	13(25)		11(38)
Justification for self-harm	11(4)	6(43)	7(20)		3(34)	20(30)	17(48)	18(41)
Perception of self-harm as a coping mechanism	7(45)	6(50)	4(43)	6(33)	3(30)	12(11)		7(10)
Vicious cycle	11(20)							
Distancing self from self-harm					5(4)			20(46)
Learning to live with a new self								
Self-acceptance	13(32)	9(54)	4(12)	2(55)	2(45)	24(24)	18(38)	7(9)
Residual urge to self-harm	21(30)	10(4)	11(24)		5(3)	24(50)	15(10)	7(17)
External attribution of responsibility			8(42)					
Increased self-awareness and self-confidence	14(1)	15(19)	10(44)	8(47)		10(20)	6(17)	6(3)
Taking responsibility for the self	21(3)	13(29)	9(10)	7(24)	9(24)	8(18)	14(25)	24(9)
Self-efficacy	13(21)	15(30)	10(41)	2(55)	6(31)	21(9)	5(10)	19(38)
Discomfort with the 'new' self		16(16)	11(33)	9(5)	6(40)			

Part Two

Professional Practice

Client Case Study

A case study of co-morbid alcohol abuse and social anxiety

Part A: Introduction and the start of therapy

Introduction

This case study describes a six week course of brief cognitive behavioural therapy (CBT) with Tom*, a 24 year old white male with co-morbid social anxiety and alcohol misuse. I have chosen this client to write up as a case study because I believe this intervention demonstrates my ability to confront and work flexibly with multiple issues simultaneously which I believe is one of the key challenges of clinical practice as a Counselling Psychologist.

**The client's name and all other identifying information have been changed to protect client confidentiality*

Theoretical orientation

The cognitive behavioural approach developed by A.T. Beck (1976) proposes that emotional problems such as anxiety and depression are influenced and maintained by distorted thinking processes of which an individual may or may not be aware (Sanders and Wills, 2005). These processes are highly idiosyncratic as a person's appraisal of events is influenced by his or her own unique experiences and personal history. The aim of CBT is to work collaboratively with the individual client to identify and challenge these distorted thinking patterns and the underlying beliefs that influence them (Sanders and Wills, 2005).

Social anxiety is defined as an exaggerated fear of social or performance situations (Book and Randall, 2002). It usually becomes manifest during adolescence and is commonly associated with a history of shyness or anxiety in childhood (Veale, 2003). A cognitive model of social anxiety has been developed (Wells, 1997) which suggests that those who experience it maintain dysfunctional beliefs and assumptions about themselves that are activated in social situations. A core feature of the model is a fear of negative evaluation (Veale, 2003; Wells, 1997) and this often leads to an increase in self-processing and self-conscious thoughts in social situations. This preoccupation with the self increases anxiety and reduces the ability to focus externally, compromising social performance, preventing the accurate appraisal of others' behaviour and reinforcing the negative evaluation of the self (Wells,1997).

Those who suffer from social anxiety often engage in actions known as 'safety behaviours' (Salkovskis, 1991) that are believed to avoid or prevent the feared consequences of exposure in social situations (Thwaites and Freeston, 2005). Typical safety behaviours include drinking alcohol and avoiding eye contact (Veale, 2003). These behaviours are often counterproductive and maintain social anxiety however by impairing performance or attracting unwanted attention. Furthermore the absence of feared consequences in social situations is often credited to the use of safety behaviours while the distorted beliefs that maintain the problem remain unchallenged (Wells, 1997).

People with high levels of social anxiety claim that alcohol helps them cope in social situations (Book and Randall, 2002). One explanation for this effect is that alcohol use helps alleviate anxiety symptoms (Corrigan and Randall, 2003; Lingford-Hughes *et al.*, 2002) and those suffering social anxiety self-medicate with alcohol (Morris, Stewart and Ham, 2005). Not everyone with social anxiety uses alcohol in this way however and it is suggested that gender, situational context and expectancies about drinking can all influence whether or not this occurs (Book and Randall, 2002; Morris, Stewart and Ham, 2005). Morris *et al.* (2005) recommend a combined treatment for co-morbid social anxiety and alcohol misuse that directly addresses drinking expectancies and attitudes towards alcohol and the CBT approach offers an ideal way to do this. While there is some evidence that pharmacological therapies can be effective in the treatment of social anxiety (Veale, 2003) CBT has been shown to be at least as effective (Veale, 2003) and its effects more enduring (Book and Randall, 2002).

One therapeutic approach that has proven efficacy in the treatment of non-dependent alcohol misuse is motivational interviewing (Burke *et al.*, 2003). Motivational interviewing (MI) is a directive, client-centred method for enhancing intrinsic motivation to change by exploring and resolving ambivalence (Miller and Rollnick, 1991). MI was specifically developed for clients who are ambivalent and is particularly suited to those resistant to change (Arkowitz *et al.*, 2008). Motivation to change is enhanced if there is a gentle process of negotiation in which the client rather than the therapist articulates the benefits and costs involved (Treasure, 2004).

Context for the work

Appointments with Tom were held at the local alcohol and drug service, a specialised clinic employing a team of psychiatric nurses and counsellors. The majority of clients of the service are aged eighteen and over and most are alcohol users. The clinic offers a number of services including detoxification and relapse prevention programmes. Where no clinical intervention is indicated, clients are offered counselling instead. This typically involves the use of person-centred therapy, motivational interviewing or cognitive behavioural therapy depending on the needs of the client.

The referral

Tom referred himself to the service. He was allocated to a counsellor as he described himself as a binge drinker and no clinical intervention was indicated. Tom specifically requested one-to-one contact, explaining that he has difficulty in group situations.

Initial impressions

Tom arrived at his first appointment dishevelled looking and appeared highly agitated. He was poorly dressed in dull, shabby clothes and was unshaven with unkempt hair. My first impression was that he looked much older than twenty-four.

Initial assessment

Although Tom appeared to have come to the service voluntarily it proved difficult getting the information needed for a comprehensive assessment of his situation as his responses to even the simplest questions were vague and often monosyllabic. He also had difficulty maintaining eye contact, preferring to look at a computer screen as we talked instead.

Tom had already had contact with the service the previous year as he had been arrested while under the influence of alcohol and a report had been prepared for the court. This court report provided valuable background information that helped with the initial assessment.

Social history

Tom appeared to have had a difficult childhood. His parents separated when he was around 5 years old and his mother later formed a relationship with another man who

was a heavy drinker. Tom consequently spent a lot of time in the pub from a young age. He continued to visit his father at weekends until he was a teenager when he says he refused to go anymore, claiming that his father used to bully him. Tom was vague about exactly what form this bullying took however and did not seem willing to talk about it. He was more forthcoming about his mother's more recent partner who he claims had been physically abusive towards him.

Tom revealed that as a child he had experienced night terrors and used to sleepwalk. He claimed to have enjoyed school although he left without any qualifications to train as a builder at a local college. He found a permanent job shortly afterwards but lost it because of his heavy drinking. Since then he had worked in various short-term and temporary contracts. At the time of his assessment Tom was out of work, living in his own flat and surviving on benefits. He would often have meals with his mother or grandmother and sometimes stayed overnight.

Client's view of the problem

Tom revealed that he had begun to drink and smoke cannabis regularly as a teenager. He claimed that both substances helped him to regulate his mood initially but later found that cannabis made him feel increasingly anxious so he stopped using it. Since then he claimed his anxiety problems worsened and he found being around other people, even family members, difficult. Tom said he had to 'psych himself up' to go out and avoided busy streets altogether. He found himself increasingly reliant upon alcohol to perform in social situations but claimed to have restricted most of his drinking to weekend binges which would begin on a Friday and carry on until he ran out of money. The rest of the time he rarely went out at all except to visit his family. Despite his anxiety, Tom claimed that he did not drink at home and preferred to go to the pub instead. His drink of choice was beer and he avoided spirits as he did not like the effect they had on him. Although he claimed to enjoy drinking Tom appeared concerned about the effects his behaviour had on others, especially his family, as he often became belligerent after drinking.

Therapist's view of the problem

Tom appeared visibly agitated during his assessment session. His behaviour and the evidence he presented together suggested that anxiety was likely to play a major role in

his misuse of alcohol. The earlier court report provided further support for this hypothesis as it concluded that Tom's principal problems were psychological. While many people experience some degree of anxiety in social situations, his evident distress, self-consciousness and avoidance behaviour were all indicative of social anxiety (Wells, 1997; Corrigan and Randall, 2003).

Alcohol seemed to serve a dual purpose for Tom. Firstly he appeared to believe that it helped relieve the symptoms of anxiety and secondly it seemed to facilitate a social life that he might not otherwise have had. This helped explain why despite the many negative social, legal and financial consequences Tom retained positive expectations of drinking. These positive expectations suggested that he would be ambivalent about change because of the perceived benefits associated with his use of alcohol (Miller and Rollnick, 1991).

Contract and aims of therapy

Tom was offered six sessions initially in line with the policy of the service. The boundaries of confidentiality were explained and his consent sought to tape sessions. While Tom appeared reluctant to forego the perceived benefits of alcohol altogether his stated aims were to reduce his alcohol consumption, avoid further conflict with his family and stay out of trouble with the law.

Part B: The development of the therapy

Therapeutic plan and main techniques used

Tom's co-morbid social anxiety and alcohol misuse presented the dilemma of which problem to address first or indeed whether to tackle both together. Opinion in the literature appeared to be divided as some authors recommend treating the alcohol misuse first (Lingford-Hughes *et al.*, 2002) while others suggest the two treatments be integrated because of the risk of relapse (Morris *et al.*, 2005). While Tom was not physically dependent upon alcohol I hypothesised that he would be unlikely to reduce his consumption unless he developed a belief that he could function in social situations without alcohol. For this reason I decided that the best approach would be to tackle Tom's alcohol misuse and social anxiety at the same time.

Tom's ambivalence towards change suggested that motivational interviewing would be a useful approach to use (Miller and Rollnick, 2001), however at the same time I was aware of the need to address his social anxiety for which CBT is the recommended approach (Book and Randall, 2002). I therefore decided upon a CBT approach to conceptualise Tom's social anxiety (see Appendix A) and elicit his thoughts and beliefs about drinking while using motivational tools to address his ambivalence about change.

Key content issues

Tom's safety behaviours were not restricted solely to those situations that triggered his social anxiety but were also manifest in our sessions together. His responses to even the gentlest questions were vague and elusive and he did not attempt to explain or justify his behaviour. His reticence to speak probably protected him from uncomfortable feelings but made progress in therapy slow as it initially prevented us from being able to access the rules, beliefs and assumptions associated with his drinking behaviour and his social anxiety. Trust appeared to be a big problem for Tom. This was not surprising given the betrayals he had suffered in the past. His cannabis use may well have been the trigger for his anxiety problems, but the beliefs and assumptions activated in social situations were likely to stem from his earlier experiences of emotional deprivation and physical abuse at the hands of male caregivers (Wells, 1997). Tom's mistrust of others made the establishment of an effective therapeutic relationship difficult and this was probably complicated by having a male therapist. At the same time these difficulties provided the opportunity to use the therapeutic relationship to test Tom's beliefs (Sanders and Wills, 2005).

As Tom referred himself to the service, it could reasonably be assumed that he recognised his drinking was problematic, however he did not appear wholly committed to change. He did not seem to lack motivation altogether as he kept turning up to appointments but he did seem reluctant to cut down his drinking even after acknowledging its role in maintaining his anxiety problems. While frustrating for the therapist this is not unusual in clients with social anxiety who often develop a belief that alcohol helps them to cope in social situations (Alcohol Concern, n.d.; Book and Randall, 2002). A key challenge during Tom's therapy was to address this belief and allow him to develop a more balanced view of his drinking that properly weighed up the

benefits against the costs. Encouraging such ambivalence is a key motivator for subsequent behaviour change (Miller and Rollnick, 1991).

While the available evidence seemed to suggest that Tom's alcohol abuse was secondary to his social anxiety, the relationship between the two is a complex one. While alcohol appears to provide short-term relief from anxiety through its impact on the body's central nervous system, this is still a matter for debate. The influence of alcohol on anxiety appears to be mediated by other factors such as gender and alcohol expectancies (Book and Randall, 2002; Morris *et al.*, 2005) and the long-term abuse of alcohol is associated with an increase overall anxiety (Lingford-Hughes *et al.*, 2002; Plant and Cameron, 2000). Tackling Tom's drinking nevertheless presented the opportunity to address at least one of the safety behaviours maintaining his anxiety and to develop more adaptive coping mechanisms for social situations. Tom appeared to believe the opposite, however, as he claimed to be unable to face social situations without alcohol so this represented another key challenge of his therapy.

The therapeutic process

The first steps in helping Tom to develop the motivation to change were to identify his alcohol consumption through the use of a drink diary (Alcohol Focus Scotland, n.d.) and decisional balance sheet (see Appendix C). These tools were chosen as they have both been shown to help with developing and maintaining motivation to change (Miller and Rollnick, 1991). The drink diary also helped socialise Tom to the cognitive model by providing him with homework to do in between sessions (Beck, 1995) thus emphasising the collaborative nature of cognitive behavioural work. It also helped tackle Tom's reluctance to talk as each week's drink diary helped provide material for discussion at the beginning of the next session.

Many alcohol users underestimate their overall consumption (Plant and Cameron, 2000) and Tom proved no exception. He appeared to be shocked by the 50 units he had consumed in the first week he kept a diary, particularly when it was pointed out that the recommended daily limit for an adult male is 3-4 units of alcohol (Spada, 2006). Although Tom was surprised by his excesses this information alone did not appear to be enough to motivate him to change. The decisional balance proved more effective in giving him a different perspective on the problem. As therapy progressed more and

more disadvantages of continued drinking were identified and as the evidence became weighted in favour of change Tom eventually made a commitment to change and set a target for reduced consumption. A copy of Tom's decisional balance sheet can be found in Appendix C.

Tom's social anxiety was not the main focus of therapy it could not be ignored altogether as it was inextricably linked with his alcohol use. The cognitive model developed by Clark and Wells (Wells, 1997) was used to educate Tom about the role of thoughts and behaviour, including his drinking, in maintaining his anxiety. This information also provided the basis for devising behavioural experiments involving the dropping of his safety behaviours although Tom remained reluctant to put himself into social situations without having a drink first.

Difficulties in the work

Tom returned to the second session of therapy with his drink diary only partially completed. While it would have been easy to put this down to his avoidance I suspected that it was more likely that his literacy skills were limited, as I remembered his lack of qualifications. He had not volunteered this information and I was reluctant to raise the issue as I did not want to jeopardise our fragile rapport. I used the opportunity to work collaboratively with Tom instead and suggested we fill some of the gaps in his diary together (see Appendix B). This provided the dual benefit of demonstrating effective collaborative working as well as tackling Tom's avoidance by confronting his drinking behaviour.

Tom had approached his doctor for a referral to the local Psychology department, who contacted me as I was mentioned in the referral letter. After seeking Tom's permission to share information I spoke with a psychologist from the department about his case. It transpired that they too had assessed Tom for a court report the previous year and their conclusions about him were very similar to my own. Tom had also previously scored highly for avoidance on a personality inventory, albeit at a sub-clinical level. Rather than duplicate appointments we agreed that I would continue to see him for the time being and refer him on once he had achieved his goal of reduced consumption.

Use of supervision

Discussing Tom's case during supervision early on allowed me to express some of my own anxieties and frustrations about the lack of communication and poor rapport between us. After our first session I was concerned that I would not be able to get anywhere with him as he was so uncommunicative and seemed almost resigned to his fate. My supervisor was able to address these concerns by explaining the characteristics of the avoidant personality and assuring me that it would take time to establish a relationship of trust. This helped to address my own anxiety as I no longer felt that dealing with Tom would be beyond my capabilities. My supervisor also advised me to consider the problems Tom would have in listening and in processing information given the excessive self-focusing that is associated with social anxiety (Wells, 1997). This allowed me to demonstrate a greater amount of patience and empathy towards Tom which subsequently appeared to improve the quality of our therapeutic relationship.

PART C: The ending of therapy and the review

The therapeutic ending

During our last session together Tom surprised me by revealing that the previous Friday he had been out but drank only orange juice. He claimed that this was the first time in years that he had not had an alcoholic drink on a Friday night. He said that it had been difficult and felt weird but appeared pleased that he had done it and this achievement seemed to represent an important step forward for him. The final session with Tom focused on consolidating his learning and on developing a blueprint (Sanders and Wills, 2005) together to help prevent a return to problem drinking. Strategies for continuing to limit his alcohol use in the future were discussed including continuing to keep a drink diary and giving someone else control of some of his money. At the end of therapy Tom was referred on to the local psychology department for further help with his social anxiety.

Evaluation of the work

Tom proved a difficult to client to work with as although he kept turning up to appointments he proved highly resistant to change. Tom's claim during the last session that he had gone a whole night without alcohol seemed such a sudden and implausible shift that I wondered whether it was genuine or born of a desire to avoid the negative

evaluation those who suffer social anxiety seem to fear most (Veale, 2003). Nevertheless, Tom seemed to have achieved his aims of reduced consumption and staying out of trouble with the law. The six sessions we had together had also offered him the opportunity to begin to challenge the avoidance of social situations that maintained his anxiety.

Learning about psychotherapeutic practice and theory

A fundamental question that arose while dealing with Tom's co-morbid social anxiety and alcohol use was to what extent his unshakeable belief that alcohol reduced his anxiety in social situations was actually true. Although many people with social anxiety appear to use alcohol for symptomatic relief its efficacy is still a matter for debate as the results of empirical research have been inconclusive (Corrigan and Randall, 2003; Morris *et al.*, 2005).At present there only appears to be limited support for this tension reduction hypothesis and some researchers even claim that the pharmacological properties of alcohol suggest it could actually increase stress (Book and Randall, 2002). This is something well worth pointing out to those suffering from social anxiety as such revelations could be used within a CBT approach to challenge a client's positive expectancies about the use of alcohol.

What did seem to influence Tom's behaviour and encourage him to consider change was an opportunity to evaluate the positive and negative consequences of his drinking. While this decisional balance technique is commonly used in motivational interviewing (Miller and Rollnick, 1991) it is also consistent with the CBT approach which employs a similar technique addressing costs and benefits to help clients resolve difficulties with making decisions (Beck, 1995) or increase motivation (Wells, 1997). Miller and Rollnick (1991) narrowly define CBT as an approach that assumes the client is already motivated to change and emphasises skills training, in contrast to motivational interviewing in which the emphasis is on building the commitment to change. This definition appears to misrepresent CBT, however, as there is scope for working with ambivalence within a CBT approach through the use of Socratic questioning (Sanders and Wills, 2005). Where client resistance is encountered, such as when they fail to complete homework tasks, it can provide valuable information about beliefs and schemas that might cause such behaviour such as pessimism about change (Arkowitz *et al.*, 2008). This information can help case conceptualization and help guide the therapy.

Wells (1997) claims that spending time with clients early on exploring the evidence for their thoughts and allowing them to come up with their own solutions makes later verbal reattribution easier. This kind of guided discovery is also recommended over the didactic presentation of the model in treating social anxiety, as clients like Tom often believe there is good evidence to support their beliefs (Wells, 1997). It would seem that a CBT approach, albeit a more non-directive one employing the careful use of Socratic questioning to elicit assumptions and beliefs, was a valid choice in attempting to address Tom's drinking behaviour and social anxiety together.

Learning from the case about myself as therapist

My first encounter with Tom invoked a strong countertransference reaction which could easily have threatened our therapeutic relationship had I chosen to ignore or suppress how I felt. I felt irritated by Tom's shifty and evasive manner and angered by his own irritation at being asked so many questions. Taking these feelings to supervision and reflecting upon them allowed me to realise that they were useful in providing further evidence for the conceptualisation of Tom's difficulties. I hypothesised that Tom's self-focusing in social situations was likely to make communication difficult as it would impair his ability to pay attention to what I was saying and formulate his own responses to questions. I also realised that the feelings of irritation I was experiencing were most likely a response to the safety behaviours he employed such as avoiding eye contact. This experiential learning provided an important insight for me into how as a therapist I am not immune from the contaminating effects of my client's safety behaviours and the need to be vigilant for such effects in the future.

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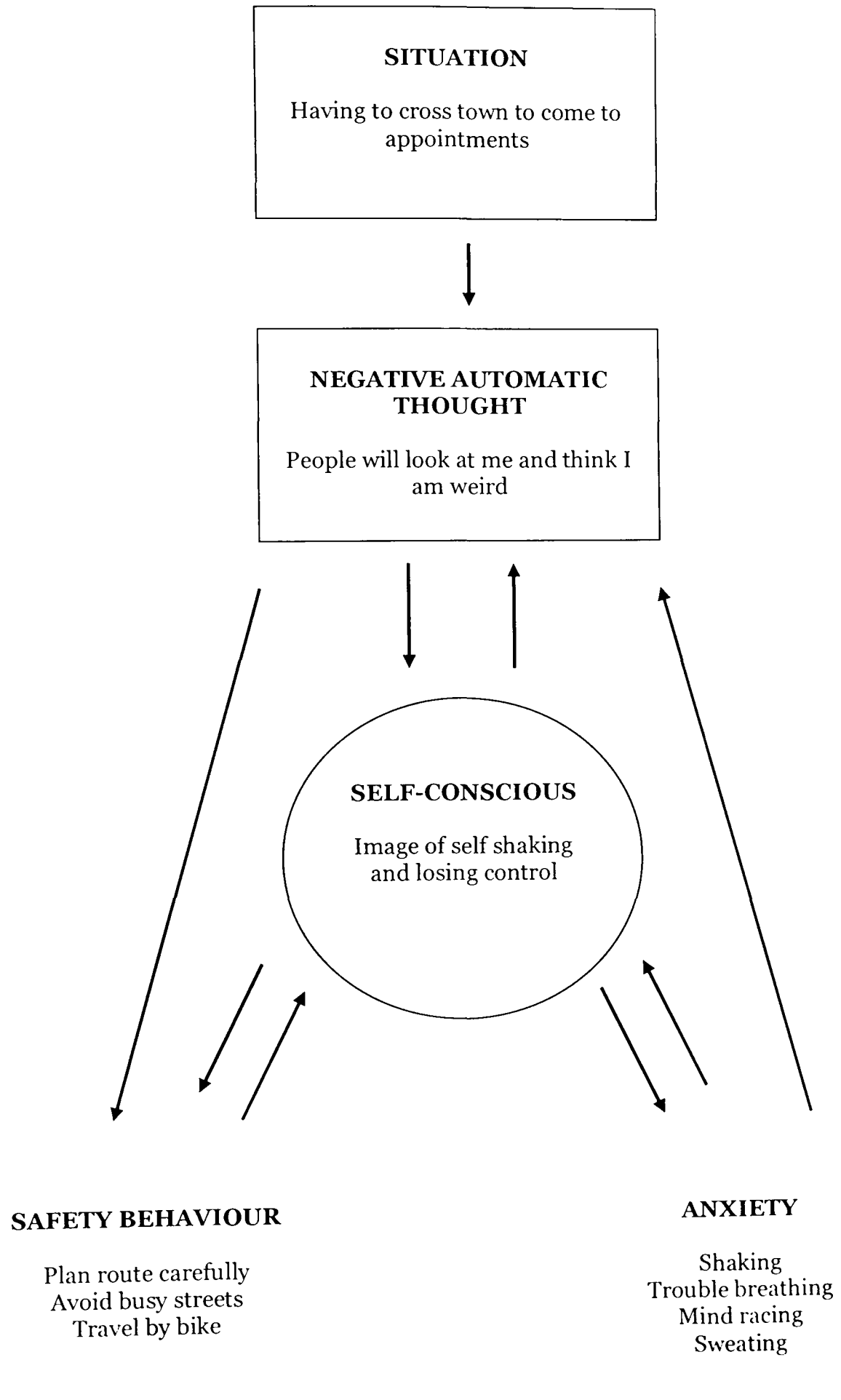
APPENDIX A

Figure 1: Cross-sectional formulation of Tom's social anxiety



(Wells, 1997)

Tom's drink diary

Diary

Day	Time	Place	People	Other activities	Money	Before	Consequences – Good and Bad	Units
Sun								X
Mon	2 hours	Pub.		—		Very anxious 80%	A bit calmer 50%	5 Pints
Tue		Pub Work's gaff.	Friend.			Very anxious 80%	Calm. 40%	5-PINTS 2 cans of CIDER
Wed			Friends					X
Thur								X
Fri		Pub				Very anxious 80%	A bit better.	DONT KNOW
Sat		Pub Work's [illegible]	[illegible]			Very anxious 50%	A bit calm 30%	8 PINTS + 8 CANS
							Total units per week	50

ALCOHOL FOCUS SCOTLAND DRINK DIARY & SELF HELP GUIDE

APPENDIX C

Figure 2: Tom's decisional balance sheet

	Benefits	**Costs**
Changing my drinking	It will be easier to find work It will make my family happy I won't have to worry as much about my health I will have more money to spend on other things	I might find it difficult to cope I will become anxious I won't be able to go out on a Friday night
Continuing to drink	It helps me to cope with difficult memories from childhood It will make me more sociable and I will come out of my shell	There will be conflict with my family especially my Nan and my Mum I will overdo it and become an idiot I will black out and not remember what I have done I will become nasty I will get into trouble with the law

(Miller and Rollnick, 1991)

PROCESS REPORT

CBT for substance misuse and anxiety : a process report

Introduction

This process report is taken from the third session of six with Robert*, an 18 year old male with substance misuse and anxiety problems. I have chosen this case as I believe that it demonstrates my ability to respond to the challenge of a complex presentation within the cognitive behavioural model.

**The client's name and all other identifying information have been changed to protect client confidentiality*

Theoretical framework

Cognitive behavioural therapy (CBT) was developed principally from the work of A.T. Beck (1976) who proposed that emotional disorders such as anxiety and depression are accompanied and maintained by distorted thinking processes that influence emotions and behaviour. These thinking processes in turn are influenced by the way knowledge is represented in memory in the form of beliefs and assumptions called schemas (Wells, 1997). These schemas are often the product of an individual's interactions with significant others early in life and are highly idiosyncratic (Sanders and Wills, 2005).

The cognitive model of anxiety proposes that problems are established and maintained by a preoccupation with danger and an underestimation of one's ability to cope with threat (Beck *et al.*, 1993). These negative appraisals activate underlying danger schemas that can lead to a worsening of anxiety symptoms (Wells, 1997). The behaviour resulting from these appraisals is often problematic. Some avoid anxiety provoking situations altogether and some turn to alcohol or other drugs for symptomatic relief (Lingford-Hughes *et al.*, 2002) while others indulge in subtle 'safety behaviours' (Salkovskis, 1991). These cognitive and behavioural responses to anxiety are assumed to protect against danger but serve to maintain the problem by preventing the disconfirmation of erroneous beliefs and assumptions (Wells, 1997).

The therapeutic relationship within the CBT framework is a collaborative one in which therapist and client work together to identify problems and develop strategies for tackling them. Its aim is to empower clients by teaching them the skills to apply CBT so that they can continue to use them to tackle similar problems themselves in the future (Beck, 1995).

The aims of the work were:

- Identify the rules, beliefs and assumptions underlying and maintaining Robert's continued substance misuse and anxiety symptoms
- Provide education about the nature of anxiety and the role of safety behaviours, including drugs and alcohol, in their maintenance
- Address safety behaviours and modify beliefs through the use of behavioural experiments and verbal reattribution techniques

Client profile

Robert lived at home with his parents, worked part-time in a specialist shop and was also a student at a local college of further education. Although legally an adult Robert seemed to retain an adolescent gawkiness that was accentuated by his tall, skinny frame. He spoke quickly with what seemed to be a nervous energy and avoided eye contact.

Referral

Robert referred himself to the local community drug team on the recommendation of his supervisor at work. At the weekly referral meeting it was decided that as Robert did not appear to have a drug dependency he could be a suitable client for counselling and was offered an assessment appointment.

Presenting problem

Robert complained of feeling somehow different to other people and described himself as the 'odd one out'. He claimed to be experiencing sudden changes of mood and to have lost control of his drug use even though the substances he was using were widely considered to be recreational drugs. Robert also claimed that he was having difficulty distinguishing between what was real and what wasn't.

Initial assessment

Robert was invited to an assessment session at the beginning of which the boundaries of confidentiality were explained and his permission sought to tape sessions. He appeared pleased to have found someone to talk to about his experiences. He spoke quickly and was sometimes difficult to follow. This appeared to be a reflection of the intensity of his racing thoughts and an indication of the inner turmoil he was facing at the time.

Background and family history

Robert was born and raised locally and claimed to come from a stable family background although he described his father as a perfectionist with high standards for himself and others. He was active in many sports as an adolescent and had not shown any interest at all in drugs at all until he was 17. There appeared to be a lot of pressure from his maternal grandmother in Scotland to avoid drugs as Robert's cousin had died from a heroin overdose and she feared that he would go the same way. While this helped him to avoid temptation during adolescence Robert said he later developed a fascination with drugs as he discovered that the terrible picture of misery and addiction his family had painted for him did not appear to reflect the reality. Many of his friends seemed to be taking drugs on a regular basis and having a really good time. His curiosity eventually got the better of him and he began to experiment with a wide range of substances including ecstasy, butane gas, magic mushrooms and cocaine during the last year.

Formulation

Robert's family history suggested that he may have come under a lot of pressure when he was younger from his perfectionist father and also from well-meaning relatives in Scotland. Although his parents were not overly critical these two predisposing factors appeared to have combined to encourage Robert to develop the belief that he was not good enough. For much of his adolescence Robert attempted to compensate for this belief by trying to make things perfect, indulging in a variety of minor obsessive thoughts and behaviours. Their ultimate failure to maintain the perfection he sought resulted in an annual ritual of renewal that Robert found impossible to resist. This ritual consisted of completely rearranging all of his possessions, indulging in an increasingly complicated process of erasing all traces of the previous year and starting the new one afresh with a 'new me'.

Since becoming involved with drugs Robert's rules for living were continually broken and this contributed to a high degree of anxiety from which he sought relief through further drug use. This had resulted in a vicious cycle of increasing anxiety and escalating drug use over recent months. Robert explained that he had tried various substances until he found those that 'worked' for him. This suggested that his reasons

for using drugs may have been functional rather than hedonistic and helped explain why he felt dependent upon them even though none of the substances he used were physically addictive. Robert appeared concerned that these substances were having a detrimental effect on his mental health. Some of the substances he was using had psychedelic effects and induced visual or auditory hallucinations that Robert claimed were more intense for him than for others. He was also concerned that the drugs he had taken had altered his brain chemistry in some way. Robert described a particularly dark period about eight weeks before coming for therapy during which he felt he was losing touch with reality and although he had not had any contact with mental health services revealed some paranoid thoughts and a couple of episodes of self-harm.

A longitudinal formulation for Robert is included in Appendix A.

Contract and counselling plan

Following his assessment Robert was offered six sessions initially in line with the policy of the service after which it was agreed that we would review his progress together and decide if further sessions were necessary. Robert's goal for treatment was to achieve and maintain abstinence from drug use.

Lead-in to the session

The focus of this report is a ten-minute segment starting thirty-five minutes into the third session of therapy with Robert. At the start of the session we agreed an agenda in keeping with the collaborative nature of CBT (Sanders and Wills, 2005). We agreed that this third session together would focus on exploring the historical background and nature of his anxiety.

Robert described a history of 'weird behaviour' which had started when he was aged 10 in the year 2000 and coincided with the change from primary to secondary school. He revealed that this behaviour was the outcome of a constant striving to achieve perfection that preoccupied his thoughts and compelled him to try to create a 'new me' at the start of each year by rearranging his room and keeping everything neat and tidy. Robert revealed that his father had also been a perfectionist and was obsessive about tidiness. The impact of Robert's obsessional thoughts and behaviour on his life were fairly mild however and he did not appear to have considered them problematic until fairly recently

when he recognised that the mental energy involved was not worth the outcome. A summary of the cognitive model of anxiety was given to introduce the idea that while Robert's thinking and behaviour could be seen as irrational by others, his context and family background meant that for him it was an entirely rational response to the problem (Sanders and Wills, 2005).

Transcript

KEY	
CL	Client turn
TH	Therapist turn
COM	Commentary

TH1 **What is says to me is not that you are different or strange or a weirdo. What it says to me is that you are human. Yeah?**

CL1 Yeah.

TH2 **And the thing about human beings is we are not perfect. We have our good points and bad points and that is what makes us human and it's not a good thing it's not a bad thing it's just that's the way things are.**

CL2 But I still will be doing like I know for a fact I will still be doing this thing on probably the day before New Year's Eve.

COM *Having summarised the cognitive model this intervention (TH1, TH2) represented an attempt to challenge and modify Robert's belief that he was somehow different or strange as this appeared to be instrumental in maintaining his anxiety.*

TH3 **Right. What makes it a fact?**

CL3 That regardless of what anyone says or whatever sort of progress I've made I will still sort of need to do it or like have to do it.

COM *As my previous direct challenge had proved unsuccessful I chose to change my approach and question the evidence that supported this belief using collaborative empiricism (Sanders and Wills, 2005) instead (TH3-TH8). Seeking Robert's opinion offered the opportunity to explore the feared*

consequences of not indulging in his annual ritual and its meaning with the aim of identifying and challenging his beliefs about what might happen.

TH4 **What would happen if you didn't do it?**

CL4 Oh I don't even want to think about it like I just …

TH5 **What are you afraid would happen if you didn't do it?**

CL5 Oh I don't know it's just not good it just doesn't feel right it just doesn't feel good at all ... like at all.

COM *Socratic questioning failed to elicit Robert's fears and also appeared to activate his anxiety as he became suddenly agitated. These sudden changes in affect are often accompanied by 'hot cognitions' (Beck, 1995, p80) and asking what was going through his mind at that moment during the session may have helped to identify one or more of these important negative automatic thoughts (NATs).*

TH6 **You would feel anxious.**

CL6 I don't know ... I don't, I don't …

COM *Having picked up on Robert's evident discomfort and resistance tried to put a name to the emotion he was experiencing. Rephrasing this statement as a question such as "Would you feel anxious?" or perhaps "What might that feel like?" may have been better as it may have opened up the possibility of exploring what Robert's own predictions were. This kind of question would have represented a more collaborative approach in keeping with the principles of CBT (Sanders and Wills, 2005).*

TH7 **Would you start to panic?**

CL7 Er probably a little bit not … yeah I actually yeah I would (laughs) cos then it would be like well I can't do it at all this year now erm yeah I can't do it at all this year I don't think I could ever start it in 2009 because I hate that number so it would be like a case of 2010 which is two years away so um I couldn't do it I wouldn't feel right doing it halfway through the year if I hadn't already

attempted it like at the start of the year. I honestly believe that if I do it this last time then that will really be the last time. I ...

COM *I picked upon the absurdity of Robert's belief and immediately challenged it.*

TH8 **Have you said that to yourself every year?**

CL8 Yeah I have just the same as like it's the same with the drugs, 'This is the last time I really believe this is the last time' and all that but like for some reason I think this is different it's like I have a bit more um something more to go for like it's yeah it was just sort of too easy in the past I can't really explain it because it would be trying to stay clean off drugs would be like a more er something more of a challenge so it would be more it'll be easier to do in a way because it'll be like I'm constantly trying to do something rather than just sort of 'Well I've got nothing to do'. I don't know can't really explain it but I just feel that this time is just right.

COM *At this point I became as confused as Robert appeared to be and did not know how to respond. An uncomfortable silence followed during which I was trying to make sense of what Robert had just said and also work out where to go next. This may have been a good opportunity to summarise what had been said or ask for clarification, both of which would have highlighted the contradictory nature of his belief that 'this is the last time'.*

TH9 **Mmmm. Okay ...**

CL9 I hadn't really like noticed about these anxiety um er like buzz type things I don't know what they are or what they are called um until like what you said last week. I don't know if I was ill or what know what I mean I was actually ill last week but after I left here I felt really good that I had talked about stuff.

COM *The uncomfortable silence seemed to provide Robert with time to reflect and the opportunity to take the lead in the session for the first time. My response was intended to encourage Robert to elucidate further.*

TH10 **It is good to talk about stuff.**

CL10 Yeah but then that um I was having all these like during college I was just having like um I don't know I just felt like I was freaking out or panicking and having like the biggest one ever and it was just like the ultimate anxiety buzz (laughs) and it wasn't good at all. And that night I mean I was shaking on the phone I couldn't speak to my mate because my hand was shaking and I couldn't even speak because I was just like just that bad and I thought 'This is me I'm trapped for life' like. I just felt really bad.

COM *Possibly encouraged by my prompt, Robert simultaneously revealed a recent anxiety episode and identified a catastrophic negative automatic thought (Wells, 1997, p4) associated with it. Although he seemed to be describing a panic attack Robert's laughter and use of the word 'buzz'.*

TH11 **Right.**

CL11 I don't know if it was just because I noticed it I don't know if I was ill but …

TH12 **It is because you noticed it yeah and that is exactly the way anxiety works**

COM *I hypothesised that what Robert was describing was a panic attack and seized the opportunity to begin socialisation by educating Robert about the cognitive model of panic (Wells, 1997) and the misinterpretation of bodily symptoms as catastrophic.*

CL 12 Oh right.

TH13 **Is because what happens is we all experience anxiety it's just that some people have they develop problems with it because they focus on the physical symptoms of anxiety and they develop beliefs about what will happen and the reason people experience panic attacks is because as soon as they start to notice the symptoms of anxiety then they worry that something terrible is going to happen and what worry does it causes you to become anxious so it's again it's a vicious cycle so that's what would have been going on for you.**

CL13 I don't know I think I might have been ill as well cos it felt I know I wasn't well like with a cold and that but it felt like just before you are about to be sick

like that sort of like rush that uncomfortable not nice rush that you get it was like that.

COM *While psychoeducation is an important component of effective CBT for anxiety symptoms (Wells, 1997) explaining the role of cognitions in such a didactic manner and in such general terms(TH13) offered the opportunity for Robert to dismiss it as the cause of his own anxiety and propose his own alternative explanation instead (CL13). Breaking it down more by explaining things step-by-step, illustrating each of stage of the panic cycle using Robert's own experience (CL10) and checking his understanding would have allowed us to build a cross-sectional formulation of the problem which would have been harder for him to refute as we would have worked on it together.*

TH14 **But you weren't actually sick.**

CL14 No I wasn't and I was sort of …

COM *By pointing out the discrepancy between the reality of the situation and Robert's appraisal of it I hoped to challenge his belief that being ill was the cause of the symptoms he was describing. This challenge could have been strengthened by asking Robert about other instances when he had felt the same way in the past and whether this feeling had ever actually caused him to be sick.*

TH15 **And that's quite common with people who get panic attacks.**

CL15 To be sick.

TH16 **To feel sick. Because I mean what happens it's to do with the effects on blood pressure you get butterflies in your stomach and that can cause you to feel sick and for a long time but you are not actually sick.**

CL16 Yeah. Well my heart was going at the same rate as it does when I am on a lot of E so and I was it was really, really pounding and it was hard and it was fast.

COM *Robert's response (CL15) indicated that he had misunderstood my point and I felt that I had to explain what I had meant in terms of the symptoms of anxiety. As a non-medical professional without even a Biology O-level to my name I felt*

my explanation lacked authority and was secretly relieved when Robert did not challenge it but moved on to discuss his heart rate instead.

TH17 **And the adrenalin would have been pumping through your system yeah. And were you sat in college in class at that time?**

CL17 Well yeah I had to get up and do like a presentation to everyone and just …

COM *This reference to adrenalin was a somewhat half-hearted attempt at further education in response to Robert's comment about his increased heart rate. Not wanting to further demonstrate my ignorance of human biology I swiftly changed the subject. In my haste to move on I missed the opportunity to ask if he experienced any other physical symptoms which could have helped with building a cross-sectional formulation of this recent panic episode.*

TH18 **Oh really?**

CL18 …but it wasn't cos of that because I don't mind about stuff like that really but it was just I think the comedown from the weekend was just starting to kick in as well because it usually does it's not like for me I don't know if it's everyone else but it's usually Tuesday, Wednesday are the worst days erm.

COM: *My interest was piqued as the situation Robert described is a textbook anxiety provoking situation for many people. Conscious of Robert's perception of himself as unusual and somehow different to others I was careful to reassure him that a midweek comedown is a normal experience for the regular ecstasy user. This reassurance was intended to provide disconfirmatory evidence that challenged his belief about being strange, to attribute the unpleasant physical and affective symptoms he was experiencing to a more rational cause and to encourage his motivation to change by reminding him of the mounting costs of continuing to use drugs.*

TH19 **Yeah that's quite common if you are taking Es.**

CL19 Yeah I don't know if that was happening as well and it was like I was thinking 'Shit I've got to get up and speak to everyone now' and I thought I was just sort of going to freeze and but then I'm not like that I don't really get nerves or

anything about going up and talking to people though erm but it was just that I was in a just …

COM *Robert's spontaneous description of some of the negative automatic thoughts associated with standing up and speaking in front of the class encouraged me to reflect his concerns. My intention was to elicit further details of this recent anxiety episode so that we could draw up a cross-sectional formulation (Wells, 1997) together and expand on my earlier explanation of the relationship between thoughts, feelings and behaviours in anxiety disorders.*

TH20 **So you were worried about freezing up and not being able to say anything when you got up in front of everyone?**

CL20 Yeah I just said to my mate cos I just said 'I'm done with all this now I'm not doing this anymore' and he was 'Do you feel like you are about to explode every five minutes?' and I was like 'Yeah that's exactly how I feel' it just wasn't good at all. Um and then I felt that I was back in that weird that place I was in a while ago but it's sort of like um well like cos the earth is a circle it's everything well the whole universe is a circle it needs this little door at the top for me to go out and get this fresh air that was out of this universe because the air in this universe isn't it's not fresh cos it's like within it's sort of trapped so I think it was like I don't know.

COM *I was confronted with a dilemma here as Robert had returned to the kind of introspection and rumination that had hampered my earlier attempts to build a conceptualisation of his anxiety difficulties (CL7). One option would have been to return to the recent panic episode he had already identified (CL10) and continue to build a cross-sectional formulation by asking what physical or affective symptoms were associated with the thought that he would freeze up (CL19). As Robert spoke however I pictured the closing scene from 'The Truman Show' in my mind's eye and chose to share this with Robert instead.*

TH21 **Yeah. 'The Truman Show'.**

CL21 All that yeah. (snigger) Yeah basically. I needed to get out and go into the real place and get this stuff.

COM *This reference to 'The Truman Show' (CL21, also see Appendix B) recalled an earlier conversation in which Robert had identified a number of films that reflected his own views about life. My recollection of this was intended to subtly demonstrate empathy with Robert and introduce the idea that the film's existence suggests that if other people share his beliefs he might not be as different or as strange as he believed. I hypothesised that normalising Robert's seemingly irrational thinking by validating his beliefs and encouraging him to accept the feelings associated with them may offer an alternative way of tackling his anxiety.*

TH22 **Yeah. You're not alone thinking that way.**

CL22 How do you mean?

COM *A sudden change in Robert's tone of voice (CL22) suggested that he had become suspicious of this attempt to empathise with his position and was perhaps becoming a little paranoid. It seemed that the thought that others might share his beliefs was not welcomed as much as I thought it would be. I concluded that in the spirit of collaborative working I should explain the ideas behind my own thinking and how it related to Robert's own beliefs.*

TH23 **Well I mean there's a well like the Matrix and all sort of that stuff. It's based on philosophy and the Gnostic kind of erm it predates Christianity that there was a kind of faith um people believing that um what most people call reality is not real. All that you know life is an illusion and that kind of stuff. I mean I think it sounds to me like what you are trying to do I guess is make sense of what is happening to you and if your belief is that you know things have to be perfect in order for you to be able to start living then of course you are going to develop a belief that because we don't live in a perfect world then you are going to develop a belief that there is a perfect world out there and all you have got to do is break out of this one ...**

CL23 Yeah (laughs)

COM *To my relief, this tentative explanation for the origins of Robert's beliefs about an alternate, perfect reality appeared to be received well and with humour. I*

therefore took the opportunity to attempt verbal reattribution once more by questioning whether there was evidence to support his belief (Wells, 1997).

TH24 **... and that things will suddenly start to be perfect and of course that makes sense you know it supports what is one of your kind of deepest beliefs. You know but um the problem with that is that what if it is not true? And what if all you have is what is here and now in this world and that if you spend your whole life trying to find something better and then you look back at the end of it and say well what did I do?**

CL24 Yeah that's like I was always thinking that this was the warm-up to the life like people used to talk about heaven and stuff and I used to think that was the life and this was like the warm-up to the life and then I used to think no what if we were all like in a little waiting room like at the doctor's and coming through to the life and this is the life and now I just see it as a life and but I mean my head's still sort of spangled with all this like where are we where is this place not just the planet Earth like the whole universe where is it like and where did all the water come from and the like I know all the countries join up together if you you know there is like Russia and all that they all join up where did all that big bit of land come from and how did it all go into a circle and how does the sun go round and what is making the Earth turn and why is a heart beating and who is God and ...?

COM *Beginning to address Robert's concerns appeared to encourage more introspection and further rumination. I hypothesised at this point that trying to change the subject yet again and return to talking about his recent anxiety episode would simply meet with more resistance so I chose to continue to address Robert's own concerns in a gentle and respectful way instead.*

TH 25 **[Laughs] And somehow if you had all the answers to these questions then everything would be okay.**

CL25 Yeah but then it'd be like we've got nothing to live for because it's like well you know I don't know it's just I'm just constantly thinking well why are we living and what is the point I mean and then I'm thinking it's better than having no senses and being nothing so that might just be the reason that because we can we are.

COM *Following Robert's runaway train of thought rather than my own agenda appeared to pay off as he finally seemed to reach a point of acceptance .*

Overview, evaluation and self-assessment

This third session with Robert represented a change of emphasis from the previous two as there was less focus on his experiences of substance misuse and more on trying to identify and conceptualise the anxiety symptoms he was experiencing. My own aims for the session were to use the cognitive model described by Wells (1997) to provide Robert with further education about the nature of anxiety problems and to challenge some of the beliefs that appeared to maintain his anxiety symptoms.

My attempts to educate Robert about his anxiety within a CBT framework using the Wells (1997) model seemed to meet with mixed success. Although there was evidence that he had developed a greater awareness of anxiety and the bodily symptoms associated with it from our last session together (CL9) Robert did not respond to my initial attempts to conceptualise the problem by exploring the feared consequences of abandoning one of his safety behaviours (CL5). Asking about the feared consequences of behaviours is an important way of accessing a client's negative automatic thoughts (Beck, 1995) however Robert's avoidance prevented the direct questioning of evidence that could have begun to modify the beliefs maintaining his anxiety. I also believe that I did not take sufficient advantage of the opportunities presented during the session to work collaboratively with Robert in developing a cross-sectional formulation of his anxiety problems. Using visual aids such as drawing out an idiosyncratic panic cycle to illustrate the relationship between the thoughts, feelings and behaviours Robert described, for example, may have been more effective than relying on didactic methods. These did not appear to work well as they were either misunderstood (CL15) or rejected (CL12) by Robert.

Another opportunity I believe I missed out on was not picking up on changes in Robert's mood during the session (CL5). Sudden changes of mood or a heightening of emotion can occur when negative automatic thoughts or images spontaneously arise during a therapy session and these can provide valuable information for conceptualisation of the client's problems (Beck, 1995). Asking the client what is going through his or her mind at that particular moment allows immediate and direct access to the 'hot cognitions' (Beck, 1995) associated with these emotions. In pursuing the conceptualisation of Robert's recent anxiety episode so doggedly however I believe I

focused too much on the exploration of past events and failed to make use of what was going on for Robert right in front of me during the session.

Although Robert had revealed at our first meeting that he feared he was losing touch with reality I hypothesised that his delusional thinking was a temporary consequence of his excessive drug use and not a symptom of a more serious psychiatric disorder. Delusions are thought to occur in 10-15 per cent of the non-clinical population (Freeman and Garety, 2005) and cause varying degrees of distress. Nevertheless, substance misuse is commonly associated with first episode psychosis and recreational street drugs such as cannabis and amphetamines have been particularly implicated in this regard (Haddock and Lewis, 2005). Consulting my supervisor about this issue provided reassurance by allowing me to place Robert's delusional thinking within the context of his anxiety problems and substance misuse. It also helped me to address my own fears about working with these thoughts as I had no experience of therapeutic work with psychosis. This understanding helped later inform the therapy by providing a rationale for Robert's delusional thinking. Robert's reference within the session to being 'back in that weird place' (CL19) fitted with the conceptualisation of his problems as a catastrophic misinterpretation of anxiety symptoms rather than a psychotic episode. His preoccupations with numbers and his belief in alternate realities appeared rather more irrational, however, and were less easily accounted for but nevertheless could be seen to make sense to him in terms of his own context (TH22).

Whenever Robert became anxious during our session he appeared to return to the obsessive thoughts and rumination that had alarmed me when we first met (CL7, CL19). I now recognised this as a strategy for avoiding anxiety and was faced with the dilemma of whether to try and continue with trying to conceptualise his problems using the cognitive model of anxiety or try and address the problem of avoidance presented by this rumination. While I did not want to encourage his avoidance I surmised that exploring the nature of his thoughts might provide the opportunity to explore the veracity of his beliefs and the utility of his rumination as a means of avoiding anxiety. Robert's rumination was functional and did not appear to cause him undue distress. Nevertheless it seemed likely that this rumination was also one of the things that made him think he was different to other people. Dropping my own agenda and giving Robert room to talk represented a more gentle and empathic approach, more in keeping with my own interpersonal style and one that offered the opportunity of reducing Robert's

discomfort by normalising his beliefs rather than trying to challenge them. This new approach led to a rich dialogue at the end of which Robert appeared to reach a point of acceptance (CL25).

Although I acknowledge the perils of therapeutic drift (Wells, 1997) and the necessity of working within a structure I am happiest when engaged in an open dialogue with a client and least comfortable when having to adopt an expert role, something I have occasionally fallen into as a way of compensating for the anxieties of being a trainee. This appeared to be reflected in the awkwardness of some of the exchanges between myself and Robert, most noticeably when I attempted to adopt an authoritative position on the relationship between anxiety and blood pressure, something I quickly realised I actually knew little about. As I have progressed through my training however I feel I have become increasingly confident with my own style of delivery and less reliant upon the expert role. I believe that this has enabled me to establish more effective collaborative working relationships with clients such as the one I eventually developed with Robert.

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Appendix A

Figure 1: Longitudinal formulation for Robert

Predisposing factors

Developmental experiences
Perfectionist father with exceptionally high standards
Pressure from family in Scotland to be 'good'
Death of cousin by suicide and loss of grandfather

Core Belief
(I am not good enough)

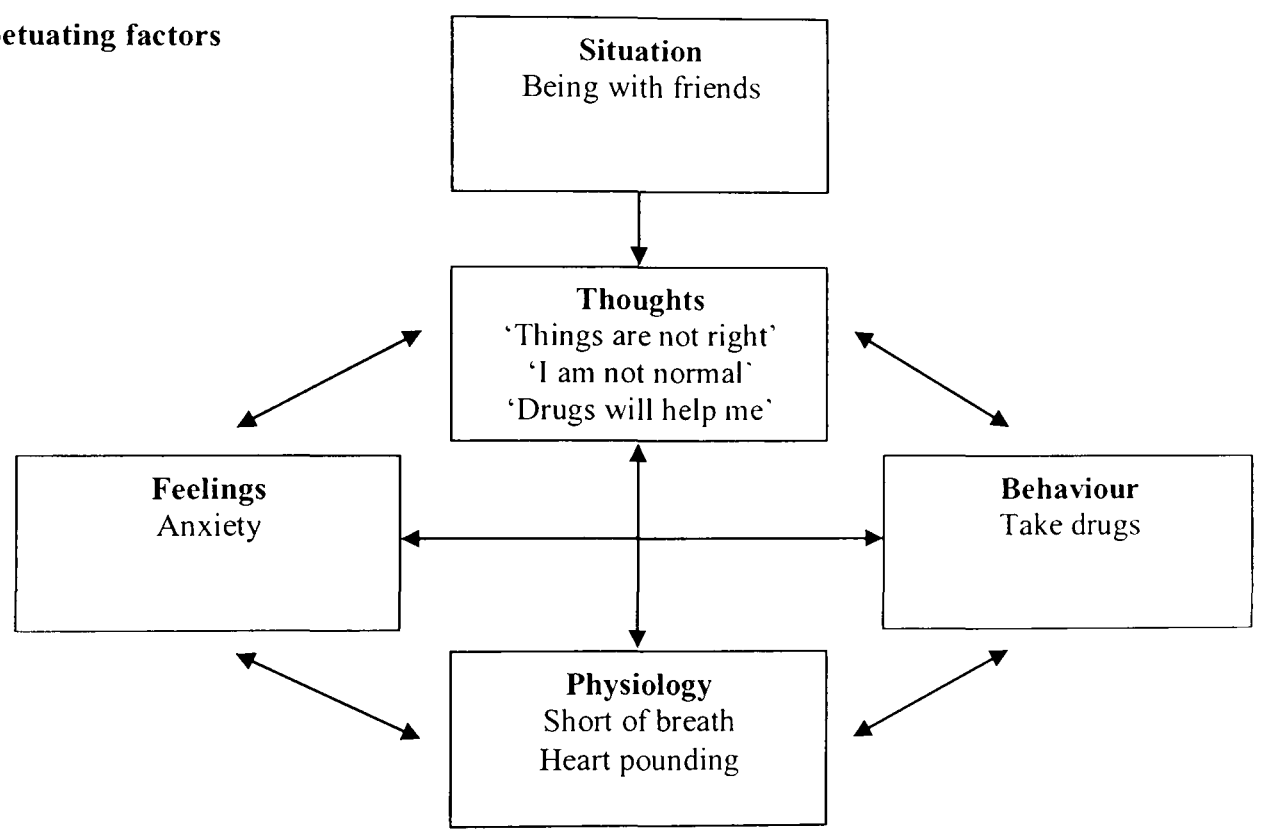
Rules and assumptions or conditional beliefs
If I can make things perfect then everything will be OK

Compensatory strategies
Obsessive neatness
Overanalysing

Precipitating factors

Triggering events
Moving from primary to secondary school
Starting to take drugs

Perpetuating factors



Presenting Issues

Problems
Anxiety
Sudden changes in mood
Feelings of unreality
Escalating drug use

Protective factors

Resilience and strengths
Supportive family and girlfriend who disapproves of drug use
College
Enjoyable work and supportive supervisor
Sports activities

(Dudley and Kuyken, 2005)

Appendix B

Plot outline of 'The Truman Show'

The film is set in a hypothetical world, called Seahaven, where an entire town is dedicated to a continually running television show. All of the participants are actors, except for Truman Burbank, who is unaware that he lives in a constructed reality for the entertainment of those outside. Central characters fake friendship to Truman, and in the case of his "wife", bury their real feelings of disgust.

Truman was chosen out of five unwanted babies to be a TV star. After some years with external filming, producers built a gigantic studio which encapsulates Seahaven. To prevent Truman from trying to escape, his father is "killed" in a staged boating incident to make him afraid of water. Despite Truman's staged relationship with his wife Meryl, he is actually obsessed in finding a girl he met in college who was caught by the producers while trying to explain to Truman the true nature of his life. Eventually, close to the thirtieth year of his life, Truman begins to figure out that it is all fake. Everyone tries to reassure him, but Truman has already reached the point of no return, and tries to escape Seahaven.

Along his path to truth and escape Truman encounters obstacles placed in his way, including choreographed traffic jams, the inability to book any trips, buying a bus ticket out of town where the bus suddenly breaks down, a "leak at the plant", a long bridge to cross, and an artificially created hurricane-force storm on the "ocean". He finally reaches the edge of the constructed reality and exits via a door in the wall, to an audience of millions.

Reference: Wikipedia (n.d.) [Online] Available: http://en.wikipedia.org/wiki/The_Truman_Show [25/04/08]

Part Three

Critical Literature Review

Existing treatment options are failing to prevent the repetition of deliberate self-harm among young people

Introduction

Deliberate self-harm is considered a serious public health problem by health professionals (Hawton and Rodham, 2006). To the wider public, it appears to provoke both fascination and disgust. Certain forms of self-harm such as tattooing, body piercing and ritual scarification are socially sanctioned in some cultures, while other self-harming behaviours are pathologised and condemned. Contemporary Western culture, characterised by its preservation of life at all costs, has come to view self-harm as an irrational behaviour and a social taboo (Rayner and Warner, 2003).

Despite this taboo, or perhaps because of it, deliberate self-harm among young people appears to be increasing. During the 1960s and 1970s the rates of self-injury and intentional overdose in Europe, the USA and Australia increased significantly (Fox and Hawton, 2004; Hurry, 2000). During the 1980s there was a more moderate increase among young people in the UK as a whole, although some studies identified a marked rise in the level of deliberate self-harm among older females within this population (Kerfoot, 1996). This trend appears to have continued, as further increases in the rate of deliberate self-harm among young women have also been identified by more recent studies (Hawton *et al.*, 2002; O'Loughlin and Sherwood, 2005).

It is beyond the scope of this literature review to offer a full examination of the reasons behind this recent rise in self-harm among adolescents. What will be offered is a brief exploration of the phenomenon based on the available literature, firstly by defining the term 'deliberate self-harm' and examining its prevalence in the UK, then by exploring the characteristics of young people who self-harm and outlining some recent developments in treatment to prevent its repetition. Young people's views about their experiences of self-harm and the treatment they have received will briefly be explored, as will some of the implications for Counselling Psychology practice. Finally, some recommendations will be made for further research that could strengthen the available evidence and further improve practice in this area.

What is deliberate self-harm?

The report of the recent national enquiry into self-harm among young people published by the Mental Health Foundation (MHF, 2006) claims that deliberate self-harm affects one in 15 young people in the UK. One 2002 estimate suggested that 25,000 adolescents attend hospital every year in England and Wales (Hawton *et al.*, 2002) while the National Institute for Clinical Excellence claimed in 2004 that there were as many as 150,000 cases (Sutton, 2007). Despite the many thousands of young people engaging in the behaviour as yet there is no standard definition of what actually constitutes deliberate self-harm. Neither of the most widely used systems for the classification of mental disorders, the DSM-IV-TR and the ICD-10, contain specific diagnostic criteria for deliberate self-harm as a separate clinical syndrome (Fox and Hawton, 2004). Self-harm does appear within the DSM-IV-TR (APA, 2000) as a defining criterion of other syndromes, however, most notably borderline personality disorder (BPD). This association does not appear to be particularly helpful as the BPD label has been criticised as pejorative and stigmatising (Sutton, 2007).

The term 'deliberate self harm' itself is contentious and proves difficult to define as there appears to be a lack of consensus as to what actually constitutes self-harming behaviour (Sutton, 2007). A variety of terms such as 'attempted suicide' and 'parasuicide' have been used in previous studies to describe self-harming behaviours (Anderson, 1999; Fox and Hawton, 2004; Hawton *et al.*, 1999b), but these terms are misleading as most young people who self-harm are not attempting suicide at all. The term 'deliberate self-harm' is considered preferable as it encompasses a wide range of different behaviours, from cutting, scratching or burning to more life-threatening acts, such as self-poisoning. Some definitions also include eating disorders and alcohol or substance misuse as self-harming behaviours but they have been excluded from this review as they have already been extensively researched elsewhere and are better understood than other forms of deliberate self-harm (MHF, 2006). Although self-harming behaviour can be life-threatening the intention behind the behaviour is not usually to end life and a distinction should be made between deliberate self-harm and the act of suicide itself.

While deliberate self-harm and suicide have been found to differ in their epidemiology, there is nevertheless a clear link between the two. Around half of those who commit suicide have a history of deliberate self-harm (Ayton, Hufrize and Cottrell, 2003) and 20-25 percent of completed suicides are known to have deliberately harmed themselves during the previous year (Hawton *et al.*, 1998). Deliberate self-harm has also been found to be the single biggest predictor of eventual suicide (Hawton *et al.*, 1999b). Van Heeringen, Hawton and Williams (2000) argue that deliberate self-harm and suicide are not separate issues at all but exist on a continuum, with suicide the potential outcome of increasingly unbearable levels of hopelessness, anger and suicidal thoughts that cannot be contained. One implication of this is that that if deliberate self-harm goes unnoticed and the emotional turmoil that fuels is not dealt with, there is a risk that it could eventually lead to suicide. This clearly has implications for Counselling Psychology, as its practitioners will come into regular contact with troubled young people or adults who may be self- harming and may help to prevent it from escalating, thereby reducing the risk of more serious harm and possibly eventual suicide.

Studies exploring the aetiology of deliberate self-harm suggest that the reasons behind it are varied and complex, but a consensus among professionals seems to be emerging. The Mental Health Foundation report (MHF, 2006) suggests that young people engage in deliberate self-harm because they feel unbearable distress and have no other way to deal with it. The causes of this distress are many and varied and could be due to one or more of a number of factors including bullying, depression, sexual abuse or family problems (Fox and Hawton, 2004). While self-harming behaviour is undoubtedly distressing for the families and friends of those who do it to witness, it is now understood that it provides those who do it temporary relief from intense emotional pain and a release from feelings such as anger and sadness (Bywaters and Rolfe, 2002; Hawton and Rodham, 2006; MHF, 2006).

Once a pattern of self-harming behaviour has been established it has been claimed that biological factors play a role in its maintenance. Smith, Cox and Saradjihan (1998, cited in MHF, 2006) suggest that self-harming releases pain-killing opioid chemicals into the brain that induce a sense of calm and a feeling of well-being. There is no evidence that these chemicals encourage dependency but it is likely that over time a tolerance develops to their effects and increasing levels of pain are needed to achieve the same

result. While such explanations help to explain how self-harm is maintained and increases over time in frequency and intensity, they fail to account for variations in self-harming behaviour between males and females, between young people from different cultures, and between individuals within a single culture. Individual, social and cultural factors all appear vital to a fuller understanding of deliberate self-harm and self-harming behaviour cannot be explained away in terms of biological factors alone. This highlights the shortcomings of a purely clinical approach and presents an opportunity for counselling psychology which can accommodate and work with these social and cultural influences as well as purely biological factors.

The prevalence of deliberate self-harm among young people in the UK

There have been no reliable figures to date on the prevalence of self-harming behaviour among young people in the UK because there are no official statistics nor are there any standardised procedures for collecting data. Even now knowledge of its true extent is still limited as the majority of self-harming behaviour is hidden (Hawton and Rodham, 2006). Young people with superficial wounds do not report their injuries while those who have attempted suicide are much more likely to be in contact with services or to have attended hospital (Hurry, 2000). Most of the data that is available comes from hospital sources and studies using this data reveal a bias towards self-poisoning and underplay or ignore other forms of deliberate self-harm that do not require hospital treatment. A recent study of trends in deliberate self-harm among young people in Oxford over a 10-year period (Hawton *et al.*, 2003) revealed higher levels of self-poisoning than self-injury, as did a 20-year review of data from the Kidderminster area (O'Loughlin and Sherwood, 2005). Performing studies outside of clinical settings would be one way to get a more comprehensive picture but is fraught with methodological problems. The terminology used in such studies has been shown to influence reported prevalence rates, as has whether the method for data collection is anonymous or not (Evans *et al.*, 2005). This may be why existing community-based studies do not appear to be any more reliable than hospital data in revealing the true nature of deliberate self-harm in the UK. The prevalence rates they report vary widely and their results may not be relevant to the UK as most have been conducted in the USA or mainland Europe. One notable exception is the recent schools study by Hawton *et al.* (2002), which used a self-report survey to investigate self-harming behaviour among a

sample of over 6,000 adolescents from 41 schools in the UK. This study provided the most comprehensive and representative picture yet of deliberate self-harm among young people in the UK. Only 12 percent of the young people surveyed who reported an act of self-harm during the previous year had attended hospital and self-cutting was by far the most frequently reported method among both males and females (Hawton *et al.*, 2002). These results suggest that hospital presentations represent only a minority of cases and indicate that deliberate self-harm among young people is a much more widespread and largely hidden problem.

Deliberate self-harm has been shown to have a higher prevalence amongst particular population groups. It has been assumed for some time, for instance, that deliberate self-harm is more common among young women than among young men (Evans *et al.*, 2005; Clarke *et al.,* 2001; Hawton *et al.*, 2003). These findings are largely based on studies of self-poisoners in clinical settings, however, and the majority of these are young women. Young men are more likely to deal with their feelings in other ways that do not necessarily get recorded as self-harm, such as increased risk-taking, aggression or alcohol abuse (Hawton and Rodham, 2006). Webb (2002) suggests that a gender bias in the research exists as a result and that to date much of the study of adolescent self-harm is actually the study of female adolescent distress, and that the needs of young men may be being overlooked. While hospital data continue to show a bias towards females (Hawton and Harriss, 2008) some community based studies using self-report measures have found equivalent rates among males and females (Gratz, 2001; Meltzer *et al.,*2004) and challenge the idea that deliberate self-harm is a predominantly female problem. This finding has spurred an interest in the characteristics of self-harming behaviour peculiar to young men which appears to be an area that warrants further research.

Research suggests that particular minority groups may be at greater risk of deliberate self-harm as some hospital studies have identified particularly high rates among young Asian women (Hawton and James, 2005; Marshall and Yazdani, 1999). The recent schools study by Hawton *et al.* (2002) found however that Asian young women were less likely to self harm than their white peers. Marshall and Yadzani (1999) point out that Asian culture is itself diverse and that it is dangerous to make assumptions on the basis of shared cultural identity alone. Where ethnic groups form a large proportion of

the local population, deliberate self-harm has been shown to be less frequent than in areas where they are in the minority (Hawton and Rodham, 2006). This suggests that deliberate self-harm among minorities may be more directly related to the stresses of social prejudice and marginalisation than their membership of a particular culture, although no firm conclusions can be drawn without further studies being done.

The psychosocial and health characteristics of young people who deliberately self-harm

The reasons behind deliberate self-harm are complex and it is difficult to attribute the behaviour to a single cause (Fox and Hawton, 2004) however research studies have identified a number of psychosocial and health factors that contribute to an increased risk.

Psychiatric disorders and deliberate self-harm are closely related and the co-morbidity of two or more disorders during adolescence has been shown to be associated with an increased risk of deliberate self-harm (Hawton and Rodham, 2006). Childhood trauma or abuse is also often cited by young people as a reason for their self-harm (Bywaters and Rolfe, 2002, Hawton *et al,* 2002) and maltreatment in childhood is one of the most widely reported causal factors (Sutton, 2007). In the schools study by Hawton *et al.* (2002) adolescents who experienced physical abuse were four times more likely to report deliberate self-harm than their peers. Deliberate self-harm has been characterised as a way of outwardly expressing the inner torment experienced by survivors of childhood trauma or abuse (Babiker and Arnold, 1997) and a way of speaking the unspeakable (McAllister, 2003).

Depression and hopelessness are particularly strongly linked to self-harming behaviour (Burgess, *et al.*, 1998; Kerfoot, *et al.*,1996; Webb, 2002) although Kerfoot (1996) found that depression often remits following an episode of self-harm. A study by Hawton *et al.* (1999) revealed that young people with a history of repeated deliberate self-harm scored higher for depression and hopelessness and lower for self-esteem when compared with non-repeaters. Not all young people who are depressed or feel hopeless engage in self-harm, however, and a systematic review of research literature (Webb, 2002) suggests that depression and hopelessness should not be viewed in isolation. When depression

was controlled for, impulsivity, poor problem-solving and family problems emerged from the review as factors that distinguished self-harmers from control groups. While there is no indication that they actually cause self-harm by themselves, these psychosocial factors may increase the risks by intensifying existing feelings of hopelessness or depression. It appears that depression or hopelessness alone are not sufficient explanations for deliberate self-harm, but that there is a complex relationship between these and a number of other contributory factors and that social circumstances as well as individual factors may need to be taken into consideration.

Certain individual characteristics such as problem-solving ability and impulsivity have been associated with an increased risk of deliberate self-harm. People who self-harm perform poorly on means-ends problem-solving tests and have overly generalised autobiographical memories (Evans, 2000), suggesting that those who self-harm have fewer mental resources to draw on in dealing with their problems. Repetition also appears to be related to perceived problem-solving ability as repeat self-harmers have been shown to rate themselves lower than non-repeaters in terms of ability and effectiveness at problem-solving (Hawton *et al.*, 1999). Addressing this perceived problem-solving deficit would appear to have the potential to reduce the repetition of deliberate self-harm. Impulsivity has been found to be a common trait among young people who poison themselves (Fox and Hawton, 2004; Hawton and Rodham, 2006; Webb, 2002) and attempted suicide is often an impulsive act. Similar results were found in a schools survey by Hawton *et al.* (2002), which revealed that young people who cut themselves were also likely to do so impulsively.

Relationship problems, especially within the family, are a significant factor in all self-harming behaviour and are especially pertinent to young people. Hurry (2000) reports that among children under the age of 16, conflict with a parent accounts for 50-75 percent of all deliberate self-harm, while among those aged 15-24, relationship problems with boyfriends or girlfriends become more significant. Conflict between parents or family members can also be a contributory factor, although its effects appear more pronounced for females than for males (Hawton and Rodham, 2006).

While the importance of family relationships is not to be underestimated, during adolescence the influence of the family diminishes and the importance of the peer group

increases. In the recent UK schools study by Hawton *et al.* (2002), having a friend who had recently self-harmed was one of the strongest predictors of self-harming behaviour. Males were seven times more likely to self-harm if a friend already did it and females were four and a half times more likely. Self-harming behaviour is known to occur in clusters and appears to spread in institutional settings such as children's homes. An infection model has been proposed to explain the increased risk of deliberate self-harm in such situations (Hawton and Rodham, 2006) but nothing is known about the psychological processes involved.

There is substantial evidence that the way self-harm and suicide is portrayed in the media can also exert a powerful influence on behaviour, especially in young people. There are many examples of variations in the rates of deliberate self-harm which have been linked to the way stories, both real and fictional, have been reported. In 1988 a study of hospital presentations for self-poisoning revealed a 17 percent increase the first week and 9 percent the next following a single episode of the television hospital drama *'Casualty'* that featured a paracetamol overdose (Hawton *et al.*, 1999a, cited in Hawton and Rodham, 2006). Of the patients surveyed, 20 percent admitted that watching the episode had influenced their decision to poison themselves. This ability of the media to influence the decision to self-harm appears to work both ways and has been used elsewhere to tackle suicidal behaviour. Organisations across the world have collaborated with local media in developing good practice in the reporting of suicidal behaviour and this has already led to successes in terms of reduced suicide rates (Sonneck, G., Etzerdorfer and Nagel-Keuss, 1994, cited in Hawton and Rodham, 2006). It appears that stories focusing on deliberate self-harm, if handled correctly, may also present the opportunity to model positive coping strategies and help-seeking that could exert a powerful positive influence on young people who self-harm.

It appears that there are a number of different psychosocial and health factors that can influence self-harming behaviour and it is best viewed not as a symptom of a particular disorder but as the result of an interaction of the personal characteristics of the young person with his or her social circumstances and environment. The nature of environmental stressors, their perceived meaning and the behavioural reaction of the young person all appear to contribute to this interaction.

Approaches to treatment

A number of treatment options for deliberate self-harm currently exist but many require several appointments and compliance with treatment is poor. Only a small minority of young people who deliberately self-harm appear to enter treatment in the first place as most do not have any contact with services at all (Hawton *et al.*, 2002). Given the diverse nature of this heterogeneous group, it is no surprise that there is currently no consensus as to the appropriate treatment for deliberate self-harm amongst young people. Deliberate self-harm is a behaviour, not a diagnosis, and as such there is no standard treatment for it. A number of systematic reviews evaluating the effectiveness of various types of treatment have been published but the literature is limited and no clear conclusions can be drawn from it (MHF, 2006). One such review (Hawton *et al.*, 1998; Hawton *et al.*, 1999b) criticised the small sample sizes involved in the studies it examined and stated that they made it impossible to detect a statistically significant relationship between experimental and control groups, even when the results of similar studies were synthesised via meta-analysis. Despite the lack of clear conclusions the authors reported promising results for problem-solving therapy and emergency card provision, although their recommendations did not address the specific needs of young people. Most systematic reviews of this type include adults as well as young people and are based mainly on studies of hospital presentations. These represent only a small proportion of those who self-harm and include a disproportionate number of people who poison themselves compared to those who use cutting, bruising or burning. A recent review of the literature focusing exclusively on self-cutting (Scottish Development Centre for Mental Health, 2005) found no recorded evidence-based treatment for those who repeatedly cut themselves.

Problem-solving therapy

A perceived deficit in the problem-solving abilities of people who engage in deliberate self-harm has led to the creation of interventions designed to improve patients' cognitive skills using cognitive behavioural techniques. A meta-analysis of six randomised controlled trials comparing problem-solving treatments with standard care (Townsend *et al.* , 2001) revealed significant improvements in scores for depression and

hopelessness amongst experimental groups at follow-up and a significant number of patients offered problem-solving therapy also felt that their problems had become less severe. These studies included adults as well as young people, however, and most involved small sample sizes. No firm conclusions can be drawn from these results about the efficacy of problem-solving therapy for young people who deliberately self-harm. In fact, there is evidence from neurological research which suggests that the problem-solving abilities of adolescents may be impaired by changes occurring in the brain. The onset of puberty brings with it sudden changes to the parts of the brain regulating emotion, while those regulating cognitive control remain undeveloped. This introduces the adolescent to powerful emotional responses that he or she may have difficulty coping with (Young Minds, 2006). These changes may help explain some of the peculiar stresses that young people face during adolescence and also suggest that adolescents who self-harm may not benefit as much as adults from problem-solving therapy because of their impaired cognitive abilities. Given the promising results of problem-solving therapy with adults, this appears to be an area that merits further investigation.

Emergency card schemes

Immediate access to services may also provide an alternative to deliberate self-harm for people with poor problem-solving skills and difficulty regulating their emotions. This has led to the creation of 'emergency card' schemes offering immediate access to psychiatric services as an alternative to deliberate self-harm. One trial providing emergency cards to young adolescents presenting with deliberate self-harm yielded positive results, but the sample size was too small for the results to be significant (Cotgrove, Zirinsky, Black and Weston, 1995, cited in Hawton and Rodham, 2006). Since Hawton *et al.* (1999b) reported promising results for emergency card provision, a large randomised controlled trial has been conducted with adults that achieved positive results for first timers, but led to an increase in self-harm among those with a previous history. This effect may be due to the numbers of repeat self-harmers in the trials with a personality disorder, as their excessive sensitivity might lead them to perceive the emergency card as a form of rejection and reinforce dysfunctional thoughts and behaviour including deliberate self-harm (Evans, 2000).

Dialectical Behaviour Therapy

Dialectical Behaviour Therapy (DBT) is a particularly intensive form of cognitive behavioural therapy that was developed in the USA to help people with borderline personality disorder who engage in repetitive self-harm. A full programme of DBT involves a year of intensive therapy alongside group sessions, social skills training and emergency contact. It has been found to be particularly effective with adult women (Hawton *et al.*, 1999b) and promising results were also found in a study of adolescent inpatients, who reported fewer behavioural problems than a control group offered psychodynamic therapy (Katz *et al.*, 1994). Although these results are promising, the results cannot be generalised and there is a need for further research to determine whether this form of therapy is also effective with adolescents and with outpatients in the UK.

Medication

The presence of depressive symptoms and poor impulse control in those who deliberately self-harm have led to the trial use of certain drugs in an attempt to address these symptoms and prevent its repetition. There is evidence that the serotonin system plays a role in deliberate self-harm and paroxetine, a selective serotonin re-uptake inhibitor (SSRI), was used in one clinical trial (Evans, 2000). Other SSRIs, especially fluoxetine, have been shown to be effective in the treatment of adolescent depression, one of the major risk factors for deliberate self-harm (Hawton and Rodham, 2006). There has been serious concern however since unpublished evidence from previous trials revealed an increase in self-harm and suicidal thoughts associated with the use of most SSRIs with fluoxetine the sole exception. This presents particular problems for those treating adolescents at risk of or engaged in deliberate self-harm. Clinical guidelines from the National Institute for Clinical Excellence (NICE, 2005) state that adolescents diagnosed with moderate or severe depression should be offered cognitive behavioural therapy (CBT), interpersonal therapy (IPT) or short-term family therapy and that medication should only be used alongside a therapeutic intervention. Hawton and Rodham (2006) state however that there are not enough suitably trained therapists to fulfil this requirement at present. The shortfall of suitably trained therapists suggests

a gap in provision that could offer opportunities for suitably trained counselling psychologists interested in working with young people who deliberately self-harm.

Family therapy

Many young people who deliberately self-harm have family problems and arguments with the family are the most commonly reported trigger for self-harming behaviour. Family therapy is an approach to problems that focuses on improving communication and problem-solving within the family. In theory this should work to everyone's advantage, allowing young people who self-harm to feel valued and understood and allowing their families to better understand the issues involved. In practice, there is only limited evidence for the effectiveness of family therapy in treating deliberate self-harm in young people. In one study comparing family therapy with routine psychiatric care, the experimental group received four home visits during which the family were asked to focus on communication and problem-solving (Harrington *et al.*, 1998). No significant differences were found between the two groups in terms of repetition of deliberate self-harm, but interestingly parents were more satisfied with family therapy than with standard care. It appears that four sessions of family therapy may have a beneficial effect on the family as a whole but in this case did little to address the self-harming behaviour of adolescents themselves. Given the secretive nature of self-harming behaviour it is likely that a therapeutic relationship will take some time to develop and it could be that four sessions did not allow sufficient time for this to occur. Further studies offering more prolonged interventions would help to address this issue.

Group therapy

Group therapy has been tested in one study with adolescents who repeatedly self-harm (Wood *et al.*, 2001). Young people were randomly assigned to treatment in groups using a variety of therapeutic techniques or to routine care. Routine care consisted of a variety of interventions delivered by either a psychologist or Community Psychiatric Nurse and included family sessions, counselling and pharmacological interventions where clinically indicated. At follow-up, those who received group therapy had fewer episodes of repeated self-harm and fewer behavioural problems than the control group. There were no differences in the levels of depression between the experimental and control

groups, however, suggesting that successful behavioural changes may have been a function of the group rather than any individual improvement. Nevertheless these findings suggest that group therapy may be an effective way to address self-harming behaviour and provide a promising foundation for future research in the area.

Young peoples' views and experiences

No account of deliberate self-harm among young people would be complete without some attempt to represent the views of young people themselves. These often differ from those of professionals, who may have only a partial understanding of the problem that can be further distorted by prejudicial views and stereotypical attitudes towards young people. Young people face a number of pressures and adolescence is a time of particular emotional turmoil (Young Minds, 2006). On top of this young people who deliberately self harm can also suffer prejudice as a result of a lack of understanding and judgemental attitudes about their behaviour. It is not surprising to learn that young people consulted by the national enquiry into deliberate self-harm revealed that they find it hard to talk about their behaviour and are often afraid of the reaction that they will get. Young people who had disclosed to adults mostly did so to their doctor or teacher (MHF, 2006) and many were unhappy with the reaction they received. People who self-harm do not appear to expect to be treated well by professionals and are particularly sensitive towards any perceived judgement or rejection. This is illustrated by young peoples' belief that accident and emergency staff treat them as if they were wasting their time (Bywaters and Rolfe, 2002). It seems that the perceptions of young people about professional attitudes towards them are important as any perceived rejection could lead to self-harm. Further research into young people's perceptions and professional attitudes towards those who self-harm would help shed further light on these issues.

Young people's reasons for self-harming are varied and complex (MHF, 2006) and qualitative studies exploring young people's attitudes towards their own self-harm reveal a variety of reasons given for their behaviour (Bywaters and Rolfe, 2002). A study of seven Asian young women in Newham identified four diverse themes from their research (Marshall and Yazdani, 1999). These were taking control, ending it all,

effecting change and as a coping strategy. The fact that such diverse meanings were attributed to deliberate self-harm, even among such a small and relatively homogenous sample, reinforces the notion of self-harm as a complex issue that defies categorisation. As the authors of the study point out, it also highlights the need to further consider the similarities and differences within particular sub-groups and avoid labelling people on the basis of a socially constructed identity.

While the current attention focused on deliberate self-harm by young people should be welcomed given the scale of the problem, current treatment approaches have been criticised by those who receive them because of their focus on the behaviour rather than on them as an individual. Young people interviewed about their experiences have complained that treatment was unhelpful and even damaging for them. They criticise its failure to address the circumstances which caused their behaviour and complain that it resulted in even greater levels of distress (Marshall and Yazdani, 1999; Bywaters and Rolfe, 2002). This could be related to the feeling of control that young people say deliberate self-harm can provide. Young people seem tofear that disclosing their self-harm will make their previously private behaviour public and they will lose control of it as others will try to stop them from harming themselves. This causes considerable distress as they are afraid that their only coping strategy will be taken away from them and this increased distress is likely to increase deliberate self-harm (MHF, 2006). Young people have singled out psychiatric services and social services as particularly unhelpful because of the amount of compulsion and control they use, such as removing sharp objects and the use of sanctions to prevent self-harm (Bywaters and Rolfe, 2002). They argue that it would be more helpful to give young people responsibility for their own behaviour.

Young people's experiences of treatment have not been wholly negative, however, and research highlights some aspects which young people who deliberately self-harm have found particularly useful (Bywaters and Rolfe, 2002; Sinclair and Green, 2005). Talking to a psychologist or counsellor appears to have proved particularly useful for some, but not all, young people as some were reluctant to because of the uncomfortable memories or feelings it would provoke. The attitude of services and professionals, regardless of the service they offer, has also been found to be significant. Young people who deliberately self-harm report positive experiences when they feel that they have been

treated with respect and that the person they were dealing with showed tolerance and tried to understand their point of view (Bywaters and Rolfe, 2002). In one qualitative study young people contrasted their difficulties in forming new therapeutic relationships with the comfort and familiarity of existing relationships of trust with their doctor or school counsellor (Sinclair and Green, 2005). It would appear from these findings that what is of paramount importance for young people who deliberately self-harm is the quality of their relationship with a professional rather than the mode of treatment offered. Counselling psychologists seem well placed to offer appropriate interventions because of the central importance of the therapeutic relationship to their practice and their focus on developing an understanding of the client's own world of lived experience.

The recent schools survey by Hawton *et al.* (2002) revealed that 53 percent of young people who engaged in deliberate self-harm did not seek help beforehand. Fortune *et al.* (2005) reported on the reasons why these young people had not previously tried to get help. Many appeared to believe they could cope on their own or intended to sort their problems out for themselves, and this was found to be especially true for boys and those engaged in self-cutting rather than other forms of self-harm. Others were worried that once they had disclosed their behaviour someone would try to stop their self-harm, they would not be taken seriously or that services would not be able to help. A further question asked why they did not seek help afterwards. The majority replied that their circumstances had changed and that they no longer felt that they needed to self-harm. These findings suggest that many young people are prevented from help-seeking because of their beliefs about how they will be treated. Their behaviour may be preventable if services are made more accessible to them by addressing these fears. They also highlight the fact that sometimes deliberate self-harm is an isolated incident and that some young people who deliberately self-harm may not need help at all. Further research focusing on those who do not access services is needed to identify how they might be better supported within the community.

The national enquiry into self-harm among young people recognised that recovery is a long, slow process and that the main goal for many is to achieve a general sense of well being which may initially include some form of managed self-harm (MHF, 2006). Recovery from deliberate self-harm is a long, slow process. It claimed that young

people consider success in terms of positive action and getting help and support to move on from their current difficulties rather than stopping their self-harm altogether (MHF, 2006). In the short term, young people have said that distraction techniques can help them to 'surf the urge' and wait until the emotions that have built up gradually fade away. The techniques used to do this will vary according to the individual and the type of deliberate self-harm that they normally engage in, but a majority of young people consulted by the national enquiry into self-harm said that they had found techniques that worked for them (MHF, 2006). This approach would appear to be particularly useful for young people who cut themselves, as they are less likely to seek help than those attempting suicide and would benefit most from being able to manage their own behaviour. This has implications for professionals who work with young people as they have to balance their duty of care with the perceived needs of young people who deliberately self-harm. Attempts to prevent deliberate self-harm can prove counterproductive as making abstention a condition of treatment or hiding the tools used have been shown to make the behaviour worse (MHF, 2006). Contracts prohibiting self-harming behaviour are viewed as particularly unhelpful as they take away choice and control from the client (Sutton, 2007). Counselling psychologists working with young people who self-harm have to consider therefore how they are going to respond to the behaviour.

Issues for Counselling Psychology

Therapeutic guidelines for the treatment of deliberate self-harm place great emphasis on the therapeutic relationship (Babiker and Arnold, 1997; Sutton, 2007) and in particular creating a safe environment. Trust is a particular issue for many people who deliberately self-harm who have difficulty trusting others and can believe that they do not deserve to be treated well (Sutton, 2007). While contracts prohibiting self-harm may not be a good idea, clear and consistent boundaries are essential so that trust can develop. To work effectively with young people who self-harm in helping them manage their own behaviour counselling psychologists will need to be familiar with and adhere to the ethical guidelines of their registering body, usually the British Psychological Society (British Psychological Society, 2006). In addition, they should be familiar with child protection legislation and the issue of consent to treatment. This will ensure that clear

and consistent professional boundaries are maintained while allowing young people the choice and control needed to learn and apply more adaptive coping mechanisms.

As the majority of young people who self-harm do not seek help for their behaviour it is likely that a counselling psychologist's first contact with a young person who self-harms will be in relation to some other problem such as depression or anxiety. Their self-harming behaviour may be hidden or not immediately recognisable as such, particularly if the client is male. Counselling psychologists should already be vigilant for the signs of emotional distress and where this is present or perhaps unexpectedly absent asking about self-harm creates the opportunity for the client to talk about it. Creating an environment where the behaviour can be acknowledged encourages acceptance which is an important first step towards self-management (Alderman and Marshall, 2006; Babiker and Arnold, 1997).

Working with deliberate self-harm can provoke strong reactions and be a distressing experience for all involved. Maintaining effectiveness in this context demands that the counselling psychologist attends to his or her own needs by seeking support through regular and appropriate supervision and maintaining an adequate balance between work, play and rest (Sutton, 2007). As Turp (1999) points out, therapists tend to defend against distress and this may interfere with the ability to be fully with the client. Babiker and Arnold (1997) stress the importance of being aware and dealing effectively with the feelings generated by deliberate self-harm.

Many young people who engage in deliberate self-harm do so because of traumatic experiences in childhood (MHF, 2006). Repeated exposure to traumatic material can lead to vicarious traumatisation, an internalisation of the client's pain which can have a significant impact on a therapist's personal and professional performance (Alderman and Marshall, 2006). It is vital therefore that those working with young people who self-harm monitor and attend to their own emotional needs.

Counselling psychologists also need to be prepared to face the very real threat that an episode of deliberate self-harm may accidentally lead to the death of a client. It is estimated that over 20 per cent of trainees encounter a clinical situation involving suicide during training (Schwartz and Rogers, 2004). Client suicides have been shown

to have a considerable impact on the mental health of counselling psychologists (Schwartz and Rogers, 2004). The prevalence of self-harming behaviour among young people with depression, low self esteem or other mental health problems demands that counselling psychologists working with this age group possess the skills to assess and evaluate suicide risk. There is evidence that these skills may be lacking, however, as the results of a study by Reeves, Wheeler and Bowl (2004) exploring risk assessment training for counsellors found that one third of the courses examined did not consider different theoretical perspectives on risk assessment for suicide or self injury, suggesting a serious skills deficit in this area.

On a brighter note, counselling psychology may present an opportunity to succeed in addressing deliberate self-harm where previous treatment options have failed. Its phenomenological approach based on humanistic principles offers what young people who deliberately self-harm say they want from treatment services, to be respected and treated like a person (Bywaters and Rolfe, 2002). At the same time, counselling psychologists also possess the skills to be able to apply the evidence-based treatments that have been shown to be effective, such as problem-solving therapy or even elements of Dialectical Behaviour Therapy. It is important however for counselling psychologists working with young people who deliberately harm themselves not to expect that they stop self-harming immediately unless that is what they want to do. It would appear that a more collaborative approach that allows young people a degree of control and the opportunity to take responsibility for their own behaviour may be more likely to result in a positive therapeutic outcome.

Conclusion and recommendations

The term 'deliberate self-harm' has been shown to describe a wide range of body-focused behaviours, from cutting, burning or bruising to self-poisoning. Much of the available literature has focused on self-poisoners in hospital settings, however, and it is only recently that larger community-based studies have begun to explore the issue in a wider context and confirmed that deliberate self-harm is a widespread and hidden problem among young people in the UK. Current gaps in the research that have been highlighted by this review include:

- How the problem-solving abilities of young people relate to their deliberate self-harm
- The characteristics and needs of specific sub-groups of young people engaged in self-harm, particularly young men
- How the majority who do not access services might be helped to manage or reduce their self-harming behaviour
- The attitudes of health professionals towards young people who deliberately self-harm

In response to the growing problem of deliberate self-harm among young people, a number of treatments have emerged during recent years aimed at reducing repetition among high-risk groups (Hawton *et al.*, 1999b). These have met with mixed success and no clear picture has emerged from the clinical studies or subsequent systematic reviews that have been conducted so far. What is apparent is that despite greater awareness about the problem, the majority of adolescent self-harm remains hidden and treatment approaches are currently marred by the reluctance of young people to remain engaged with them or to approach services for help.

Once young people's own views are taken into account, it becomes apparent that the reason they do not approach services is because they do not trust them. Many of those that have disclosed their self-harm appear unhappy with the response that they received and others fear that they will lose control of the one thing that they feel helps them to cope with their unbearable distress.

Young people find it hard to disclose their self-harming behaviour for a number of reasons. They need the response they receive to be non-judgmental, caring and respectful. Many counselling psychologists who possess these qualities will come into contact with young people who are anxious or depressed and therefore at risk of deliberate self-harm. These encounters provide a valuable opportunity to assist young people in the effective self-management of self-harming behaviour provided that counselling psychologists are able to attend to their own emotional needs.

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